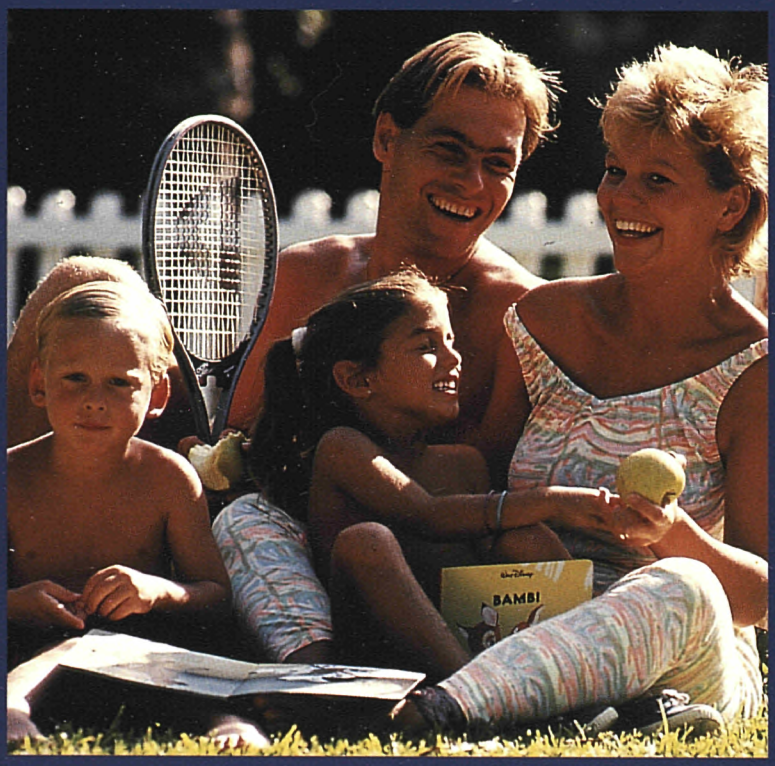
Public health in Europe

Public health



Employment & social affairs

European Commission

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European Commission
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Preface

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This issue of the 'Employment and social affairs' series focuses on public health and the work we are doing to give effect to the new competence in this area that the Treaty on European Union gave to the Community.

Almost immediately after the Treaty came into force in November 1993, the Commission took the first step towards implementing its public health provisions by adopting my proposal for a series of priority programmes within an overall framework for action in the field of public health.[1] A large part of that framework has now been put into place.

The health problems facing the Community are too urgent and too large in scale to allow complacency. Every year in Europe millions die prematurely or suffer ill health from serious conditions that could have been prevented. At the same time health systems throughout the Community are coming under increasing strain as a result of the mounting demands being made upon them and the difficult financial situation that Member States are facing. The pressures of having to cope with rapidly changing medical technology, with an ageing population with ever-growing needs for health care and social support and with people's constantly rising expectations about health services are therefore forcing Member States to take sweeping measures to reform their health systems and to control costs.

Against this backdrop, Community policies must be geared to supporting Member States in their efforts to make their health systems as effective as possible so that the health of the population is protected and improved. We must also ensure that our actions have practical value for individual citizens by, for example, working to secure the continuity of services across internal borders. To make a real impact on this situation implies a continuing and growing long-term effort and commitment both by the Community and by the Member States individually. Viewed from that perspective, our work to date is an important first step.

Indeed, it is now time to begin thinking about what the future will hold. So, in close contact with the Member States, we are now beginning discussions in order to determine the strategy to be followed in the first years of the new millennium.

I hope that this issue of the series devoted to public health will help bring to the fore both what has already been achieved and the main problems that remain to be resolved. In this way it can help inform public discussion and debate on public health and show how the issues to be faced and the actions we are taking are not only of the greatest importance in their own right, but are also vital elements of the Community's social policy as a whole.

Pádraig Flynn

Member of the European Commission with responsibility for employment and social affairs

[1] COM(93) 559 final of 24 November 1993.

I

Public health policy in the European Union

Public health in today's European Community

It is one of the great paradoxes of public health in the European Community today that while the population has never been healthier, the demand on Member States' health systems, and thus the tendency towards increased expenditure, is ever-growing and expenditure on health is being constantly forced upwards. The Community's public health strategy has been developed against this background and is designed to reflect and respond to the problems which are putting pressure on Member States' health services; pressure which is likely to become even greater in the future.

Pressure on health services

What are the causes of this pressure? The first of these is that of ageing populations. The falling birth rate and lengthening life expectancy means that progressively there will be larger numbers of elderly people who are disproportionate users of health services. Not only do elderly people need more medical treatment services than younger people, but they also make more demands on social and health-care services. Moreover, the effect of the ageing population is made more acute because it also means that the burden of paying for these services will fall increasingly on a relatively smaller working population.

Second, the development of powerful new technologies for diagnosis and treatment, including new and costly pharmaceutical products, has a considerable impact on health-care expenditure. The use of new technology does not always involve greater costs per patient or course of treatment. Indeed with, for example, increased use of day surgery and out-patient care, these costs may well drop. However, the technology is also leading to a much larger number of patients being treated for a much wider range of conditions, with the result that it is adding to the overall costs of health care.

Third, and linked to the improvements in therapy, there are rising expectations among the public about what health services can provide, and rising demands about what they should provide. One factor behind this is the growing knowledge of and interest in health of the ordinary citizen resulting notably from improved health education and information activities. Another is the increasing awareness of differences in levels and standards of provision within and between Member States resulting from increasing travel and mobility.

Fourth, increasing population mobility can be a factor in the spread of communicable diseases and may also lead to the establishment of migrant communities which have particular health needs that can put increased strain on local health services.

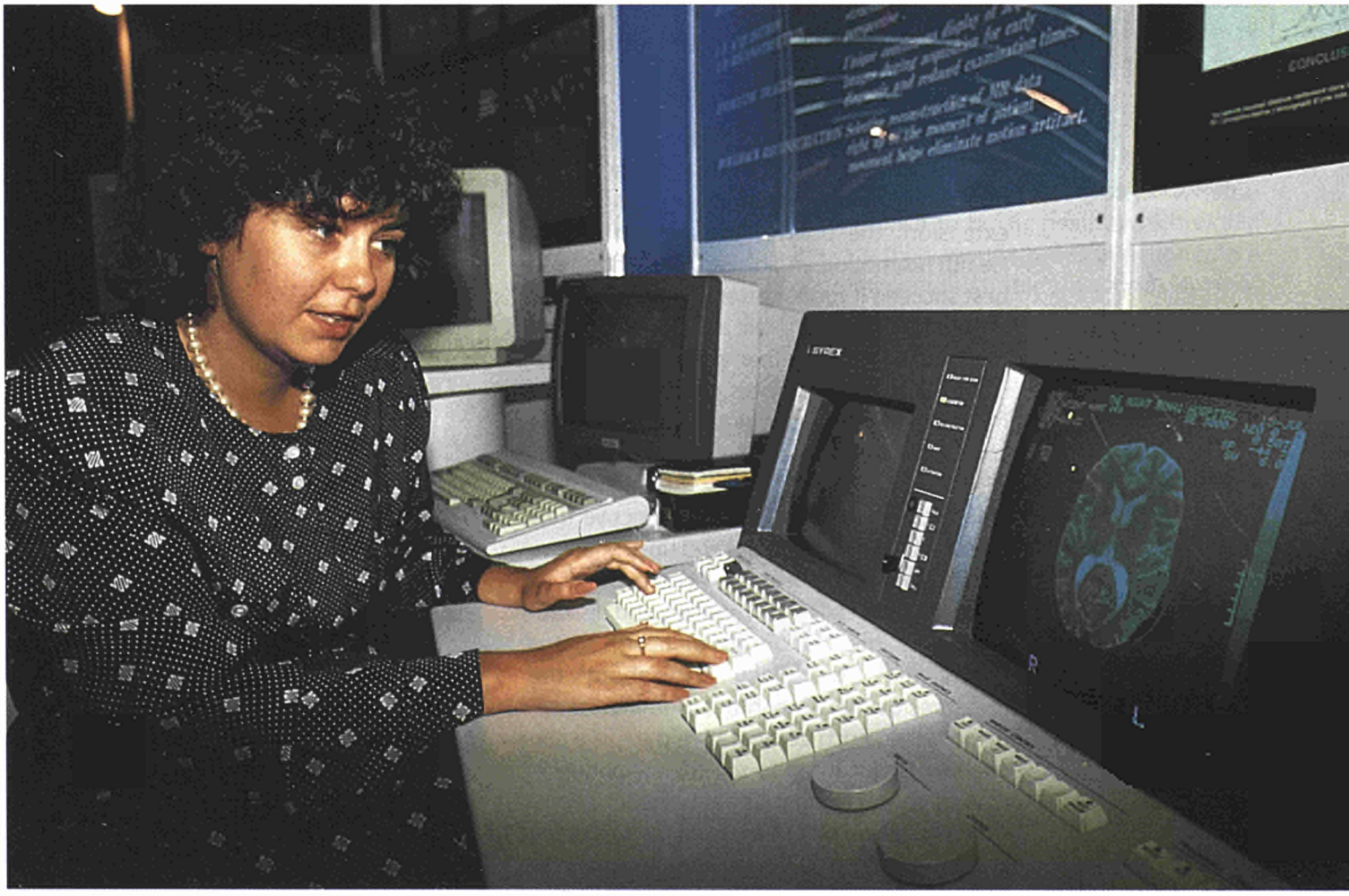
Finally, there are mounting levels of certain diseases which arise in part from changes in the natural and working environments, such as rising levels of asthma and allergic disorders and certain forms of cancer, as well as the return of certain communicable diseases which had almost been vanquished, such as tuberculosis.

Health expenditure

As a result of these developments health spending has risen rapidly in the Community over the last two decades, although it is now tending to stabilize, the Community average in 1991 being 7.4% of GDP. Moreover, this has been happening at a time when Member States are facing serious economic difficulties, such as slow growth and persistent high levels of unemployment. The pressures on public finances have led Member States to place constraints on public expenditure, including health and social benefits.

In recent years Member States have made strenuous efforts to control the rise in health expenditure and in certain cases, notably Sweden and Ireland, have managed to stabilize or even to reduce health-care spending as a proportion of GDP. Some States have tried to control health spending by taking measures to reduce what is supplied, for example by limiting the numbers of doctors being trained, limiting the range of drugs they can prescribe, or imposing charges on patients. A number have introduced wide-ranging reforms of their health systems and methods of financing health care. But although controlling expenditure by these means can help to improve the efficiency of the health system, it does nothing to remove the underlying pressures.

The development of powerful new technologies for diagnosis and treatment has a considerable impact on health-care expenditure.



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One way to reply to such pressures is to place greater emphasis on prevention of disease and promotion of health. It is a truism that prevention is better than cure, but it is also true that it is likely to be more effective in financial terms in the active part of the population. It has been calculated that smoking is responsible for half a million deaths each year in the Community. Over-indulgence in alcohol, poor and unbalanced diets and lack of physical exercise are other important contributors to morbidity and thus to the demand for health services. If one adds to these drug abuse, sexually-transmitted diseases, traffic, work and domestic accidents, the effects on health services are only too apparent.

It is exactly in these areas that the public health work of the Commission can make a significant impact. And it can do so in several ways. First, the actions in our programmes can complement and strengthen the prevention and promotion activities in the Member States. We can, for example, help organizations to join with others in multinational work, so promoting exchanges of ideas and experience and spreading best practice. In addition, the use of European weeks, for instance, can provide a focus and catalyst for activities in the Member States.

Second, as we are urged to do by the Treaty, we can bring attention to bear on the health aspects of other Community policies and, by extension, the policies of Member States. Health promotion and disease prevention can best succeed if proper attention is paid to the environmental, economic and social determinants of health together with actions to increase people's awareness of their impact on health and to address any potentially adverse consequences.

Third, for health policies to be effective they must be based on accurate and up-to-date information. We can help the Member States by improving the collection, analysis and dissemination of information about health status across the Community and about the measures being taken in the Member States. By providing such comparative data, we can enable all concerned to see their situation in a wider context, and thus gain a better appreciation of the effectiveness of their actions and the extent of the problems they have to face. We can also help draw attention to specific issues that would not be so evident if viewed from a purely national perspective.

In conclusion, the work that the Community is doing in public health is still at a very early stage, but it is already clear that its emphasis on prevention and promotion is of great value in complementing the actions of the Member States and in helping them to overcome the difficulties they face today, and will progressively face in the future.

Integration of health requirements in Community policies

The growing importance of health at the level of the European Community has been increasingly recognized by its progressive addition to the texts of the Treaties. The European Coal and Steel Treaty of 1952 did not contain any mention of health. Yet it rapidly gave rise to social research covering health and safety at work, based on its Article 55. In contrast, the Euratom Treaty, adopted five years later, contains an entire chapter on health and safety, and this led to the development of ionizing radiation standards designed to protect the general population and workers.

Introduction

As regards the EEC Treaty, one of its underlying objectives is that of raising the standard of living (Article 2), which clearly has a health dimension. Community legislation based on this Treaty has given rise to a significant body of legislation with a health component. This includes dangerous substances, pharmaceutical products or foodstuffs. The Single Act strengthened the legal basis for measures relating to health protection, in particular by extending the scope of Community action to the health and safety of workers, environmental and consumer protection and the requirement for legal measures establishing the market to ensure a high level of health protection.

The Treaty on European Union, which amended the Treaty establishing the European Community, continued the gradual evolution of Community policy on health. First, the specific Community competence on public health as provided by Articles 3(o) and 129 of the EC Treaty opened up, for the first time, the prospect of developing a consistent Community approach to public health which would integrate the various strands of action into a coherent overall strategy. Second, it introduced or strengthened provisions in a number of policy areas with an impact on health such as transport, consumer protection and education.

An important element of the new public health competence provided for in Article 129 of the Treaty is the link it creates with other policy areas: 'Health protection requirements shall form a constituent part of the Community's other policies'. This puts an obligation on the Community institutions and the Member States to take health requirements into account when agreeing Community policies.

Photo: © Isopress

One of the underlying objectives of the EEC Treaty is that of raising the standard of living (Article 2).

A structure for consultation and coordination

The Commission has already set up a mechanism to respond to this obligation. When developing policies, services themselves are obliged to ensure that health requirements are met by their proposals. Under Commission rules, they are then required to proceed with a consultation on proposals with a bearing on health. The Commission Interservice Group on Health serves as a forum for discussion and information exchange for the Commission services on health-related questions. Finally, the Commission reports annually on the integration of health requirements into the different areas of policy. This is supported by the European Parliament, which, in its Resolution on the medium-term social action programme, called upon the Commission to present guidelines on incorporating health protection requirements into the other Community policies. In 1995, the first of these annual reports — covering activities in 1994 — was adopted by the Commission. A second report dealing with 1995 followed in 1996. These reports are unique in the Community and a model on which similar efforts could be undertaken in the Member States. In welcoming the first report, the Council regarded it as an important step towards giving effect to the provisions of Article 129 and reaffirmed the need for coordination, consistency and complementarity for all Community activities with a health dimension. The Council suggested a number of priority areas for future reports and called upon the Commission to provide an early and transparent evaluation of the impact of Community policies on human health.

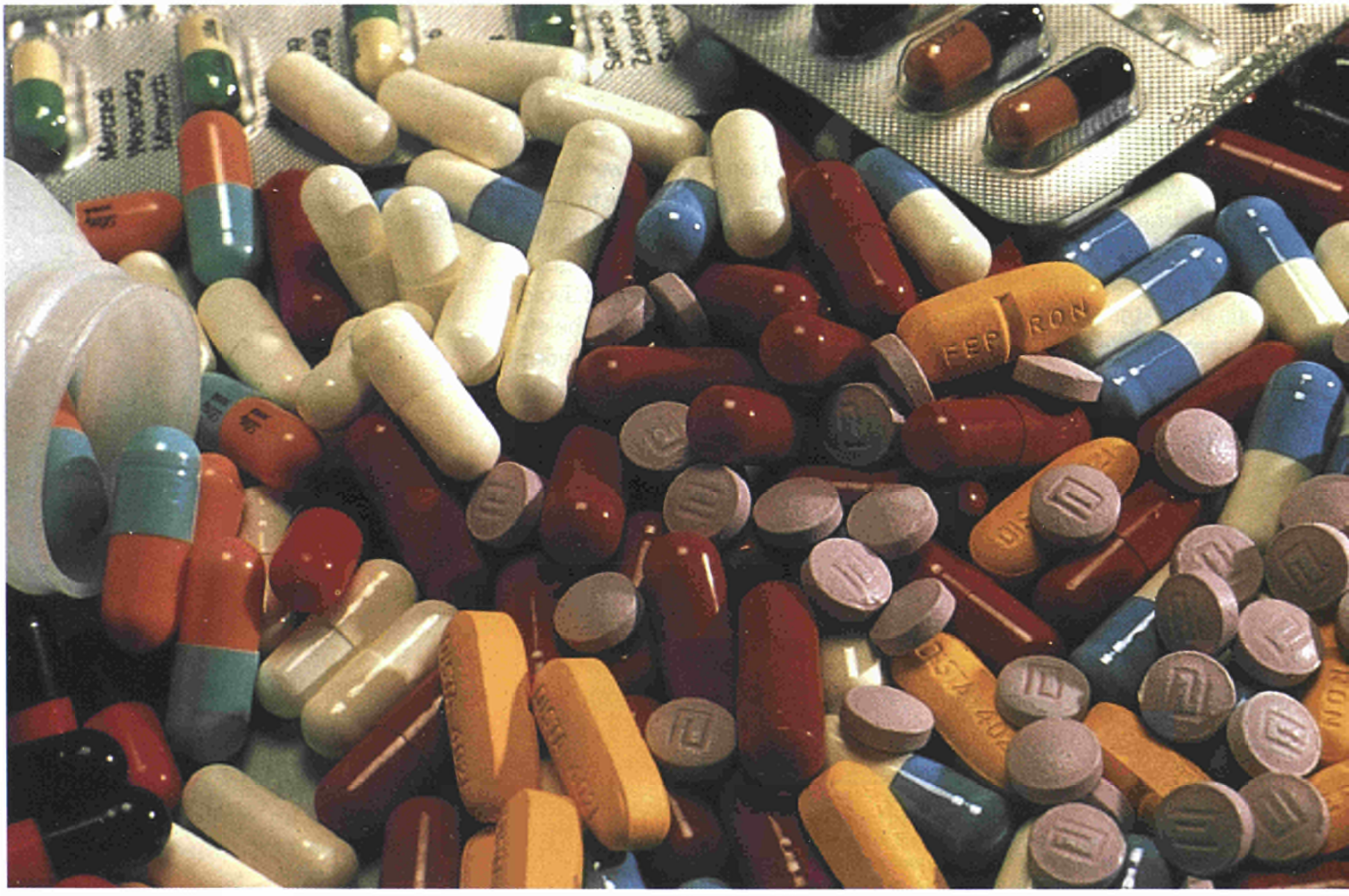
The reports attempt to give an overview of all areas of Community policy with repercussions on health. Ideally, they should spell out clearly the health implications in qualitative and, if possible, quantitative terms. This is not always possible, as is the case in the 1994 report. Often, there will not be a clear recognition of the health dimension of a certain policy area. But, as such reports become an annual exercise, these initial difficulties should gradually be overcome.

The reports cover almost all areas of Community activity but concentrate on those areas which are considered as having the most bearing on health. In 1995 these were social policy, the internal market, agriculture, food and fisheries, research and development, environment, energy and transport, as well as international cooperation.

Interaction between health and other activities

The result of these activities is that, for the first time, a clearer picture is emerging of the different ways in which public health and other Community activities interact. In the first place, it can clearly be seen that other Community policies can have a considerable impact on public health. This is the case for policies which are not primarily directed at health protection, but at rather different areas such as transport and energy. Other policies may have a more direct influence, such as measures leading to the improvement of the quality of the environment or activities in agricultural policy.

Pharmaceuticals is an example of an area where supplementary public health activities concerning their role in the public health system may be needed.



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The reports demonstrate, secondly, that other Community policies which have an impact on health may themselves need to be complemented by public health measures to ensure that their consequences on health are as beneficial and effective as possible. One example is the area of pharmaceuticals, where supplementary public health activities may be needed concerning, for example, their role in the public health system, and also concerning labile blood components.

Thirdly, the reports demonstrate that the converse is also true, namely that public health activities themselves need to be accompanied by measures in other areas if they are to be fully effective. HIV/AIDS provides an interesting example of this. As a global and multifaceted phenomenon, AIDS requires a response spanning a number of areas of policy. The Community's public health actions, which cover the areas of prevention, education and support, are therefore complemented both by a large-scale commitment within the Biomed programme and by a programme of AIDS-related development cooperation.

Finally, the reports illustrate how Community policies can contribute to improving human health while maintaining a balance between economic and social interests.

By outlining interrelationships between different policy areas, the reports aim to reinforce the intersectoral coordination of health protection aspects in Community policy. Such coordination can increase synergy and avoid duplication of effort and thus improve the efficiency and effectiveness of the operations undertaken to the benefit of all Community citizens.

An ongoing task

Council meetings devoted to health have now become a regular feature of the European Community agenda. The wide range of topics that are now discussed by Health Ministers demonstrates their interest and involvement in dossiers that are important to them both at national level and in the Community context. This is also reflected in the demand from the general public for more information on health matters. To satisfy these demands the Community has to continue to develop its response to the obligations laid down by Article 129 of the Treaty on European Union. The Commission has already set out a strategy which allows a gradual implementation of the provisions of the Treaty and adaptation to changing conditions and needs. The success of this policy, however, depends on the willingness of all concerned to achieve these aims as quickly as possible.

Report on the state of health in the European Community

In July 1995, the Commission produced its first report on the state of health in the European Community.[1] This report presents an overview of health in the Community at the end of 1994, including a description of the main demographic trends and patterns of morbidity and mortality, and a discussion of the main determinants of health. It also contains information about some of the major Community activities which have implications for health.[2] The Commission's intention, as set out in the communication on the framework for action in the field of public health, is that these reports will be published each year. General overviews, like the first report, will be produced at intervals of about five years to reflect important new developments and changing trends. But in the other intervening years each report will focus on one specific issue. The 1995 report concentrates on women's health in the Community.

Vehicles for information

In presenting this first report, Pádraig Flynn set out its objectives in the following words: 'This report reveals clearly the main factors influencing people's health in the Community and what needs to be done to improve it further. It is vital that messages about the causes of ill health and death are widely understood. This report will help get those messages across. It is an important step towards fulfilling the commitment we have made to provide accurate information about the health situation in the Community'.

In short, the Commission sees these reports as important vehicles for the provision and dissemination of key health information. Such information can be used to underpin the development of policies and the selection of priorities both at Community level and in Member States, for example by helping to establish a baseline against which new trends and developments in health — both good and bad — can be assessed.

Specifically in terms of health promotion and disease prevention, the reports can assist in focusing the attention of health professionals and the general public on the key messages and issues about the determinants of health and the causes of ill health. Finally, the reports will also help to explain to the citizens of the Community the reasons behind our public health strategy and make the impact of our actions more visible.

[1] COM(95) 357 final of 19 July 1995. A full colour version of the report has been published by the Office for Official Publications of the European Communities.

[2] The report does not cover the three new Member States since it is based on work carried out before their accession.

Demographic change

Several main themes emerge from the first report. The first is that of the importance of demographic change and its impact on health. Throughout the Community, life expectancy is increasing: the average was 76.5 years in 1991. Women are living longer than men: in 1991, the average male life expectancy was 73 years, while for women it was just under 80 years. Differences still remain between Member States in life expectancy, but these have narrowed greatly in the last 20 years.

The infant mortality rate has also been falling; the Community average is under 10 per thousand. These welcome trends have, however, been accompanied by a significant fall in the fertility rate since the 1970s. The result is that the population is ageing: the proportion of children in the population is falling and the numbers of old people both in absolute terms and as a proportion of the total population are rising.

In the Community the numbers of old people both in absolute terms and as a proportion of the total population are rising.

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In the next 15 years the proportion of people aged 65 or over is projected to rise from 15 to 17%, which will be matched by a fall in the proportion of those aged 15 to 64.

This ageing of the population has important consequences for the provision and financing of health services. Older people consume more health services than younger people and the increase in the proportion of the elderly and very elderly therefore means that there will be greater pressure on services and at the same time fewer people of working age to pay for them.

Premature deaths

A second major theme is that, despite the lengthening in average life expectancy, too many people in the Community are dying prematurely. One fifth of all deaths occur below the age of 65. It is also striking that between the ages of 15 and 34, three times as many men die as women. The main causes are heart disease, strokes, cancer and accidents. Many factors are responsible, but there is no doubt that lifestyle and risky behaviour play a key role.

It is well known, for example, that cigarette smoking is responsible for much ill health and very many deaths. Yet in 1992, despite the great efforts that have been made to deter people from smoking, across the Community as a whole as many as 42% of men and 28% of women were smokers. Moreover, although the general trend in the Community is for fewer men to smoke, more women appear to be doing so. This may well lead to a rise in premature deaths among women.

Differences across the Community

A third theme is that of the substantial differences that exist in patterns of mortality and morbidity within the overall Community population. Differences persist between Member States, between areas within individual Member States and between population groups. The report contains some notable examples of these. In terms of behavioural determinants, for example, there are large variations between countries. Only 12% of women in Portugal smoke, compared to 42% in Denmark. Some 55% of men in Greece smoke, but only 35% in the UK and Ireland. There are similarly wide disparities in relation to alcohol consumption. For example, the average consumption per head in France in 1990 was 12.6 litres, compared to 7.4 litres in Ireland.

There were similarly very large differences in causes of mortality and morbidity. For example, in 1992, the rate of recorded suicides was nearly seven times higher in Denmark than in Greece, and the occupational accident death rate was over five times as high in Italy and Luxembourg as in Ireland and the Netherlands.

Another important determinant of health status is socioeconomic status. There is evidence that people with higher income and educational levels have longer life expectancy and lower mortality rates. The report cites a survey in Germany, for example, which suggested that blue-collar workers had a life expectancy of some two years lower than that of white-collar workers.

Finally, the report emphasizes the wide variety of influences on people's health. These include the environment, the social and economic context, the structure of health service provision in a country, individuals' genetic make-up and their behaviour.

The importance of prevention and promotion

In the light of this complex range of factors which affect health, the report reaches the conclusion that to improve the health status of the population of the European Community the provision of effective health care and treatment is likely to be of less importance than preventive and promotion measures addressing the relevant behavioural, economic and social issues.

Public health framework programme — Article 129

Under the Treaty on European Union, the European Community was given a new competence in public health. Article 3(o) of the Treaty establishes a broad aim of making 'a contribution to the attainment of a high level of health protection', and Article 129 then goes on to set out how the Community should pursue this aim.

Under the Treaty, the Community is required to make a contribution towards ensuring a high level of health protection. The main vehicles for doing so, under Article 129, are:

(i) the encouragement of cooperation between the Member States and, if necessary, the provision of support to their action;

(ii) the promotion of coordination of policies and programmes of the Member States in the areas of disease prevention, research into causes and transmission of diseases, health information, and health education;

(iii) the fostering of cooperation with third countries and the competent international organizations in the sphere of public health.

The communication on public health

The Commission set out how it intended to implement the new provisions in its communication on the framework for action in the field of public health (COM(93) 559), which was published in November 1993. The first part of the communication describes the context in which Community public health strategy has to be developed. This includes the principles that govern Community action, such as subsidiarity and proportionality, and also the demographic background, the determinants of health and the present pattern of, and main trends in, Community mortality and morbidity.

A number of significant problems are identified which are increasing the pressure upon Member States' health systems. Clearly the Community could not, and should not, attempt to address every major health problem at the same time. Indeed, to be effective Community actions must be properly focused. The communication therefore puts forward a number of criteria on which to base the choice of priorities. These are:

(i) a disease's impact on mortality and morbidity;

(ii) a disease's socioeconomic impact;

(iii) how far a disease is amenable to effective preventive action, and of particular importance;

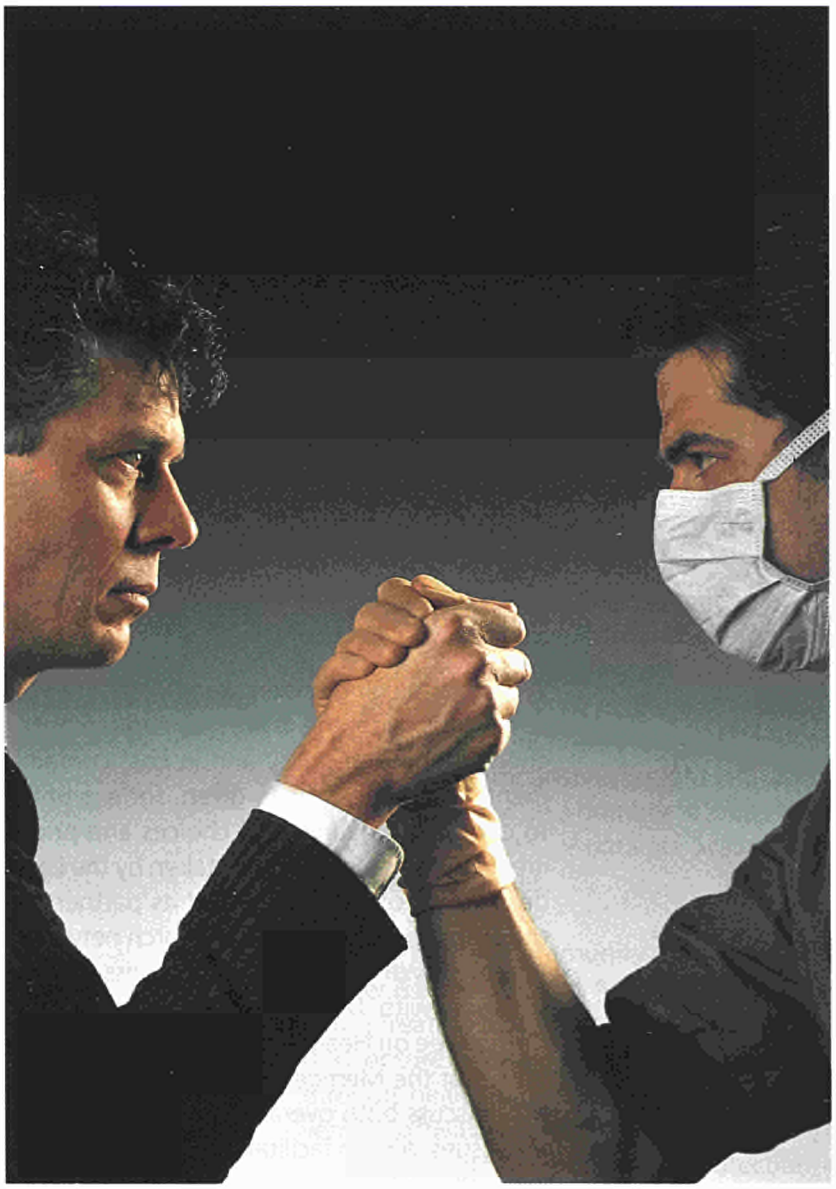
(iv) how far there is scope for Community actions to complement and add value to what is being done by the Member States.

Priority action programmes

On the basis of the analysis of the general health situation and in the light of the criteria advanced, the communication proposes that the Community's public health strategy until the end of the century should be centred on the development of eight action programmes. Of these, six would focus on specific disease areas and health problems — the major scourges mentioned by the Treaty. But, in order to help cement the overall strategy and ensure that these disease-specific programmes worked in a synergistic manner, they were to be complemented by two further 'horizontal' programmes, one on health monitoring and the other on health promotion.

The strategy set out in the communication was given a broad welcome by the other Community institutions, and in the last two years considerable progress has been made in bringing it into effect.

Five of the eight proposed action programmes have so far been put forward by the Commission. Of these, three have now been adopted by co-decision and are being brought into effect. These are the programmes on AIDS and other communicable diseases and on cancer, together with the horizontal programme on health promotion, information, education and training. It is expected that the programme on drug dependence will be adopted by co-decision shortly. The Commission's proposals for the fifth programme on health monitoring were published in October 1995. This programme contains three parts: the establishment of a set of health indicators, the creation of an electronic network for the dissemination of data, and the development of the capacity to undertake analyses of information. It is currently under consideration in the co-decision procedure, and it is hoped that it will be adopted soon for implementation from 1997.



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Article 3(o) of the Treaty establishes a broad aim of making 'a contribution to the attainment of a high level of health protection'.

Finally, work is in hand on the preparation of the three remaining action programmes proposed in the communication. These are on rare diseases, pollution-related diseases and accidents and injuries. The Commission will be putting forward its proposals on these programmes shortly.

One important aspect of all these action programmes is the emphasis placed on their thorough evaluation; and in this connection work is currently under way aimed at developing possible mechanisms for the evaluation and assessment of public health measures.

Other initiatives

In addition to these action programmes, the public health strategy contains several other important elements which are also referred to in the communication. These include work on the setting-up of a network for the surveillance and control of communicable diseases at Community level, on which the Commission has put forward a proposal, and on cooperation concerning blood safety and self-sufficiency in the Community. The Commission has also committed itself to the production of two annual reports: first, on the state of health in the Community and, second, on the integration of health protection requirements into other policies. The first such reports were published in 1995.

Work is also being undertaken to assist Member States with the issues of fundamental choices in health policy and in cost containment. Support has been given, for example, to comparative surveys of choices and priorities in Member States undertaken by the London School of Economics and its partners in the European health policy research network. As a means of developing the process of consultation with Member States, a high-level Committee on Health, consisting of representatives of the Member States, meets regularly to discuss both overall strategy and particular issues, and so facilitate such cooperation. In parallel, an initiative is under way aimed at discovering more about the general public's views on the effectiveness of their national health systems and their priorities for spending on health by means of a Eurobarometer survey. The results of this survey will be available in 1997.

These actions together amount to a substantial programme of work. When it is combined with actions under way elsewhere in the Commission — for example, the Biomed research programme, the work on consumer protection and on the environment — it should make a significant contribution to the efforts being made across the Community to protect and improve public health.

A new Community action programme on health monitoring

The collection of health indicators, such as infant mortality and life expectancy, dates back to the second half of the 17th century, when the majority of deaths were due to infectious diseases. This century's developments in public health, standards of living, and medical advances have to a large extent reduced or even eradicated these scourges. As a result, the traditional health indicators have come to be viewed as insufficient to portray the health status of a population. Consequently, the last few decades have seen the development and proliferation of a large number of health indicators.

Background

Today every country in the European Community collects a variety of health indicators. Moreover, international organizations, particularly the World Health Organization (WHO) and the Organization for Economic Cooperation and Development (OECD), collect a number of health data and indicators at the national level. Yet despite this proliferation of health data and indicators, the much desired goal of obtaining accurate and comparable data remains elusive. Many of the data that do exist are collected by different methods and indicators are defined differently, making cross-country comparisons fraught with problems. Furthermore, in a number of areas there are virtually no data, or data are available for only a few countries.

Why is this a Community concern? The answer is to be found in Articles 3(o) and 129 of the Treaty which state that the Community is to 'ensure a high level of health protection' through health promotion and disease prevention activities. One of the prerequisites for ensuring a high level of health protection is knowledge about the health problems facing citizens in the European Community. Appropriate measures to monitor health and its determinants, as well as a capacity for the monitoring and evaluation of actions, are therefore needed.

In its communication of 24 November 1993, the Commission defined a framework for Community action in the field of public health in order to attain the objectives on health protection contained in the Treaty. This framework identified a number of priority areas for Community action. Among these priorities was the development of appropriate health data and indicators.

The action programme on health monitoring

Addressing itself to this priority, the Commission recently (October 1995) launched a new initiative to establish a Community action programme on health monitoring. The proposed programme, for which ECU 13.8 million over five years is earmarked, has three aims:

(i) to permit measurement of health and health determinants throughout the Community and comparisons with third countries;

(ii) to facilitate planning, monitoring, implementation and evaluation of Community programmes and actions;

(iii) to provide Member States with high-quality, comparative health indicators and appropriate health information which support and add value to their national health monitoring systems and contribute to the development of national health policies.

To achieve these objectives, the development of a Community health monitoring system is proposed, involving the establishment of a set of health indicators, a network to collect and disseminate the data, as well as a capacity to undertake analyses of the health indicators.

The health indicators collected would consist of two types, core and background. Core indicators are those essential to Community health policy, such as on health status and health determinants (for example, alcohol and tobacco consumption). Background indicators are linked indirectly to public health but are nevertheless important for health policy purposes. As priorities change over time, the indicators to be collected (both core and background) will have to cover a wide range to permit a good understanding of the interplay of various factors impinging on health and allow future problems to be anticipated.

One of the prerequisites for ensuring a high level of health protection is knowledge about the health problems facing citizens in the European Community.

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The principles behind the system

The development of the Community health monitoring programme is to be guided by a number of principles. The system should:

(i) build on readily available European data and indicators, such as those held by Member States, international organizations, notably the WHO and OECD, and the Commission;

(ii) avoid any unnecessary duplication of work: the work already being carried out by international organizations, European networks and the Commission should be mutually complementary and congruent;

(iii) avoid imposing unnecessary burdens on Member States which already transmit health data to a number of international organizations, networks and the Commission;

(iv) carefully assess available options for developing the various parts of the system with respect to the costs and benefits involved;

(v) be as flexible as possible in order to be capable of adapting to future changes in needs and priorities;

(vi) respect data protection requirements.

A Community-wide electronic network

The principles guiding the development of the health information system have a number of implications, in particular as regards the mechanism for collecting and disseminating the health data and indicators. In order to minimize the burden of data collection imposed on Member States, and to provide the most cost-effective method of data collection and dissemination, the Commission intends to promote the development of a Community-wide electronic network which would link the competent authorities in the Member States. Such a system would also have the advantage of providing Member States with easy and timely access to the health information contained in the system.

Under the ENS-CARE programme of the third framework programme on research and technological development, the infrastructure for such a system was developed in a pilot project. This infrastructure is in the process of further development under the programme of telematic interchange of data between administrations (IDA). The IDA health network is being designed so as to ensure compatibility with the needs of the health monitoring programme.

Uses of the health data and indicators

The data to be contained in the proposed Community health information system would be of little value if they were not put to good use. The Commission therefore intends to build the capacity to undertake a variety of analyses, including health status and health trends reports, analyses of specific health problems and health determinants, and analyses of the impact on health of other policies. These analyses would make a useful contribution to the further development of Community policies.

Conclusions

The proposed Community health monitoring programme is intended to fill an important gap in the information currently available at Community level. The programme involves a major developmental effort, which means that considerable time is likely to elapse before the proposed Community health monitoring system becomes fully operational, even if the programme starts as expected in 1997.

A safe and secure blood supply

Of the many public health issues facing Member States, perhaps the one that elicits the strongest feelings among the citizens of the Community is the safety of blood. Since blood donation first came to be viewed as an altruistic gesture and blood transfusion became an integral and indispensable part of medical treatment, the general public and the health-care community came to count on its relative innocuousness. It was only with the onset of the AIDS pandemic and confirmation of the direct link between blood and the human immunodeficiency virus (HIV), which causes the disease, that such complacency was shattered.

Community self-sufficiency

Fully recognizing the immense importance of safeguarding public health while ensuring the free circulation of the vital medicinal products industrially prepared from human blood and plasma, within the internal market of the European Community, the Council of Ministers adopted Directive 89/381/EEC[1] to ensure the quality, safety and efficacy of these products. The Community, through this Directive, also committed itself to the goal of reliance upon its own citizens, through voluntary unpaid donations, for the blood and plasma required both for direct transfusion and for the preparation of medicinal products. This has become known as Community self-sufficiency.

Following an extensive survey[2] of the situation regarding self-sufficiency in the Member States, the Commission informed the Council[3] that in 1989 the Community was self-sufficient in the labile components used for transfusion but that there was a significant deficit in the source plasma used for the preparation of medicinal products. Subsequent surveys carried out on the situation in 1991[4] and 1993[5] supported these findings, although there is evidence that some progress is being made, albeit slowly.

1 Council Directive 89/381/EEC, OJ L 181/44, 28.6.1989.

2 Collection and use of human blood and plasma in Europe. W. G. van Aken, Council of Europe, 1993, p. 31 (ISBN 92-871-2240-7).

3 Communication from the Commission to the Council, the European Parliament and the Economic and Social Committee on blood self-sufficiency in the European Community (COM(93) 198 final (Brussels) of 25 May 1993, p. 13).

4 The collection and use of human blood and plasma in the European Community in 1991. W. G. van Aken, July 1994, European Commission, EC/LUX/V/F/159/94, p. 39.

5 The collection and use of human blood and plasma in the European Community in 1993. F. M. Delaney, November 1995, European Commission, EC/LUX/V/F/1/33/95, p. 43.

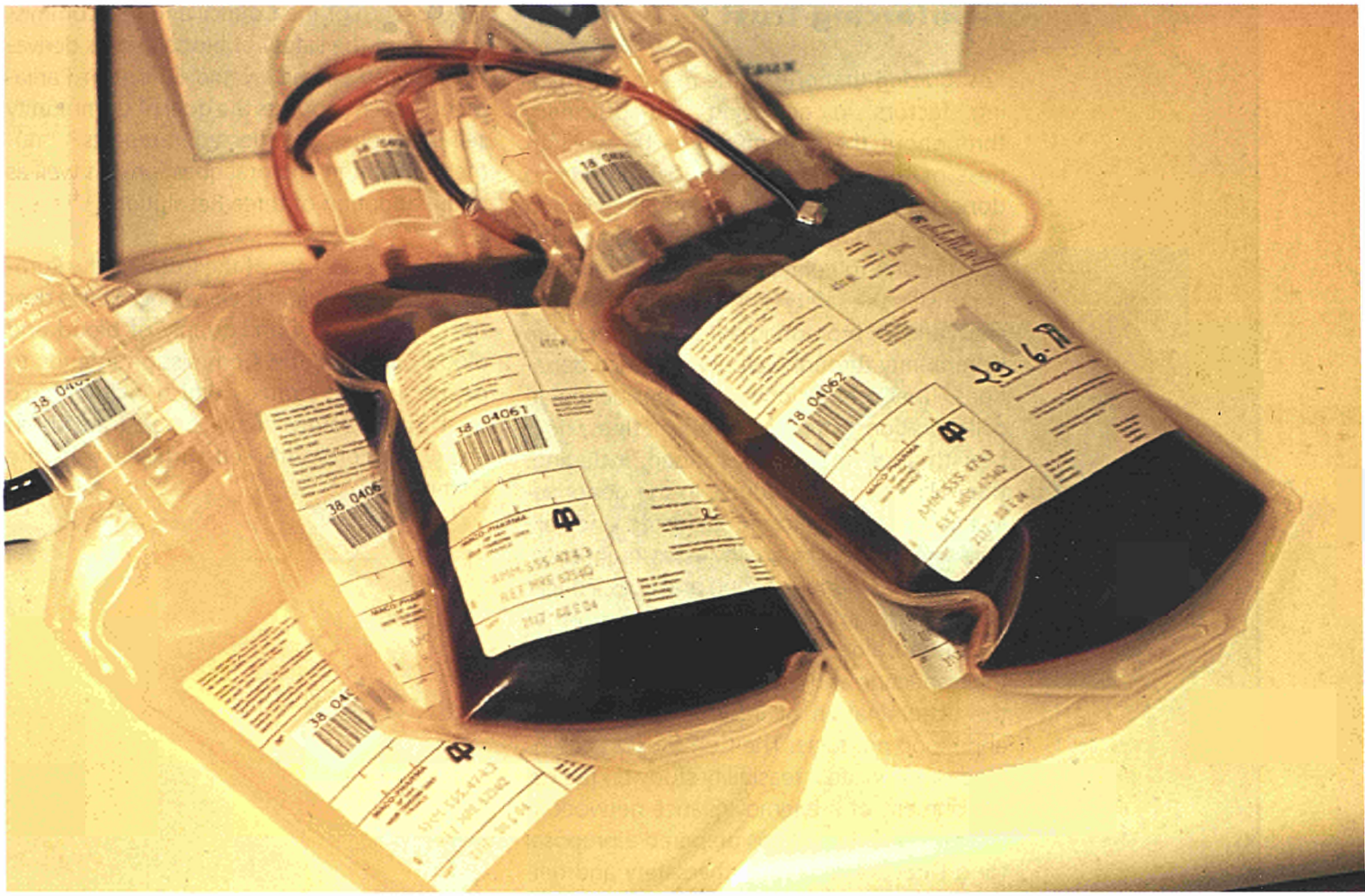


Photo: © Isopress

The Community has committed itself to the goal of reliance upon its own citizens, through voluntary unpaid donations, for blood and plasma.

Reaffirming the need to achieve self-sufficiency through cooperation between Member States, the Council, in its conclusions (94/C15/03)[1] on blood self-sufficiency in the European Community, also agreed, *inter alia,* to continue to promote the quality and safety of blood collection and blood-derivative production. It requested the Commission to report on the legal provisions and current practices in the Member States regarding the collection, control and treatment of blood and the distribution of and trade in blood and blood products with a view to proposing common safety criteria. Recognizing that Directive 89/381/EEC specifically excludes whole blood, plasma and blood cells of human origin, the Commission's report[2] to the Council addressed the safety aspects of the entire blood transfusion chain, and identified issues and problems that required further attention. The report also presented the significant findings of a survey[3] carried out in 1994 among some 13 000 European citizens aged 15 or over, on a nationally representative basis in 12 Member States, regarding their perception and understanding of questions relating to blood. The findings of this survey showed that, while Community citizens are reasonably well-informed about blood itself, there is a considerable number of misconceptions and lack of information regarding blood-related issues. Among them is the erroneous fear of contracting HIV/AIDS from a blood donation and the general lack of awareness about the Community's goal of self-sufficiency through voluntary unpaid donations.

1 OJ C 15, 18.1.1994, p. 6.

2 Communication from the Commission on blood safety and self-sufficiency in the European Community (COM(94) 652 final (Brussels) of 21 December 1994).

3 Eurobarometer 41, Europeans and blood, INRA (Europe), February 1995, p. 69.

Reinforcing trust

Recognizing that one of the major determining factors in achieving self-sufficiency throughout the Community is the willingness of the citizens of the Community to donate, the Council, in its Resolution (95/C 164/01)[1] of 2 June 1995, called on the Commission to define a strategy for reinforcing trust in the safety of the blood transfusion chain and for promoting self-sufficiency in the Community through voluntary unpaid donations. The Commission is now considering, in collaboration with the Member States, how best to address the issues raised, including: the policies and procedures in the donor selection process; efficient, validated and reliable screening tests; quality assessment criteria and good manufacturing practices; educational programmes related to optimal use of blood and blood products; basic criteria for the inspection and training of inspectors; and the dissemination of information on blood and blood products. The Commission has already authorized a feasibility study on the establishment of a haemovigilance network in the Community and has prepared a proposal for a Directive regarding the safety and reliability of *in vitro* diagnostic medical devices which cover reagents and equipment specifically intended for the examination of blood.

The concern of the Council and the Commission about the safety of blood and its derivatives is also shared by the European Parliament, which supports the goal of Community self-sufficiency, as reflected in reports,[2, 3] numerous written and oral questions, as well as in the adoption of three Resolutions.[4, 5, 6]

Sharing the concern of the Council, the European Parliament and the Member States over the quality, safety and supply of blood and blood products, the Commission intends to define a blood strategy which will reinforce trust in the safety of the blood transfusion chain and promote self-sufficiency in the Community.

1 OJ C 164, 30.6.1995.
2 Report of the Committee on the Environment, Public Health and Consumer Protection on self-sufficiency in and safety of blood and its derivatives in the European Community. A. Ceci, European Parliament, 25 February 1993 (A3-0075/93), p. 20.
3 Draft report of the Committee on the Environment, Public Health and Consumer Protection on the communication from the Commission on blood safety and self-sufficiency in the European Community. C. Cabrol, European Parliament, 25 October 1995 (EP 214.692), p. 10.
4 OJ C 268, 4.10.1993, p. 29.
5 OJ C 329, 6.12.1993, p. 268.
6 EP Resolution on blood safety in the European Union (EP 192.561, pp. 38-40).

II

Cancer

The 'Europe against cancer' programme and its third action plan (1996-2000)

Community action against cancer began in 1985 when the Heads of State or Government, recognizing the severity of its impact on the European population, called on the European Commission to define a common strategy to fight the disease.

Introduction

The Commission responded with the 'Europe against cancer' programme, which was adopted in 1987 and was the first Community initiative in the field of health. The programme has since been implemented through multiannual action plans, with specific priority objectives.

The first action plan ran from 1987 to 1989 and was followed by a second for the period 1990 to 1994. These plans focused on four areas: cancer prevention, screening and early detection, training of health professionals and support for cancer research.

The third action plan, which covers the period 1996 to 2000 has been adopted by the European Parliament and the Council,[1] provides for the natural continuation and further development of the measures carried out in the earlier action plans, but also contains some new elements, deriving from the ratification in November 1993 of the Treaty on European Union.

The new framework for Community action in the field of health

The third action plan to combat cancer was the first Community programme to be presented by the Commission under Article 129 of the Treaty on European Union. It is a follow-up to the Commission communication on the framework for action in the field of public health (COM(93) 559 final), which also includes measures to combat other major health scourges and horizontal measures.

The main objective of the programme's third action plan, which will run from 1996 to 2000, is to increase understanding of the causes of cancer and its prevention. Coherent and more widely disseminated information

[1] OJ L 95, 16.4.1996.

for the public should make it easier to achieve the objectives which Article 129 sets for the Community in the field of health protection.

Priorities for Community action to combat cancer

The Commission's communication on the framework for action in the field of public health proposes four objectives for Community action:

(i) to prevent premature death, which particularly affects the young;

(ii) to increase life expectancy without disability or sickness;

(iii) to promote the quality of life by improving general health;

(iv) to promote the general well-being of the population, particularly by minimizing the economic and social consequences of ill health.

The 'Europe against cancer' programme addresses all these objectives; the new Community measures to combat cancer are designed to help Member States achieve their own objectives and will be implemented with the aim of maximizing the benefits of working on a European scale.

Against this backdrop, priority will be given to selection of the following kinds of Community measures:

(i) activities which, because of their scale, cannot be carried out wholly satisfactorily by the Member States — European scale;

(ii) activities whose joint implementation would have clear advantages, in spite of initial higher costs — European added value;

(iii) complementary activities, which would have significant impact in the Community — complementary activities in the individual Member States;

(iv) activities leading to the establishment of rules of good practice — establishment of European standards and/or criteria for good practice;

(v) activities which help to strengthen solidarity and social cohesion — promotion of greater European solidarity in the field of public health.

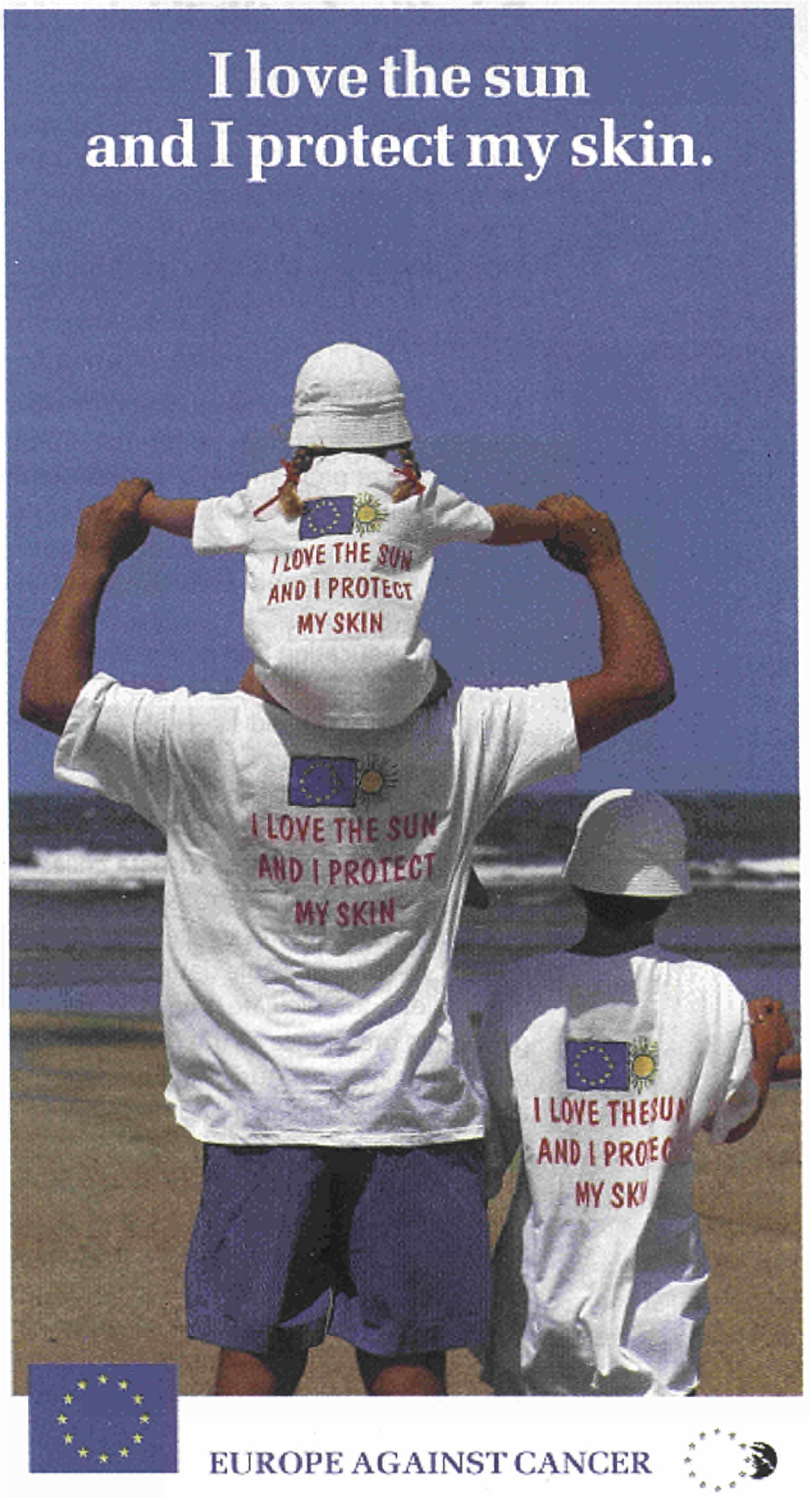


Photo: © European Commission

The aim of the third action plan is to help to improve the European citizen's understanding of the causes of cancer and how to prevent it.

Priorities for the third action plan

The Annex to the Decision of the European Parliament and the Council adopting a third action plan to combat cancer within the framework of public health (1996-2000) contains a description of the key areas for action during the period in question, and the objectives for each area.

A total of 22 different types of action will receive special attention under the Europe against cancer programme, grouped into the following headings:

(i) data collection and research

(ii) health education and information

(iii) early detection and screening

(iv) training and quality control.

The objectives in the field of data collection and cancer research are to extend and improve understanding of cancer and to make it easier to collect reliable data, which will be used chiefly to calculate trends in the incidence and prevalence of the disease, to carry out epidemiological studies at European level and to establish research priorities.

In the field of health education and information, the aim of the third action plan is to help to improve the European citizen's understanding of the causes of cancer and how to prevent it, and to encourage the adoption of a healthy lifestyle. The programme will promote and evaluate policies and measures linked to the causes and risks of cancer.

As regards early detection and screening, the aim is to improve and extend the possibilities of early detection, chiefly by developing effective screening programmes and appropriate practices.

Finally, the third action plan of the Europe against cancer programme will help to develop training networks for health professionals and will support the exchange of experience at European level and pilot projects in the field of quality assurance.

European cancer prevention weeks

Since the Europe against cancer programme was first launched in 1987, information campaigns have been organized each year to draw the public's attention to specific aspects of cancer prevention. These campaigns are organized under the programme, in close cooperation with the cancer leagues and associations, in all Member States, during the second week in October ('European cancer prevention week') and focus on a different theme each year. The 1995 week highlighted the European code against cancer, a set of 10 simple recommendations which carry essential messages for cancer prevention; the 1996 campaign targets the prevention of skin cancers.

Informing the public — a priority

The importance of informing the public in any strategy to combat cancer is self-evident, given that it is generally accepted that some 70% of cancer-related deaths have their root cause in personal lifestyle and environmental choices. Consequently, irrespective of medical progress, a significant reduction in cancer and cancer-related mortality can be achieved only if the public can be persuaded to change certain habits and attitudes, and knowledge is a prerequisite for the adoption of a lifestyle affording the maximum protection against cancer — although the risk can never be completely eliminated.

Information for the public is therefore a very important aspect of the third action plan against cancer. The plan provides for the following information measures:

(i) the organization, each year, of a European cancer prevention week;

(ii) improvement of the dissemination and impact of the cancer prevention messages;

(iii) support for networks for the exchange of information and experience in the field of cancer prevention;

(iv) the promotion of information and awareness-raising campaigns for specific target groups;

(v) the encouragement of European-scale cancer prevention projects, focusing on smoking.

The European code against cancer — getting the message across to the general public

When the Europe against cancer programme was first launched, a prestigious group of cancer experts from all Member States was asked to draw up a set of easily remembered recommendations outlining the basic essentials of cancer prevention. This resulted, in 1987, in the first edition of the European code against cancer. The text was revised in 1995 on the basis of new scientific findings (see box). The code has become the linchpin of the programme, particularly as regards information for the public. Indeed, it is normally one of the code's 10 'commandments' which is chosen as the subject for the European week; in 1995, the new revised code as a whole was the theme of the campaign.

Cancer prevention? One third of Europeans thought it impossible!

A Eurobarometer survey conducted in the 15 Member States of the European Union in spring 1995 — prior to the promotion of the code during the 1995 European week — drew attention to the need for clear and simple guidelines on cancer prevention for the general public.

The most striking finding was that one European in three (and in some countries 50% of the population) did not believe that cancer could be prevented: too many Europeans were therefore still unaware that they could reduce the risk of cancer. The code's recommendations may appear simplistic or obvious, but effective and original communication campaigns are necessary if they are to be understood and followed by the public.

European cancer prevention weeks — information campaigns with a strong European flavour

Large-scale initiatives are therefore needed to make Europeans more aware of what they can do to prevent cancer, hence the idea of organizing a European cancer prevention week each year in the second week in October. During the week, a Europe-wide information campaign is organized on a subject relating to cancer prevention (1993: dangers of passive smoking; 1994: benefits of eating fresh fruit and vegetables; 1995: promotion of the code; 1996: prevention of skin cancers). The programme attaches great importance to the close involvement in the weeks, from the outset, of the cancer leagues and associations, and the resources which the 40 or more leagues and associations involved each year can offer to the campaigns are a tremendous asset.

As regards practical organization, the programme and the leagues involved aim, above all, to make the weeks truly European, based on a common idea and with a common foundation. To this end, in 1995, the programme issued a public invitation to tender and selected a professional communication agency, with offices in nearly all Member States. This network, with the help of the cancer leagues, is responsible for attracting the media interest so necessary if any genuine impact is to be made on the public.

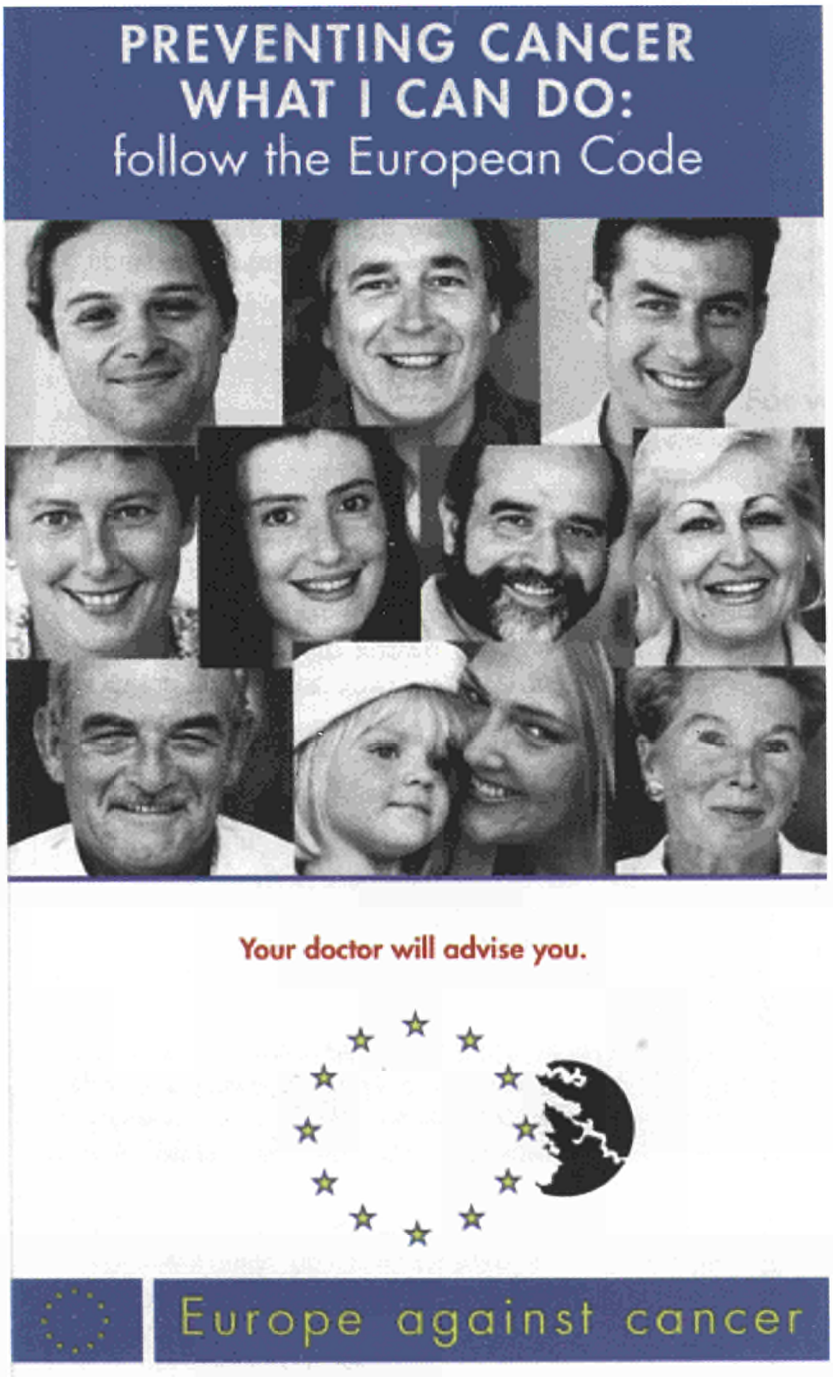
A reassuring and simple message for the general public

All the players involved in cancer prevention stress that campaigns aimed at the general public must be positive, that they must encourage and motivate rather than issue orders or attach blame.

The weeks' mass media information uses very simple language, but very great importance is nonetheless attached to its underlying scientific content. It is for this reason that, each year, a scientific coordinator is appointed to ensure that the campaign is soundly based and coherent.

During the week itself, the cancer leagues and associations have the task of distributing the information material — posters and leaflets in the 11 Community languages, all with the same presentation and content.

There are also press notices, television broadcasts and more specific activities depending on the subject of the week (e.g. promotional activities by the producers and distributors of fresh fruit and vegetables during the 1994 week, which focused on healthy eating). During the week, the cancer leagues and associations also organize a wide range of events in most of the Member States, at national, regional and local level. Although these activities are not supported directly by the Europe against cancer programme, they draw attention to the European origins of the campaign of which they are part.



Information for the public is a very important aspect of the third action plan against cancer.

Photo: © European Commission

A second target group: health professionals

In addition to the general public, the information campaigns organized for the weeks are also aimed at health professionals. Indeed, the programme calls on them to relay the cancer prevention messages to their patients; the role of GPs, for example, in educating their patients is self-evident, since they are the first line of health care for the population as a whole. It was for this reason that, for the 1995 campaign, with the active collaboration of the national associations of general practitioners, the Europe against cancer programme published a brochure on the code, geared primarily to the information needs of this group; it was distributed just before the week began, to all of the European Union's 325 000 GPs.

Assessment: considerable impact

Assessment of the quantitative impact of the weeks shows that the campaigns have extensive media coverage. For example, efforts made in 1995 allowed 150 million people to be reached through free advertising space obtained in the media (equivalent to about ECU 1 million) and a further 105 million through newspaper articles and TV and radio broadcasts.

The Eurobarometer survey mentioned earlier is a useful indicator of the qualitative impact which a campaign of this sort can have. The questions used in the spring 1995 survey were asked again in November of the same year. Comparison between these two surveys shows that the awareness of European citizens increased significantly following the 1995 campaign, the number of Europeans who did not believe it was possible to prevent cancer having fallen by 7%. A more detailed analysis shows that this increased awareness of the role which each individual can play in protecting his or her own health is directly linked to the quantitative impact: in other words, in countries where a larger number of people were reached by the campaign, the fall in the number of persons who did not believe in cancer prevention was particularly marked (for example, 14% in Germany, which means that after the 1995 European campaign, 10 million more Germans believed in the possibility of preventing cancer than had in the spring).

European code against cancer

Certain cancers can be avoided and general health improved if you adopt a healthier lifestyle

1. Do not smoke. Smokers, stop as quickly as possible and do not smoke in the presence of others. If you do not smoke, do not try it.

2. If you drink alcohol, whether beer, wine or spirits, moderate your consumption.

3. Increase your daily intake of vegetables and fresh fruit. Eat cereals with a high fibre content frequently.

4. Avoid becoming overweight, increase physical activity and limit intake of fatty foods.

5. Avoid excessive exposure to the sun and avoid sunburn especially in children.

6. Apply strictly regulations aimed at preventing exposure to known cancer-causing substances. Follow all health and safety instructions on substances which may cause cancer.

More cancers could be cured if detected early

7. See your doctor if you notice a lump, a sore which does not heal (including in the mouth), a mole which changes shape, size or colour, or any abnormal bleeding.

8. See your doctor if you have persistent problems, such as a persistent cough, persistent hoarseness, a change in bowel or urinary habits or an unexplained weight loss.

For women

9. Have a cervical smear regularly. Participate in organized screening programmes for cervical cancer.

10. Check your breasts regularly. Participate in organized mammographic screening programmes if you are over 50.

Smoking and tobacco

The consumption of tobacco is an extremely serious problem for public health. Studies have shown that about half of regular smokers will eventually be killed by their habit. The worldwide toll from smoking is estimated at about three million persons per year. If current smoking patterns continue, that toll will have risen to 10 million deaths a year by 2025. This is not to mention the levels of illness caused by smoking, or by the effects of passive smoking. In these circumstances, reduction of smoking must be a priority for all those concerned with the public's health.

Europe against cancer programme

Much Community action in the area of smoking has hitherto been concentrated in the context of the Europe against cancer programme, given that approximately 30% of cancer deaths are attributable to smoking. There are about 1.3 million new cancer cases and about 840 000 deaths from cancer annually in the European Union.

As part of the Europe against cancer programme and its various action plans (1987-89, 1989-94, and the current third action plan 1995-99), the Community has given priority to the reduction of tobacco consumption. This has been done in particular by the financing of projects carried out either at Member State level, as part of a network, or at European level. Specific mention can be made of projects to prevent tobacco addiction in target groups such as young people, women, teachers and health staff. Other projects were created to teach anti-smoking techniques to health personnel. Information projects were supported, aimed at warning the general public about the dangers of smoking, and promoting anti-smoking rules at the workplace or in other public areas.

In its latest action plan (1996-2000), the Commission aims to encourage projects with a European dimension relating to the prevention of tobacco consumption, and assessment of the implementation of recommendations on the use of tobacco in public places, particularly on public transport and in educational establishments. The new plan will promote a policy aimed at protecting the most vulnerable groups from the risks of passive smoking, in particular pregnant women and children. There will be an assessment of measures

taken in the Member States to reduce tobacco consumption, for example by the banning or control of direct or indirect advertising or exclusion of tobacco from the price index. The action plan will also support the creation of networks of no-smoking towns, hospitals and youth clubs. Pilot projects will also be supported on identifying the best methods for reducing tobacco consumption through liaison with health workers.

Preventive actions

In its 1993 campaign on cancer prevention, the Commission identified several specific preventive actions to reduce, discourage or prevent tobacco consumption:

(i) alerting at risk groups such as children and pregnant women to the dangers of smoking — a charter could be drawn up for these groups;

(ii) the protection of non-smokers, particularly in public places and at the workplace;

(iii) the development of existing networks (non-smoking towns, non-smoking hospitals, clubs for young non-smokers);

(iv) support for implementation of the most effective methods of preventing smoking and of helping people to give up smoking;

(v) support for educational campaigns directed at teachers and adults responsible for educating young persons outside the school context;

(vi) closer involvement with information campaigns organized by the WHO, particularly World No Tobacco Day (31 May each year);

(vii) an upward harmonization of tobacco prices across the Community;

(viii) encouragement of a cost of living index excluding the price of tobacco, and evaluation of the effects of this measure in the countries where it has been introduced;

Photo: © Isopress

The worldwide toll from smoking is estimated at about three million persons per year.

(ix) evaluation of anti-tobacco policies, especially restrictions on direct and indirect advertising of tobacco products which have been implemented in Member States.

These orientations for future policy will shortly be developed in a Commission communication on smoking prevention.

Public health: wider issues

The Commission communication on the framework for action in the field of public health proposes a horizontal approach aimed at eliminating or reducing the impact of particular causal factors related to several diseases. In this context, it is important to remember that while smoking and cancer are closely linked, other diseases such as cardiovascular and respiratory ailments also have significant links with smoking. Therefore, the Commission proposes actions in health information, education and promotion addressing tobacco as part of a general approach to a healthy lifestyle, and aimed at the general public or at particular groups in society.

Legal measures

Action to reduce smoking has also extended to the adoption of Community legislative measures. Legislation has been introduced on the maximum tar content of cigarettes (Council Directive 90/239/EEC) and on labelling of tobacco products with agreed warning messages (Council Directive 89/622/EEC as amended by Directive 92/41/EEC).

Advertising of tobacco products on television is banned by Council Directive 89/552/EEC. A proposal for a Directive to introduce a wider ban on advertising is currently being examined by the European Parliament and the Council.

As regards smoking in public places, the position is weaker, with the existence of a non-binding Council Resolution of 1989 on banning smoking in public places which has since been the subject of a report on its implementation by the Commission. This area is identified as one needing further attention in the third cancer action plan, by means of assessments of existing practice and by financing of pilot projects. A further Commission report on implementation by Member States of the Council Resolution has just been published.

EPIC — European prospective investigation into cancer and nutrition

Many cancers are related to lifestyle and behavioural factors and can therefore, at least to some extent, be avoided. Some experts believe that 30% of cancer-related deaths are linked to diet. Eating too many fatty foods also seems to be a significant risk factor, as does being overweight, particularly for women.

Diet and cancer

It is generally acknowledged that a balanced diet, including a sufficient amount of fruit and vegetables, offers significant protection against some of the most common cancers.

Better eating habits could, therefore, mean fewer cancer patients and cancer-related deaths in Europe in the future, and for this reason the Europe against cancer programme has focused a great deal of attention on diet. The European code against cancer contains three recommendations concerning diet:

(i) moderate your consumption of alcoholic drinks;

(ii) frequently eat fresh fruit and vegetables and foods with a high fibre content;

(iii) avoid becoming overweight and limit your intake of fatty foods.

These prevention measures need to be based on epidemiological research, in other words on the factors which determine the onset of the disease, in conjunction with the characteristics of the individual and his environment.

It is on the basis of all this information that the risk factors, the reasons for the development of the disease and the appropriate treatment methods can be determined.

The EPIC survey

As the amount of epidemiological data available was too limited for all the cancers definitely attributable to dietary factors to be identified with any certainty, the programme actively encouraged and financed studies on specific aspects of the diet/cancer relationship, and set up a network of prospective studies on cancer, diet and health. European cooperation in this area is extremely valuable. The very diversity of the EU Member States allows comparison between populations with the same quality of life but different social and dietary habits.

Better eating habits could mean fewer cancer patients and cancer-related deaths in Europe in the future.

Photo: © Iscopress

The purpose of the EPIC study is to try to identify risk factors which are unknown or only suspected for the most common cancers in men and women living in industrialized countries.

Researchers in nine countries (Denmark, Germany, Greece, Spain, France, Italy, the Netherlands, Sweden and the United Kingdom) are working together on this Europe-wide prospective study, which is coordinated by the International Cancer Research Centre in Lyons and the Commission.

The map on the next page shows the countries and national centres involved.

Nearly 400 000 Europeans will be monitored by these centres over a period of 10 years, so that the assessment of their state of health can be correlated with their way of life.

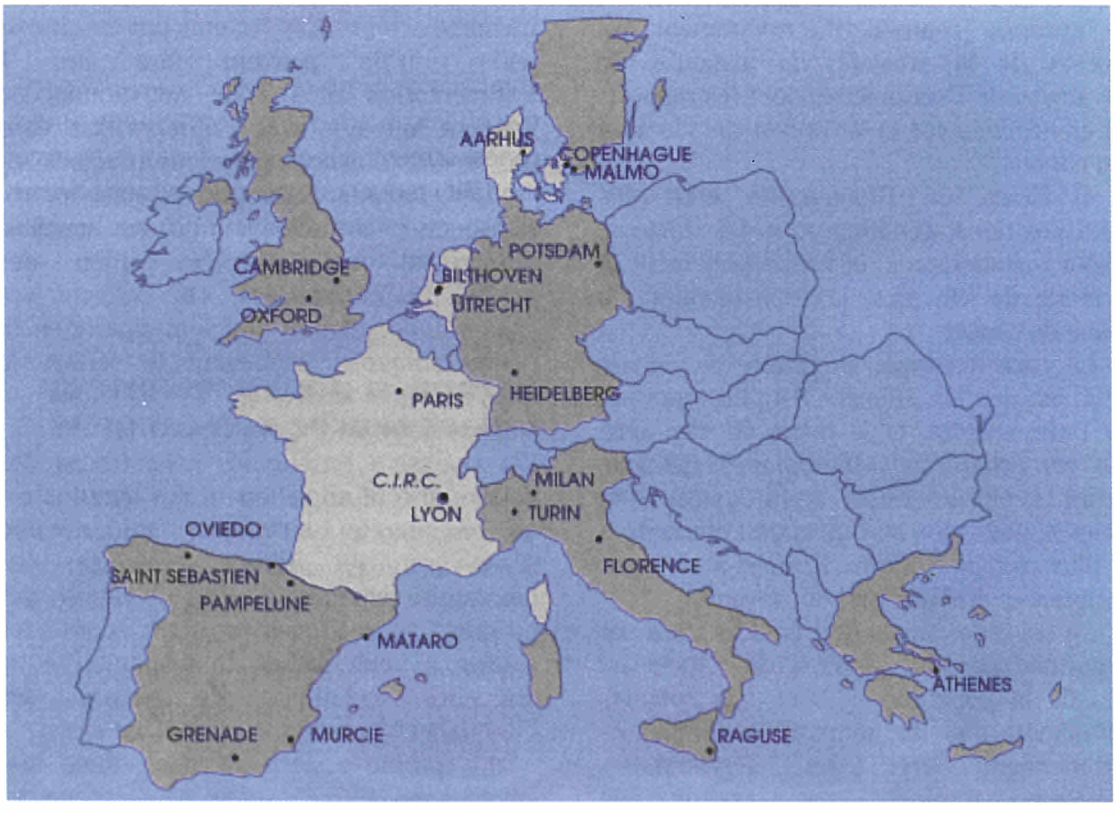
Expected results

The importance of this large-scale study, which will run until the year 2000, is that it is prospective rather than retrospective: the subjects are questioned before the emergence of the disease and the information is therefore of a better quality. The natural tendency of patients to find a link between their lifestyle and the disease from which they are suffering, as can happen in the case of a retrospective study, is thus avoided.

The questions put to participants cover four groups of factors: dietary, hormonal, genetic and psychological. These are of particular importance because little has so far been really proved about them. In fact, apart from a little, albeit fairly conclusive, evidence for the protection afforded against certain cancers by eating a diet rich in fruit and vegetables, the results of retrospective case studies on diet and cancer are still contradictory on a large number of important points, particularly on the relationship between diet and breast cancer. Subjects will therefore be monitored to study the incidence of cancer and the cancer mortality rate in relation to epidemiological data and biochemical markers.

This study will therefore be the first to adopt a very large-scale epidemiological approach, in combination with advanced techniques in the fields of molecular biology and biochemistry.

The Commission departments responsible for the Europe against cancer programme are hoping that the results of the prospective studies will enable them to improve the dietary recommendations which will be issued at the end of the third action plan against cancer, at the beginning of the 21st century. Recommendations could be increasingly specific, such as which fruit and vegetables are best, which fats are to be avoided, and so on.



Map showing centres collaborating in the European prospective investigation into cancer and nutrition (EPIC).

European initiative on breast cancer screening

Breast cancer is the commonest cause of cancer death among women in the European Community. Of the women currently affected by breast cancer, approximately 75% are aged 50 or over. The number of breast cancer deaths has doubled in absolute terms since 1960, the increase being almost wholly accounted for by the growth in the size of the population and the increasing age of the population.

The benefits of systematic screening

What is surprising is that the sharp increase in the incidence of breast cancer in the last decade has been accompanied by only a very slight increase in the death rate. This means that the chances of survival have improved. There is a great deal of evidence that biennial screening for breast cancer of women aged between 50 and 70 leads to mortality reduction, provided that the quality of the primary process as well as the assessment are excellent and negative effects such as misinterpretation of X-rays or failure to recognize cancers are limited. Breast cancers detected through systematic, high-quality screening are identified, on average, four years earlier than their clinical appearance and the survival rate of early diagnosed cancers is therefore significantly higher.

Systematic screening for breast cancer is best described as a highly organized programme in which the whole process of invitation, screening, assessment and treatment of women meets the highest quality assurance standards.

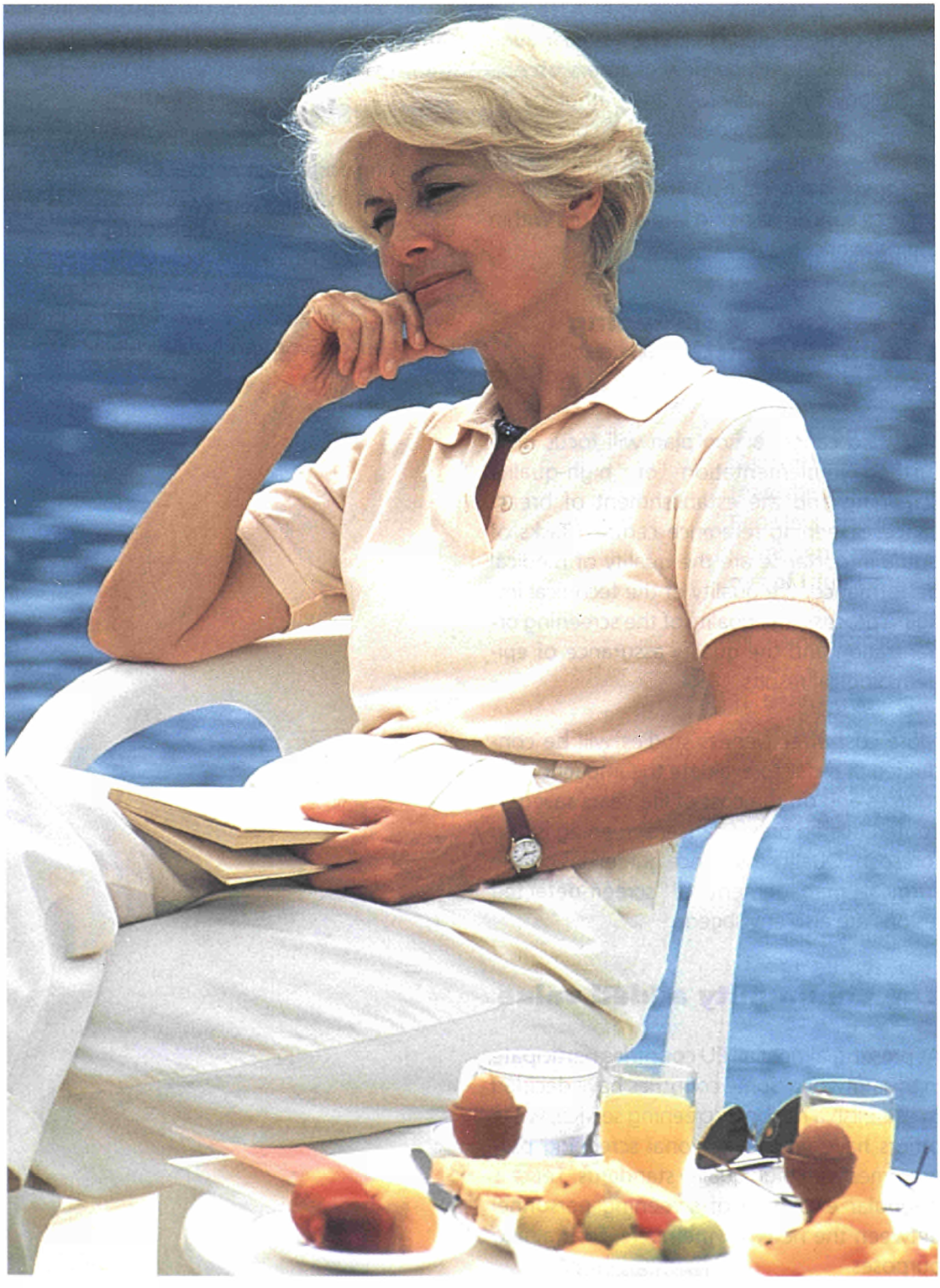
The balance between the positive and negative effects of screening is very subtle. Breast cancer screening is only successful in terms of mortality reduction and cost efficiency when all aspects of the screening process are performed at optimal levels.

The creation of the European pilot network on breast cancer screening

Within the Europe against cancer programme, priority was given to reducing the burden of breast cancer through secondary prevention. The European code against cancer reflects this in the 10th recommendation: 'For women, check your breasts regularly. Participate in organized mammographic screening programmes if you are over 50'.

In order to maximize the effectiveness of breast cancer screening in Europe, a pilot network on breast cancer screening was created in 1989. The aim of this network was not to investigate the benefits to be gained from high-quality breast screening, but to establish a medium for pooling and dissemination of experience and expertise between European countries, explore methods of wider implementation of this service and offer technical, scientific and financial support in order to achieve high quality standards.

In the first phase, emphasis was given to the methodology and epidemiology of the screening programme, i.e. invitation of a large



There is a great deal of evidence that biennial screening for breast cancer of women aged between 50 and 70 leads to mortality reduction.

Photo: © Isopress

group of women (at least 10 000 women a year), mandatory double reading of the mammograms to reduce the number of missed cancers and statistical evaluation and control of the results by epidemiologists. During the second cancer action plan (1990-94), a quality assurance policy was introduced on the basis of the 'European guidelines for quality assurance in mammography screening'. This document was drawn up for the Commission and describes minimal and optimal conditions for quality assurance and quality control of a systematic screening programme. A second version of these guidelines was issued in June 1996 and will include new chapters on epidemiology, cyto-pathology and pathology. As a result of these guidelines, the concept of quality assurance is now better understood, and there is a consensus that this quality assurance concept is being implemented within the network.

Breast cancer screening within the third cancer action plan

The third cancer action plan will focus on a further implementation of high-quality screening and the establishment of breast cancer screening reference centres. Tasks of prime importance are the quality of medical performance, the quality of the technical imaging process, the quality of the screening organization and the quality assurance of epidemiological results.

More cost-effectiveness studies will be conducted in order to evaluate the impact on resources and on the cost of life years saved. A conference on breast cancer screening is also foreseen. Quality assurance guidelines on the surgical management of screen-detected lesions are also envisaged.

The Community added value

At present, almost all EU countries participate in this network. Some countries have decided to establish a national screening service, while others have devised regional screening programmes with high quality standards. There is a regular exchange of screening personnel between the network members, for training purposes.

The added value of this network is clearly demonstrated. The expertise represented in this network is needed by countries in the process of establishing national screening programmes. The 'European guidelines for quality assurance in mammography screening' finds its way to numerous East European and Latin American countries. The European experts of the network are often asked to present an outline of the quality assurance system at international scientific conferences and, last but not least, the attention given to breast screening quality has a positive impact on the management of symptomatic disease.

Conclusion

Screening for breast cancer has become an important instrument for controlling this disease and is increasingly becoming a part of national public health policy. The Europe against cancer programme will continue to support high quality screening through the European network on breast cancer screening.

European network of cancer registers

The main purpose of the cancer registers is to collect information on new cancer cases within a given geographical area. Although, owing to lack of resources, certain registers are confined to data collection and the publication of basic statistics on the population in their geographical area, others provide the basis for a vast range of activities, such as health promotion studies, the assessment of various types of treatment or epidemiological research.

There are currently 84 cancer registers in the European Union countries, covering 43% of the total population, each linked to a specific geographical area. There are also several 'specialized' registers which, while still linked to a given population, collect information solely on specific cancers or on population subgroups. Cancer registers on children are the most relevant examples.

There is total coverage of the population in Denmark, Finland, the Netherlands, Sweden and the United Kingdom. National registers are now being set up in Austria, Belgium, Greece, Ireland, Luxembourg and Portugal. Elsewhere, registers are regional.

The European network of cancer registers, set up under the EU's Europe against cancer programme, has been in operation since 1990. It is a joint project run by the Association of Cancer Registers of the Scandinavian countries, the International Association of Cancer Registers, the International Cancer Research Centre and the Association of Cancer Registers of Latin-language countries.

Its main activities are:

1. defining and maintaining data collection standards — this work is carried out by:
   - working groups of experts on cancer registration
   - consultancies;
2. training cancer register personnel (joint basic training in data collection and analysis methods);

3. maintaining local and central databases on the incidence of cancer and cancer mortality within the European Union which involves:

    - validating and standardizing local data
    - providing the Eurocim database and analysis package
    - monitoring trends in different areas over time;

4. disseminating information through publications:

    - *Facts and figures of cancer in the European Union*
    - *Cancer in the European Union*
    - information sheets on specific cancers.

Training activities within the Europe against cancer programme

Since the start of the Europe against cancer programme in 1987, the training of health personnel has always been a high-priority objective and one of the main fields for specific actions. Under the first action plan, which covered the period 1987 to 1989, measures aimed at health professionals were focused on the need to improve their knowledge in the area of oncology.

During the second action plan, covering the period 1990 to 1994, the same objective was confirmed by the Commission Recommendation of 8 November 1989[1] concerning the training of health personnel in the matter of cancer.

In its Recommendation, the Commission encouraged the training of health professionals in cancer, following the conclusions of the Advisory Committees on Medical Training, Training in Nursing and Training of Dental Practitioners.

In particular, the Commission recognized the vital role of the different professionals both in the prevention and in the early diagnosis of cancer, and encouraged undergraduate and postgraduate training on screening methods, counselling, appropriate methods of treatment, rehabilitation and terminal care.

Within this general strategy, many initiatives have taken place in the course of the first two action plans which have had a positive impact on the quality of training at national, regional and local levels and have thus helped to reduce the substantial gaps which exist between Member States in their different training programmes for doctors, nurses and dentists.

However, the efforts made and the benefits already obtained have to be continued to ensure that health personnel involved in cancer prevention and treatment acquire the necessary knowledge and skills to enable them to intervene promptly and decisively.

[1] OJ L 346, 27.11.1989.

Since the start of the Europe against cancer programme in 1987, the training of health personnel has been a high priority objective.

For this reason, in its third action plan against cancer, for the period 1996 to 2000, the Commission has decided to consolidate this approach. The Europe against cancer programme will continue to encourage new initiatives allowing training programmes for doctors, nurses and dentists to include the most significant recent advances in prevention, diagnosis and treatment of cancer. Continuing and in-service training will be the key to this action.

In practice, this will involve the development and implementation of networks, joint actions and information exchange systems.

The training strategy of the programme will incorporate these elements and facilitate the mobility of health professionals between Member States for training purposes. These exchanges will take place in particular between centres of excellence offering high-quality training opportunities where this is not covered by existing Community programmes.

The main objectives can be summarized as follows:

(i) to improve the knowledge and skills of health personnel (doctors, nurses, dentists) in the matter of cancer, in particular its prevention;

(ii) to promote quality training, in particular through the establishment and support of training networks (basic training and continuing training) for health personnel involved in the fight against cancer;

(iii) to improve the quality of training of other categories of health personnel such as pharmacists and data managers;

(iv) to ensure that training also covers the psycho-social aspects of cancer.

As regards the group of oncologists directly involved in the management of the disease, the Europe against cancer programme, through the third cancer action plan, will support the holding of consensus conferences with the aim of drawing up and disseminating recommendations on good practice.

III

Drugs

Priority attached to drug prevention in the Treaty on European Union

The Treaty on European Union reflects the trends which have emerged in recent years, both internationally and in the Member States, in the approach to drugs and drug dependence.

Strategies focusing on reducing the supply of drugs have been called into question because of a number of factors:

(i) the uninterrupted supply of illegal drugs;

(ii) the growing misappropriation and abuse of legal substances and products;

(iii) the increased risk of contracting communicable diseases, such as AIDS and hepatitis, particularly through the sharing of syringes;

(iv) the need to meet the health and social needs of drug addicts and to develop approaches which supplement the strict application of the law.

These factors have led to the development of integrated approaches to the problem of drug dependence, which stress the importance of reducing the demand for drugs and, in particular, preventing drug dependence.

This trend is confirmed in the EU Treaty, which expressly identifies drug dependence as a priority for Community action in the sphere of public health (Article 129).

On this basis, in June 1994, the Commission presented a proposal for a Community action programme for the prevention of drug dependence to the Council and the European Parliament. This proposal forms part of the framework for Community action in the field of public health, presented by the Commission in its communication of November 1993.

Organization of the Union's drug prevention initiatives

The Treaties in force before the EU Treaty took effect provided for political and legislative measures at Community level to combat drugs, including measures aimed at reducing demand (mobilization of European cooperation through support for coordinated initiatives, European drug prevention weeks, etc.), those designed to reduce drug trafficking (intra-Community surveillance and monitoring of international trade in drug precursors, prevention of money laundering, a classification scheme for the dispensing of medicaments, establishment of Europol, etc.) and international measures. The European Monitoring Centre for Drugs and Drug Addiction has also been set up to disseminate information throughout the Community, providing the Member States with a comprehensive picture of the problem.

The Treaty on European Union has strengthened the Union's capacity to fight the drugs problem, both through Article 129 and by providing for cooperation in the fields of justice and home affairs (Article K. 4).

To ensure that the measures taken by the Union to combat drugs are consistent, and to take advantage of all the possibilities offered by the Treaty to strengthen and broaden its efforts, in June 1994, the Commission presented the European institutions with an integrated plan of action on the fight against drugs. The draft programme of Community action on the prevention of drug dependence within the framework of public health is the cornerstone of the Union's efforts to reduce the demand for drugs.

There is an increased risk of contracting communicable diseases, such as AIDS and hepatitis, particularly through the sharing of syringes.

Photo: © Isopress

A programme of Community action

Article 129 of the Treaty on European Union both empowers and requires the Community to take action. It formalizes a consensus on the need for Community measures to counter drug dependence as part of a public health programme. The basic principles of this consensus can be summarized as follows:

(i) the priority attached to prevention;
(ii) acceptance of and respect for the cultural and social diversity of the Member States;
(iii) the need to take account of the many facets of the problem.

It was on this basis that the Commission prepared and forwarded to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions a proposal for a first programme of Community action on the prevention of drug dependence.[1] The Commission's analysis of Community action in this field is based to a large extent on experience gained since 1988, the first year in which, on the initiative of the European Parliament, a Community budget heading was devoted to combating drugs and drug dependence. It also derives from the agreements reached by the Council and the European Parliament since then and, finally, from the results of the many exchanges of experience at European level, carried out with Commission support, between players involved in this field wanting to improve their routine practices.

(i) Sociocultural, socio-psychological, legal, medical and economic factors all play a part in the complex problem of drug dependence. The factors vary from one Member State to another and help to determine national narcotics policy. Nonetheless, there is general agreement on the primary importance of prevention as part of a global and integrated policy.

We still need to define what is meant by the prevention of drug dependence. In 1989, the Council identified where national approaches converged, stressing the need to focus prevention measures on the information and health education of European citizens, giving priority to specific groups, and the need to establish clear policies to resolve the problems created by drug abuse. The Council felt that these policies should, in addition to the ultimate goal — an end to drug-taking — define intermediate objectives, such as a reduction in the number of deaths, reduction in the risk of contamination by HIV and

[1] Communication COM(94) 223 final presented at the same time as the proposal for a decision.

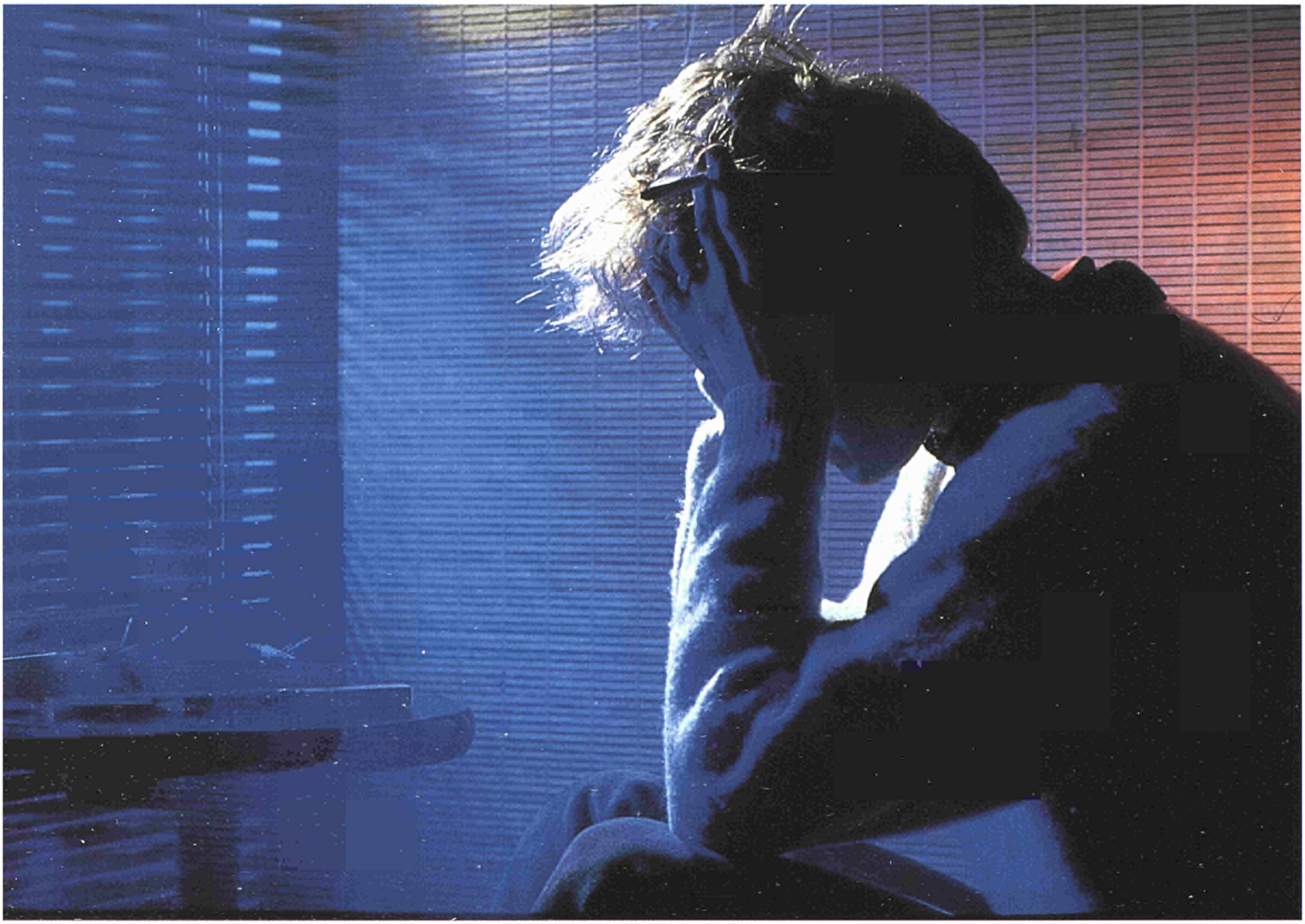


Photo: © Isopress

Sociocultural, socio-psychological, legal, medical and economic factors all play a part in the complex problem of drug dependence.

other infectious agents and a reduction in marginalization.

(ii) All these elements are interpreted and implemented in different ways in the national prevention policies. There is no single answer to the scourge of drug dependence. Each Member State has developed its own policy, in some cases gradually, in others by sweeping reform. There is now a wide spectrum of strategies being followed in the Community to address the plethora of problems that have been generated by drugs and drug dependence. This diversity is, in many respects, an asset to the Community, as it represents a vast laboratory in which to try out different tactics and conduct various programmes on drugs and drug dependence. The Community's role is to tap this enormous resource, identify the best practice and make it known for eventual adaptation and use. There is no question of harmonization here, as Article 129 plainly states. The Community action should focus on the promotion and facilitation of exchanges of information and sharing of experience between Member States. The benefits are obvious.

The more we know about the practices adopted and results obtained in each Member State, in the fields of particular interest for each of them — for example, risk reduction in the Netherlands and primary prevention in Sweden — the better able we will be to devise or improve drug and drug dependence strategies and the readier to seek transnational cooperation in these matters. This objective is stated quite categorically in the Commission's communication which was presented together with the proposal for a decision on the programme: the Community's role is

to underpin the efforts of the Member States, assist in the formulation and implementation of objectives and strategies and contribute to the provision of health across the Community, setting as a target the best results already obtained in a given area anywhere in the Community.

(iii) The problem of drug dependence cannot be tackled in isolation. Firstly, it is only one aspect of the efforts to combat drugs in general. The global action plan stresses the need to ensure a coherent drug prevention policy which takes account of all aspects of the problem. For example, public health initiatives undertaken to prevent drug dependence need to be coordinated with measures introduced in implementation of the law. There are clear interactions in areas such as alternatives to imprisonment for drug-dependent offenders, or health care for drug addicts in prison. The opening-up of prevention to a wide range of people and sectors is a trend now visible in all the Member States. The importance attached to a multidisciplinary approach to prevention and to the creation of a link with, for example, cultural, educational, sports, social and judicial policies and activities, is a trend which is common to all national programmes, and one to which particular attention was drawn in the assessment of the European drug prevention week in October 1994.

The Community's priorities for the next five years (1996-2001)

The priorities are still under discussion in the European Parliament and the Council, on the basis of the Commission's proposal and the opinions of the Economic and Social Committee and the Committee of the Regions.

Certain objectives were approved at the European Council meetings in Cannes and Madrid, in June and December 1995. Subject to the opinion of the Parliament after the second reading, the European Council recommends that the programme pursue two additional objectives:

(i) 'to improve knowledge of the phenomenon of drugs and drug dependence and its consequences and of means and methods of prevention of drug dependence and the risks relating thereto, in particular by using the information supplied by the EDMC and the possibilities offered by existing Community programmes and instruments';

(ii) 'to contribute to improving information, education and training aimed at preventing drug dependence and the associated risks, in particular for young people and particularly vulnerable groups'.

The Commission aims to achieve the objectives of the future programme by supporting the initiatives of bodies active in the prevention of drug dependence. The development of forums for cooperation and the promotion of partnerships between different national players at Community level will provide the basis for a coherent European strategy which takes account of the local situation.

At Community level, experience has shown that transnational networks guarantee the development of activities in the long term, create a better understanding of trends in drug dependence and help in the dissemination of best practices throughout Europe. The Commission attaches particular importance to the promotion of transnational partnerships in this field and to synergy between the different European networks.

Review of Community activities since 1993

Of all the European initiatives, the European drug prevention weeks are undoubtedly the best known. In October 1994, a large-scale awareness-raising campaign reached around 100 million people, including 10 million young people, through information and prevention activities and exchanges between professionals, made possible by the development of local, regional, national or Community-level partnerships. The weeks are part of a long-term Community programme and are a means of strengthening European cooperation and underpinning the measures of the individual Member States.

Since 1993, and in the transitional period prior to the adoption of the Community prevention programme, measures have been grouped into areas likely to benefit from Community support: information for the general public and for certain target groups; education and training; reducing the risks; early detection; social and occupational rehabilitation; data collection; development of research and dissemination of the findings. Efforts have also been made to ensure that projects have a trans-European dimension, with support for the establishment and extension of cross-border European or regional networks and their programmes of coordinated activities. This reflects the concern to avoid spreading the budgetary resources available for Community action in this sector too thinly, while satisfying the criteria of subsidiarity and Community added value and ensuring an optimum cost-effectiveness ratio.

Recent projects

The Commission supported the action programmes of the European Foundation of Drugs Helpline Services, including the award of grants for professionals wanting to find out more about the methods of their colleagues in other Member States, the provision of training for newly-created services, transnational discussion of the performance of these services and the production of reference documents on helplines.

Professionals working in the field of drugs in the Rhine, Meuse and Moselle area set up a network in 1986. In 1993 and 1994, with the support of the Commission, they organized two summer schools on the prevention of drug dependence among schoolchildren, both at school and outside, which gave around 100 teachers and social workers in these regions the opportunity to learn the basic theory and methods for developing and implementing coordinated measures to prevent drug dependence, geared to their specific target group and based on the best prac-

tices already in use. It also promoted training courses on the prevention of drug dependence for local representatives in the area.

The Commission also supported the activities of the T3E Federation, set up in 1991 and involving 62 institutions in Belgium, Greece, Spain, France, Ireland, Italy, the Netherlands, Portugal and the United Kingdom active in the field of reducing drug demand. Their aim is to encourage exchanges of views and practices between professionals in different institutions, allowing them to learn from each other. In 1994, with the Commission's sup-

Prison officers are likely to benefit particularly from additional training which would help them to adopt the right approach.

Photo: © Isopress

port, 80 courses were given in 44 institutions in nine Member States, by social and health professionals. In addition, a summer school was held in Portugal, involving about 100 professionals, on 'The prevention of drug dependence and public health needs: the answer?'.

There is a high prevalence of drug addiction among prisoners in the Member States, and prison officers are likely to benefit particularly from additional training which would help them to adopt the right approach to this specific population group. In the last few years, the Commission has also lent its support to a network of prison officers and external prison personnel in Belgium, Germany (Saarland), France (Lorraine), Luxembourg and the Netherlands (Limburg). The aim of the project was to permit an exchange of information on practices adopted in prisons, through traineeships, with a view to the transposal of practices where appropriate.

To complement the measures carried out under the Europe against AIDS programme, the Commission supported a pilot project, set up through a transnational network involving six Member States of the European Union, to train professionals and drug addicts in the prevention of the health risks related to the use of drugs (particularly HIV infection). Information material was produced on problems relating to the use of drugs, safer ways of using drugs and the care and treatment facilities in the different Member States.

IV

AIDS and other communicable diseases

The European Community and the AIDS epidemic

Since its emergence at the beginning of the 1980s, the threat posed by the AIDS (acquired immune deficiency syndrome) epidemic has put the European Community on its guard. The Council and the Health Ministers, as well as the Ministers for Development and Research and the European Parliament, have repeatedly drawn attention to this serious public health problem.

In response to their encouragement and to the expectations of European citizens, and in view of the urgent need to protect the health of Europeans and support the measures undertaken by non-Community countries, especially the developing countries, the Commission has launched several programmes in the fields of public health, research and development aid.

So far, the European Community has spent nearly ECU 300 million on these programmes, and this effort will continue.

The current situation and the spread of the disease in the Community

AIDS is monitored in the European Community by the European Centre for the Epidemiological Monitoring of AIDS, with the support of the European Commission and the World Health Organization. In each country, a single institution recognized by the national authorities reports quarterly to the European Centre on new AIDS cases. The Centre then processes, classifies and harmonizes the data and their presentation.

By 30 September 1996, a total of 175 892[1] AIDS cases, including 2 802 children under the age of 13, had been reported in the 15 Member States of the European Community. Three countries (France, Spain and Italy) alone reported 127 231 cases, 72% of all cases in the Community.

Between January and September 1996, 16 329 AIDS cases were reported in the 15 Member States.

In 1995, some 23 814 new cases had been diagnosed.

[1] These figures take into account late reporting of cases diagnosed in the previous year.

The incidence of the disease (new cases reported during a year) varies considerably from one country to the next. In 1995, the rate of incidence (number of cases reported per million inhabitants) varied between 7.8 per million in Finland and 176.2 per million in Spain.

Number of cases reported per million inhabitants in 1995

Belgium	23.2
Denmark	42.3
Germany	20.4
Greece	20.8
Spain	176.2
France	88.7
Ireland	14.9
Italy	100.4
Luxembourg	36.9
Netherlands	32.1
Austria	25.4
Portugal	76.9
Finland	7.8
Sweden	21.9
United Kingdom	29.6

The breakdown by transmission group of cases of adults/adolescents (aged 13 or over) reported in 1995 shows that 43.2% of the cases are linked to the use of injectable drugs, 28.3% to male homo/bisexual relations, and 18.9% to heterosexual relations. The picture also varies considerably according to gender. Of the female cases, 47.3% are linked to the use of injectable drugs and 42.6% to heterosexual relations. Of the male cases, 42.2% are linked to the use of injectable drugs, 35.3% to homo/bisexual relations and 13.1% to heterosexual relations.

Although the total number of new cases reported during a year now seems to be levelling off, the proportion of female and heterosexual cases continues to grow.

Europeans and HIV (human immunodeficiency virus)/AIDS

In April 1995, the Eurobarometer[1] survey, carried out at the request of the European Commission, contained an important chapter on 'Europeans and health', which, among other things, looked at Europeans' understanding of and attitudes towards the various aspects of infection by the HIV virus and AIDS.

In general, Europeans are concerned about AIDS and want to have more information about it (79% of replies). Young people are even more concerned and more inclined to want information than adults. They are also less certain than the rest of the population about their future and their risk of being contaminated.

On the whole, Europeans are fairly well informed about the ways in which AIDS can be transmitted (90 to 96% accurate) and are increasingly aware of the ways in which it cannot be transmitted, although more information on misconceptions of this nature, and especially on the question of blood, would be useful. Although there are differences between the Member States, they are mainly linked to the length of schooling. There is a clear need for information which is specifically geared to the less well or poorly educated. Young people are generally better informed than the older generation, particularly about the ways in which AIDS cannot be transmitted.

A large majority of Europeans (83%) agree on the classification of AIDS patients as 'patients in need of treatment'. However, an equally large proportion of people believe AIDS patients to be people who 'have taken risks in their sex life' (71%), 'have had unsafe sexual relationships' (60%) or are 'a threat to society' (41%). These figures need to be taken into consideration when selecting the measures to combat the exclusion of and discrimination against AIDS sufferers.

[1] *Europeans and health*, INRA-Europe, September 1995.

In nearly all European countries, condoms are considered by most people to be the best method of protection (93%); abstinence is felt to be effective by two thirds of Europeans, particularly in northern Europe. Trends observed in the 15 to 24 age group show an increase in the population who feel that condoms and abstinence are effective.

In comparison with a survey conducted in 1990, more Europeans today say that they have changed their behaviour because of AIDS, in particular in sexual relations: stability of partners and precautions during sexual intercourse. It is among the younger population (15 to 24 year olds) that the change in behaviour is most apparent. In 1995, three out of four said that they took precautions during sexual intercourse because of the risk of AIDS.

In general, people want more European cooperation on measures to combat AIDS. On the question of how health policy should try to eliminate AIDS, Europeans attach practically the same priority to the financing of research to find a vaccine as to information campaigns.

Community measures to combat AIDS

Towards the end of the 1980s, the Community developed a series of measures to tackle the AIDS problem on various fronts, both in Europe and in non-Community countries, in four areas in which the Community is competent:

(i) Community action in the field of public health

(ii) research

(iii) medicines and pharmaceutical policy

(iv) cooperation with developing countries.

Photo: © Isopress

Some 93% of Europeans consider condoms to be the best method of protection.

In 1991, as part of the Community action in the field of public health, the Council and Ministers for Health adopted the first 'Europe against AIDS' programme for the period 1991 to 1993. This was extended to cover 1994 and 1995 by joint decision of the Council and the European Parliament. Under this programme, the Community contributed a total of ECU 40 million to prevention, information and support measures to combat the risk of infection by HIV and AIDS.

The measures were designed to encourage cooperation and exchanges of knowledge and experience between the Member States, and to mobilize cooperation at Community level to prevent HIV/AIDS. The projects supported concerned the main areas of activity covered by the programme:

(i) evaluation of knowledge, attitudes and behaviour of the population in general and the groups most at risk; information and awareness-raising campaigns on means of transmission and prevention, focusing in particular on the use of condoms in sexual relations which might present a risk (new partners, multiple partners, etc.);

(ii) education of children and young people on sexuality and the prevention of HIV/AIDS;

(iii) prevention of the transmission of the virus to groups particularly at risk, or in particular situations: travel, tourism, border areas; prisons; use of injectable drugs, prostitution; homo/bisexual relationships; mother-child transmission;

(iv) social and psychological care for persons who are HIV positive and for AIDS patients; measures to combat discrimination against persons who are seropositive;

(v) data collection and epidemiological monitoring of HIV/AIDS.

The articles in the following sections outline some of these large-scale projects and the experiences of European networks on particular aspects of the prevention of HIV/AIDS.

The Community's framework programme for research and technological development includes a specific programme on biomedicine and health (Biomed). The research carried out under Biomed I (1991-94), which was devoted specifically to research into HIV/AIDS (monitoring and prevention, viro-immunological research, clinical research, trials of medicines, research into the development of a vaccine), and which was supported and coordinated by the Community, has led to some progress in the fight against AIDS.

Under the fourth framework programme for research and technological development for the period 1994 to 1998, Biomed II focuses on the integration of basic and clinical research and covers various fields of activity relating to the fight against AIDS, including:

(i) viro-immunological research and research into the genetics, biology and structure of the HIV virus;

(ii) research into the development of a safe, effective vaccine, and anti-viral drugs;

(iii) clinical research centring on trials for the treatment of AIDS and associated opportunistic diseases.

In the pharmaceutical field, Community measures to combat AIDS focus on two main aspects: firstly, ensuring the safety of blood products. Directive 89/381/EEC covers industrially manufactured blood products but does not apply to whole blood, plasma or blood cells of human origin.

In December 1994, the Commission adopted a communication with a view to improving European self-sufficiency in blood products, and in 1995, the Commission began work to set up a blood monitoring network in the Community, which would ensure the systematic monitoring of the risks and dangers involved in blood transfusion.

Secondly, as regards medicines, harmonization of the legislation on pharmaceutical products was completed in 1993. In particular, the Community set up a European Agency for the Evaluation of Medicinal Products, which enables new medicines to be authorized centrally prior to marketing in all Member States.

This means that promising new medicines, such as new products to treat AIDS, new vaccines, and so on, are available to patients more quickly and at the same time in all Member States. The rapid availability of new medicines throughout the European Union is particularly valuable in view of recent developments, with hopes being raised by the development in United States laboratories of new anti-viral products (combining three types of treatment) which seem to be making real progress in the fight against the spread of the disease.

In the field of general development cooperation, the Community supports the health sector in the developing African, Carribean and Pacific countries through the Lomé Conventions. Launched in 1987, measures to combat the HIV/AIDS epidemic focused on support for regional and national prevention policies aimed, in particular, at the improvement of services combating sexually transmitted diseases, the promotion of information and awareness-raising campaigns, with particular attention to the groups at highest risk, and the improvement of transfusion safety. Between 1987 and 1994, the EC contributed a total of ECU 87 million to measures aimed at combating HIV/AIDS in 85 developing countries in Africa, Asia and Latin America.

New programmes for the year 2000 and beyond

The Treaty on European Union gave the Community specific competence in the field of public health (Article 129).

To help achieve the objectives set by the Treaty in this area, the Commission proposed a framework, comprising several action programmes in priority areas, including the prevention of AIDS and certain other communicable diseases.[1]

[1] COM(93) 559 of 23 November 1993.

Biomed II covers various fields of activity relating to the fight against AIDS, including research into the development of a safe, effective vaccine.

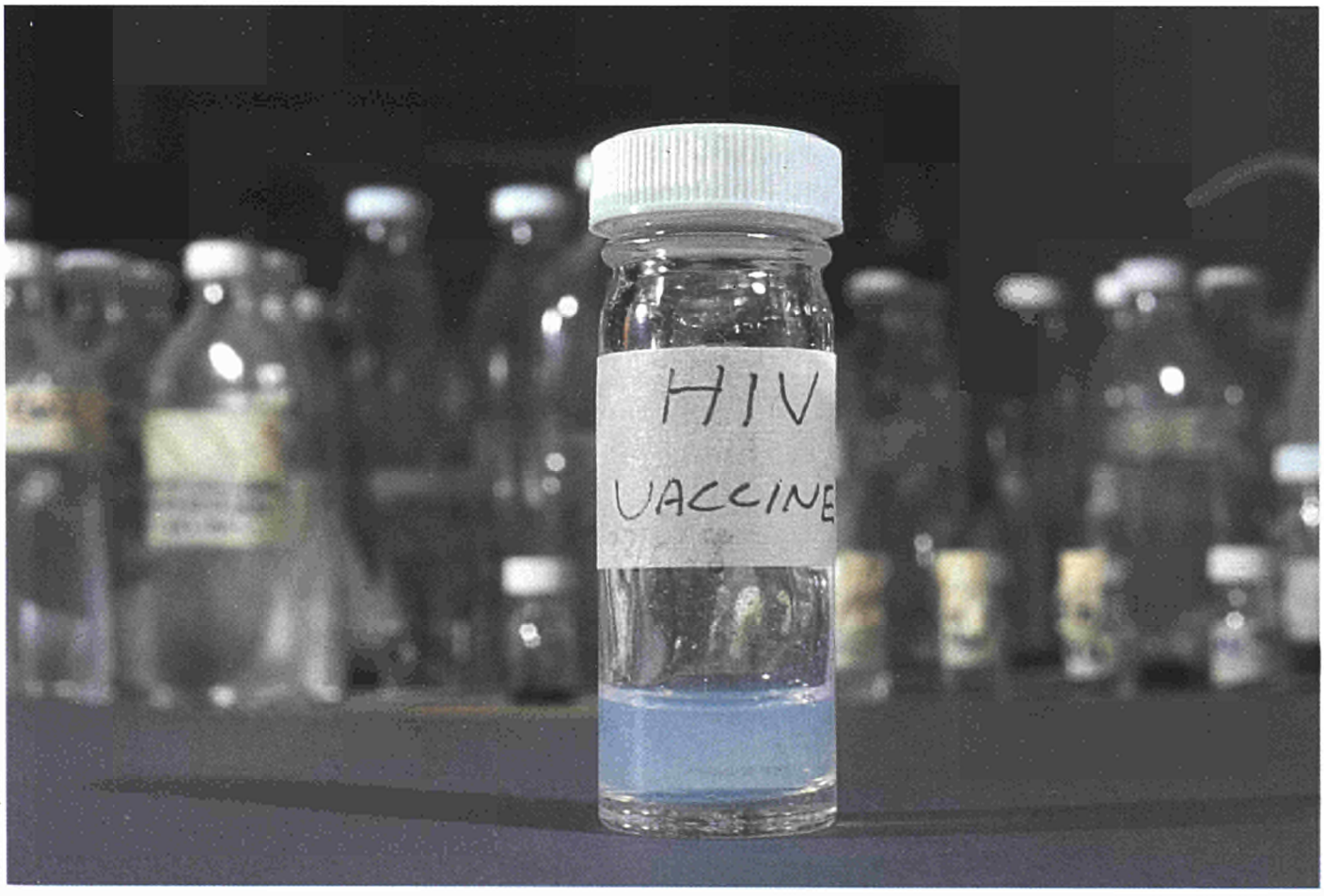


Photo: © Isopress

This resulted in the adoption by the European Parliament and the Council, on 16 February 1996, of a new programme for the prevention of AIDS. A total of ECU 49.6 million has been allocated to this programme, which will run until 31 December 2000.

The objectives of the programme will be to encourage cooperation between the Member States, to support their initiatives and to promote coordination of their policies and programmes aimed at preventing AIDS and communicable diseases. To this end, the programme comprises four chapters covering the implementation of or support for actions in four main areas.

(i) Monitoring and control of communicable diseases: actions in this field will aim to improve understanding and the dissemination of information and data on HIV/AIDS and other communicable diseases and to improve the coordination both of monitoring systems for these diseases and of the Community-wide responses, particularly in the event of an epidemic.

(ii) Combating transmission: measures will aim to prevent the transmission of HIV and other sexually transmitted diseases (STD), particularly in environments at risk (travel, prisons, etc.) and through unsafe practices (use of injectable drugs, prosti-

Measures will be aimed at educating young people on HIV/AIDS and other sexually-transmitted diseases.

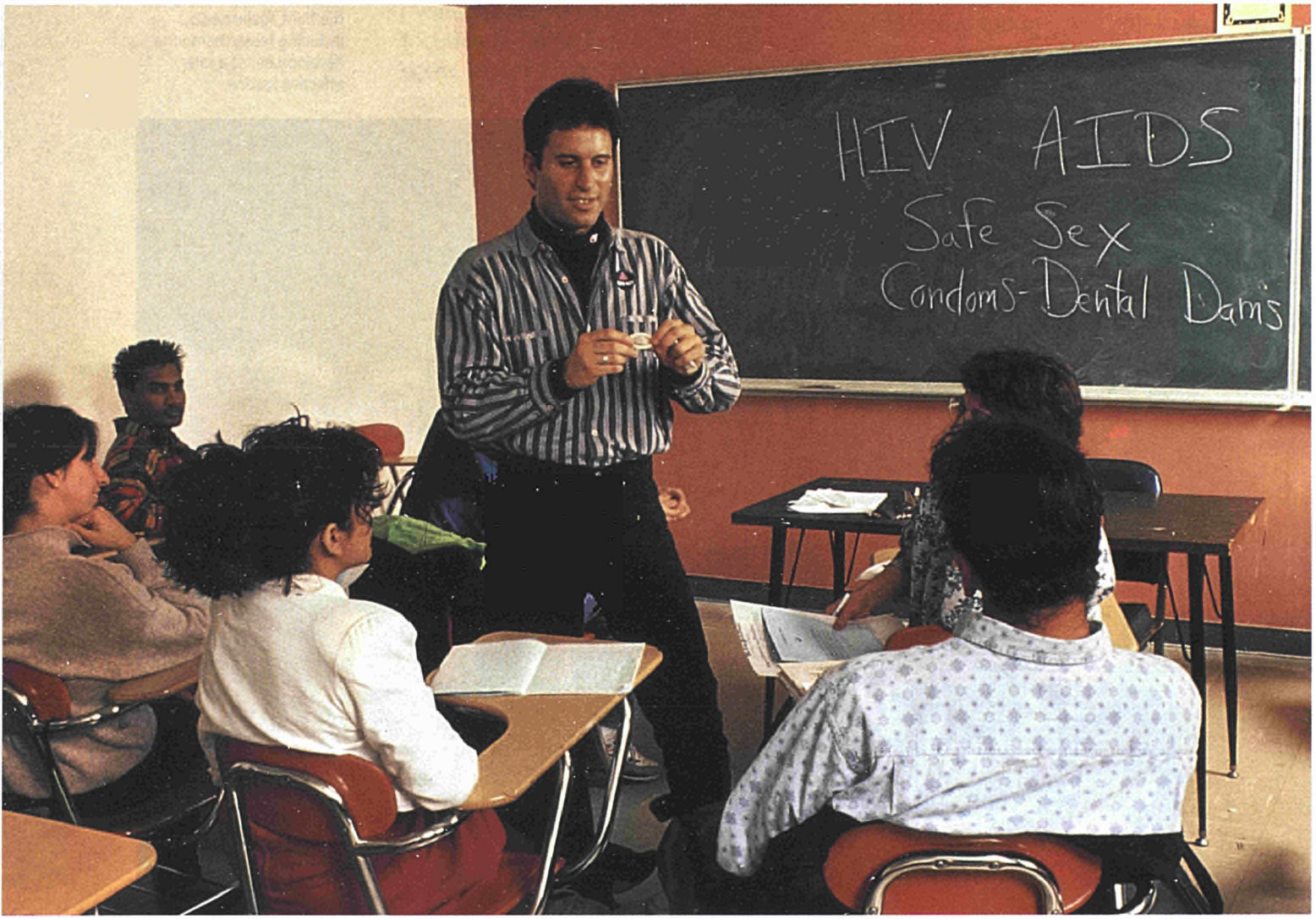


Photo: © kopress

tution, unsafe sexual relations, etc.). The aim will be to promote the exchange of information and experience on the different prevention methods and programmes (in particular, the use of condoms) and to identify and pinpoint best practices. In addition, cooperation to ensure maximum levels of vaccination against certain communicable diseases will be encouraged.

(iii) Information, education and vocational training: measures will be aimed at awareness-raising and informing the public, as well as educating children and young people on HIV/AIDS and other STD, with special emphasis on methods for assessing the effectiveness of prevention measures and information programmes. The programme will also contribute to improving the training of health professionals and persons responsible for psycho-social support for HIV positive people.

(iv) Assistance for HIV/AIDS patients and the fight against discrimination: the programme will help to provide appropriate support for HIV/AIDS patients, chiefly through support for and the exchange of experience between networks of associations involved in psycho-social care. The programme will also try to combat discrimination in any form against people with HIV/AIDS and encourage the development of a code of good practice for HIV testing.

In all of the above fields, the Commission will give priority to flagship projects implemented by organizations or associations which have proved themselves in their particular field. The projects selected for Community support must comprise a Community dimension or involve cooperation between several Member States and have real added value in terms of achievement of the programme's objectives at Community level. Even more attention than before will be paid to the assessment of the projects and of the programme, as well as to the dissemination of results.

The 'flying condom' a visual code for communication

This was the Europe-wide name adopted for the AIDS summer campaigns organized and financed by the European Commission in 1994 and 1995; a symbol which transcended all language barriers and really got the AIDS message across to young people and tourists throughout the European Union and the surrounding countries:

AIDS KNOWS NO FRONTIERS,
GET INFORMED, PROTECT YOURSELF

The summer holidays very often give young people, and tourists in general, a greater sense of freedom and offer an escape from the daily constraints of a hard-working and sometimes stressful year.

It was for this reason that the first international mass media AIDS campaign was launched during the summer of 1994 throughout the European Union and in 15 surrounding countries.

Its purpose was to get across a universal prevention message during the summer holidays using a European 'passport' against AIDS, including a condom, a multilingual cartoon strip showing how to use it and the 'flying condom' logo, a symbol which broke through the linguistic and sociocultural barriers of all countries and was therefore universally acceptable.

The campaign followed the principle of subsidiarity by reinforcing national HIV prevention measures and providing a common code for communication which could be adapted by the individual countries for the development of new prevention tools and strategies. The European Commission's investment had a significant catalytic effect, since every ecu invested from the Community budget generated three in the Member States.

How was the campaign organized?

The campaign was implemented through:

(i) the International Association of Youth Hostels

(ii) the International Association of Youth Cards

(iii) Interrail

(iv) the international media

(v) national coordination.

National coordination focused on government bodies and non-governmental organizations involved in combating HIV/AIDS, young people, the local mass media and travel agencies and tour operators.

The international media advertised the event on television (MTV, MCM, Euronews and Eurosport), in the press (*The European* and *Marie-Claire*) and on the radio (BBC and France Inter). Pop star Elton John helped to make the campaign a success by producing two videos used in the 20 press conferences organized to launch the campaign.

The results

Increased exchange of information, experience and cooperation between Member States and the recognition of the 'Europe against AIDS' message by means of a common symbol are proof of what the European Commission has achieved in the field of public health.

Specific examples are:

(i) the involvement of the main governmental and non-governmental organizations in the fight against AIDS in 25 countries;

(ii) a potential television audience of 160 million;

(iii) hundreds of press articles and local and international radio programmes promoting the use of the condom;

(iv) 14 giant flying condoms, between 14 and 20 metres in length, in the European skies;

(v) six million 'Europe against AIDS' passports, including a condom and an explanation of how to use it;

(vi) hundreds of thousands of posters, postcards, tee-shirts and badges promoting the flying condom.

The results demonstrate European cooperation on an unprecedented level, aimed at reducing the spread of AIDS among young people during the summer months.

In the light of the results of the campaign, all the players agreed that, if the virus is to be beaten, there needs to be a commitment by all and that, by working together and combining our experiences, with a common intent, we can prevent it from spreading. The campaign also shows that each one of us can help to slow the disease's progress by learning about it and informing others, by adopting and encouraging others to adopt the right behaviour to prevent it and by fostering solidarity.

The outcome of this battle depends on each one of us . . .

Prevention of HIV/AIDS in prisons: establishment of a European network

It is now widely recognized in Europe that the role of the prison is not simply one of punishment and isolation. The importance of the rehabilitation of prisoners has long been accepted and has been a priority in prisons for many years.

However, less attention has been paid to the contribution which it is known the prison system could make to public health in the Member States by improving the health of prisoners and their families. Imprisonment can aggravate health problems relating to alcohol, drugs, cigarettes and sexually transmitted diseases, as well as mental health problems, in spite of health care, counselling and social welfare. Prisons therefore provide an ideal environment for the spread of HIV infection. Furthermore, all forms of discrimination can easily be amplified in the specific conditions of the prison environment.

In 1988,[1] the Parliamentary Assembly of the Council of Europe adopted a Recommendation on the fight against AIDS in prisons, which highlighted the need for the prevention of HIV and AIDS, training and information for prison officers and prisoners, and medical, social and psychosocial care. Further measures included promotion of the condom, combating discrimination and tackling the specific problems of users of injectable drugs. In 1993, as part of the World Health Organization's global programme on AIDS (GPA), guidelines were issued on the prevention of HIV/AIDS in prisons. In particular, recognition was given to the fact that prisoners have the same rights to health care and prevention as the rest of the population.

This was followed up in the programme of Community action in the field of public health 'Europe against AIDS', under which a transnational project aimed at setting up a European network for the prevention of HIV infection in prisons has just been financed.

In view of the specific nature and problems of prisons, it was decided to work in close cooperation with the European network of services for drug-users in prisons, set up under the programme of Community action on the prevention of drug dependence within the framework for action in the field of public health.

[1] Recommendation 1080 (1988).

The aim is:

(i) to collect and compare data on the prevention of HIV/AIDS in prisons in the Member States involved;

(ii) to bring all the European partners together to develop common tools for epidemiological monitoring, the observation of unsafe behaviour in prisons and the development of common strategies for primary prevention in the European Union;

(iii) to evaluate the urgency of and conditions for the definition of strategies to reduce the risk of contamination in European prisons;

(iv) to formulate recommendations, both for persons who are infected and for those who are not, on the problem of HIV/AIDS in prisons and how to resolve it.

The results expected

Discussions between European partners in the medical, social and administrative sectors will enable the foundations to be laid for a common system for epidemiological monitoring and the observation of behaviour in prisons.

The need for a European analysis of unsafe behaviour in prisons will be evaluated on the basis of a feasibility study. Above all, the results will enable a protocol, which could be used in other European countries, to be drawn up and the conditions for cooperation between the administration and health sectors in prisons to be defined.

The results will allow practical recommendations to be put forward to achieve a definite policy on the reduction of the risk of HIV transmission in European prisons.

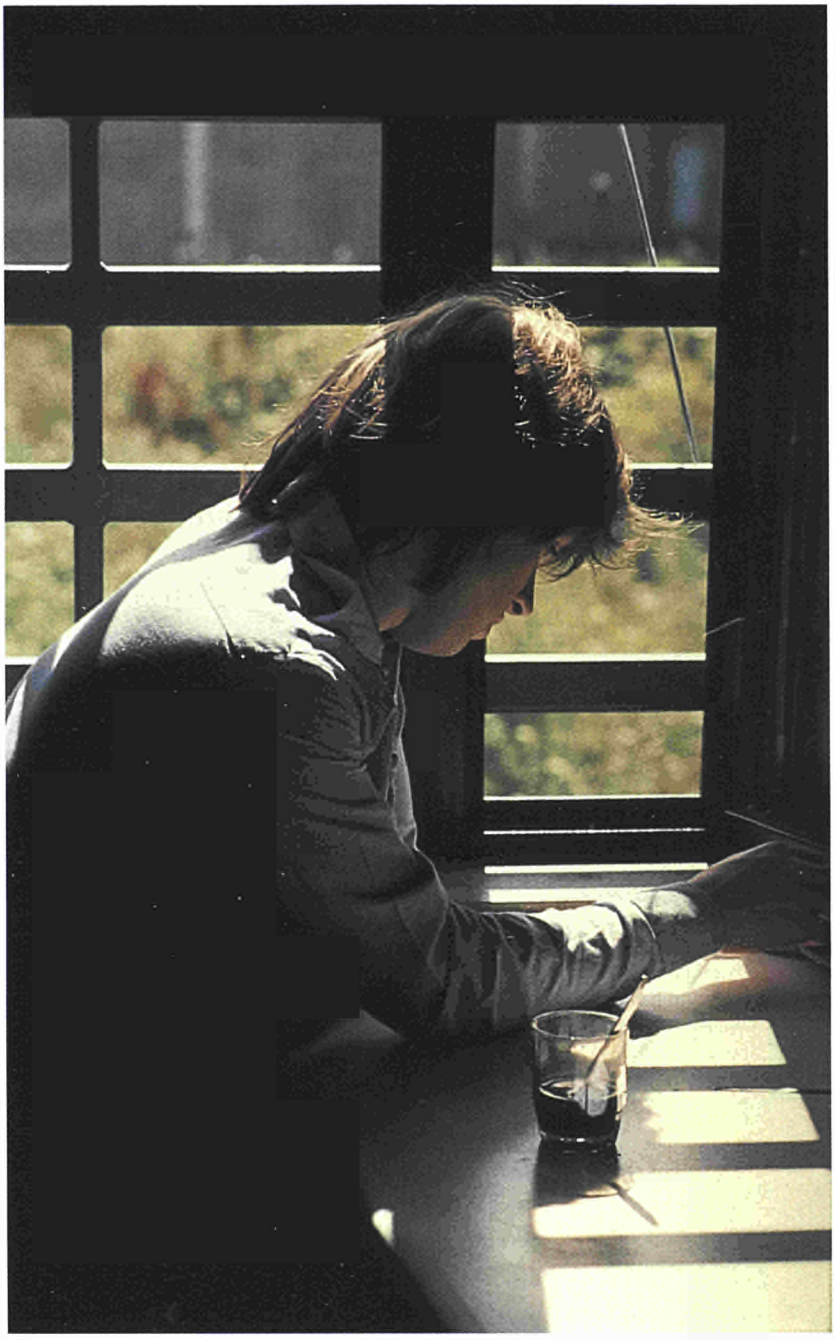


Photo: © Isopress

The Europe against AIDS programme finances projects aimed at the prevention of HIV infection in prisons.

Prevention networks in the field of prostitution

The HIV epidemic which exploded in Europe in the 1980s forced the European Union to respond in its approach to public health. The World Health Organization defines the health of an individual or group of individuals on the basis of biological, psychological and social characteristics, all of which are in a constant state of flux. Health is the capacity of the individual or group of individuals to control the balance between these characteristics. Community health requires each individual to be responsible for the protection of his own health and that of others. The Community needs to share a common, easily understood language if it is to get the prevention message across.

It is against this background that, in 1993, as part of the Community's Europe against AIDS programme, the European Commission launched HIV/AIDS prevention projects aimed at helping prostitutes to act as their own health workers. The idea was to encourage them to be involved in the development of new strategies to combat HIV/AIDS. The methodology was based initially on an 'action research', to define the needs of this group and to identify and obtain the cooperation of women whose behaviour was in line with the 'public health' approach — 'leaders' — and who could relay information. Thereafter, various groups were identified (women, transexuals, drug addicts, immigrants) and the extent to which action was possible in each of these groups was evaluated.

The cornerstone of this work was the 'prevention alliances' built up between the leaders and the health professionals. Communication, recognition and the feeling of belonging to a group with a message and a common goal led first to a national and then to a transnational movement. Two European prevention networks (Europap and Tampep) were established, and mobile units working directly with prostitutes were set up.

The aim was thus to bring to light the problems created by the marginalization of an entire social group, existing as a microcosm, with its own social strata and different cultural, ethnic and linguistic characteristics, and which is constantly changing because of the number of migrants, particularly from Central and Eastern Europe.

Photo: © European Commission

The collection of epidemiological data is an essential first step in tailoring HIV/AIDS prevention strategies.

Through the international and national coordination of these European networks, nine problem areas were identified; particular emphasis is placed on the problems of HIV/AIDS, sexually transmissible diseases and drug dependence:

(i) migrant prostitutes: because of the geopolitical changes of recent years, they are the target group for this population and specific attention is therefore needed to find out more about migratory flows, cultures, the influence of the new mafias, etc.;

(ii) the link between injectable drug users and prostitutes, which is the chief cause of the spread of HIV/AIDS and/or STD among prostitutes: Ecstasy and crack are added components of the problem;

(iii) the attitudes of prostitutes towards their clients is a difficult problem — the leaders need to work directly with prostitutes to encourage more attention to prevention;

(iv) the judicial and legislative problems of prostitution are important aspects, particularly as regards access to health and social services;

(v) the media/prostitution partnership needs to be explored in all forms, in particular the Internet network;

(vi) the collection of epidemiological data is an essential first step in tailoring HIV/AIDS prevention strategies to prostitutes: the Centre for the Epidemiological Monitoring of AIDS in Paris plays a very important role here;

(vii) training, health promotion and other health activities must be introduced with the participation of prostitutes — sharing of responsibilities between prostitutes and health professionals would help to ensure that the right services are developed;

(viii) mobile units working throughout the European Union for several years have been found to be effective in preventing HIV/AIDS, because they reach marginalized groups and work in close proximity with prostitutes — analysis of the STD/HIV/AIDS/drugs-related problems is extremely useful and an essential aid for prevention;

(ix) the collection of health education material and its accessibility and dissemination to prostitutes seem to be making an impact and should therefore be supported.

The results

For more than three years now, the Community action programme in the field of public health 'Europe against AIDS' has sought to reduce the risk of contamination by HIV and STD through prostitution, by supporting, developing and extending prevention measures aimed at prostitutes. The national and international coordination of European prevention networks has permitted Europe-wide prevention measures in a complex and often hidden world. The results are already extremely positive in terms of prevention, exchange of experience and information, and the Community added value of projects is widely accepted. Nonetheless, the events of the last decade have led to frequent and often unanticipated changes in the prostitute world, and it is therefore essential to reinforce prevention measures to combat HIV/AIDS/STD and drugs.

Combating discrimination

Discrimination against people with HIV and AIDS and those close to them is morally objectionable and undermines public health measures.
In the face of the prejudice and stigma attached to HIV infection, HIV-infected individuals are more likely to conceal their seropositivity — or even be deterred from discovering their sero-status — and less likely to maintain contact with health and social services which could assist them.

HIV/AIDS must be fought simultaneously on two fronts, one against the virus and one against psychological distancing and social backlash.

Discrimination may occur particularly in the areas of employment, credit, housing, insurance, education or health care.

In order to increase people's understanding of AIDS and HIV and its effects, and to reduce the fears and prejudices which can provoke discrimination, the European Commission supports actions aimed at ensuring that persons living with HIV/AIDS receive assistance in line with their needs and are not discriminated against in any way. To this end, projects aimed at the exchange of experience and information on assistance and support for people found to be seropositive, AIDS sufferers and persons living with them are now being funded; studies and actions on the psychosocial aspects of HIV/AIDS are also encouraged, and networks of associations providing information and psychosocial support are promoted.

A further step in Community action in this field is the exchange of information and experience on HIV-testing policies and practices which will lead to the drawing-up of a code of good practice. The code will be developed through a collaborative process and make a major contribution to increasing public awareness and understanding in this important area.

Since few other areas of public health have to contend with the guilt, shame, fear and rejection which a diagnosis of HIV infection can elicit, all issues relating to HIV-testing should bear a heavy responsibility to promote non-stigmatizing and non-discriminatory approaches.

In fact, the above code could remedy or forestall the possible emergence of isolated national solutions which may lead to confusion, inconsistencies, inequalities and hence continued discrimination amongst different population groups across Europe.

Discrimination against people with HIV/AIDS and various groups of society has already been identified as a major 'risk factor' for HIV transmission. It has also become clear that discrimination can facilitate HIV transmission in many ways, since it can lead to poorer access to information and services for prevention and treatment, and it can reduce the individual's ability to benefit from national AIDS programmes because those discriminated against were excluded from the planning and implementation processes.

Moreover, it can subject individuals and groups to coercive and punitive measures which may encourage individuals to go 'underground' where they cannot be reached, supported and cared for.

It is clear that the actions undertaken to combat discrimination may also be useful in that they could be used to support existing measures in Member States and to provide guidelines on how to avoid inappropriate media coverage of the problems of the target groups.

This inappropriate media coverage could encourage complacency in those who do not identify with such target populations, as well as reinforce stereotypes and misplaced concepts of a homogeneity of social groupings.

To identify barriers to anti-discriminatory measures in Member States and to check means and processes whereby such discrimination may be avoided or reduced in collaboration across Member States is a first step in this direction.

Human rights issues lie at the heart of a European approach to informing and increasing awareness of the general public and people who may be especially vulnerable to HIV/AIDS and discrimination, including immigrants, refugees, travellers, prostitutes, prisoners, homosexual men and young people. That is why the objective of ensuring that persons suffering from HIV/AIDS receive adequate assistance and are not discriminated against in any way is a strong commitment for the European Commission.

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Psychosocial support to HIV/AIDS sufferers

One of the basic objectives of Community action in the field of public health is to promote the quality of life by improving general health, and to promote the general well-being of the population, particularly by minimizing the economic and social consequences of ill health. As regards the HIV/AIDS epidemic in particular, to contribute towards minimizing the adverse consequences of the epidemic for individuals and for society is of paramount importance.

In response to these objectives and to the social and psychological needs of the rising numbers of people directly affected by HIV/AIDS and their families, who face enormous difficulties, the European Commission estimates that non-governmental bodies can play an increasing role in providing information, care and social and psychological assistance.

To assist efforts to ensure that persons living with HIV/AIDS receive information and psychosocial support, in 1993 the European Commission began funding the European self-care manual project for persons with HIV and AIDS. Its goal was to develop manuals which can be used to improve the quality of life of persons living with HIV and AIDS. That is why national culturally-specific self-care manuals for persons with HIV and AIDS have been developed in 10 Member States of the European Community, with strong and effective central coordination from the Foundation Augustus, Amsterdam, the Netherlands.

The Commission intended to ensure the cultural specificity of the self-care manuals to be developed in many European countries, and that proved possible in a cost-effective way by developing the manuals on the basis of the existing, tested Dutch self-care manual.

A self-care manual is a book which provides comprehensive and practical information on self-care and home care, written in a language which is accessible to persons with different levels of education. It aims to increase knowledge about HIV- and AIDS-related problems and supports self-care. During the development stage, the NGOs from different Member States made use of the translated texts of the abovementioned Dutch self-care manual. These texts served as a model and were tailored to the specific needs of the Member States participating.

The project began in November 1993 and was completed in October 1995. The following Member States took part: Belgium (Flanders and Wallonia), Denmark, Germany, Greece,

Spain, France, Ireland, Italy, Portugal and the United Kingdom. In Italy and the United Kingdom, where a regional self-care manual already existed, the project has resulted in initiatives to use this regional material on a larger scale. Because the need for a manual appeared to be very urgent, Italy produced a provisional new edition of the old manual.

The cornerstones of the project are: sharing experience and expertise, cooperation between Member States, the sharing of existing materials and central coordination of the project as a whole. These cornerstones have played an indispensable role in this project and made an undoubted contribution. All the participating organizations from Member States where no manual was available were able to produce a national culturally-specific self-care manual.

Because of cultural differences between the Member States, the manuals differ in content, format and presentation, but all of them are of high quality and user-friendly. In each Member State, distribution of the manuals is based on a plan drawn up according to the specific national situation.

The Austrian, Finnish and Swedish versions of the manual will be prepared in the near future.

This project went very well: the development of national self-care manuals based on an existing, translated manual proved to be very feasible, and was much quicker and cheaper than having to produce a manual from scratch. Furthermore, the use of the central coordination's expertise, through consultancy and the mutual contacts of the different participants during the central meetings, improved the efficiency and quality of the end products.

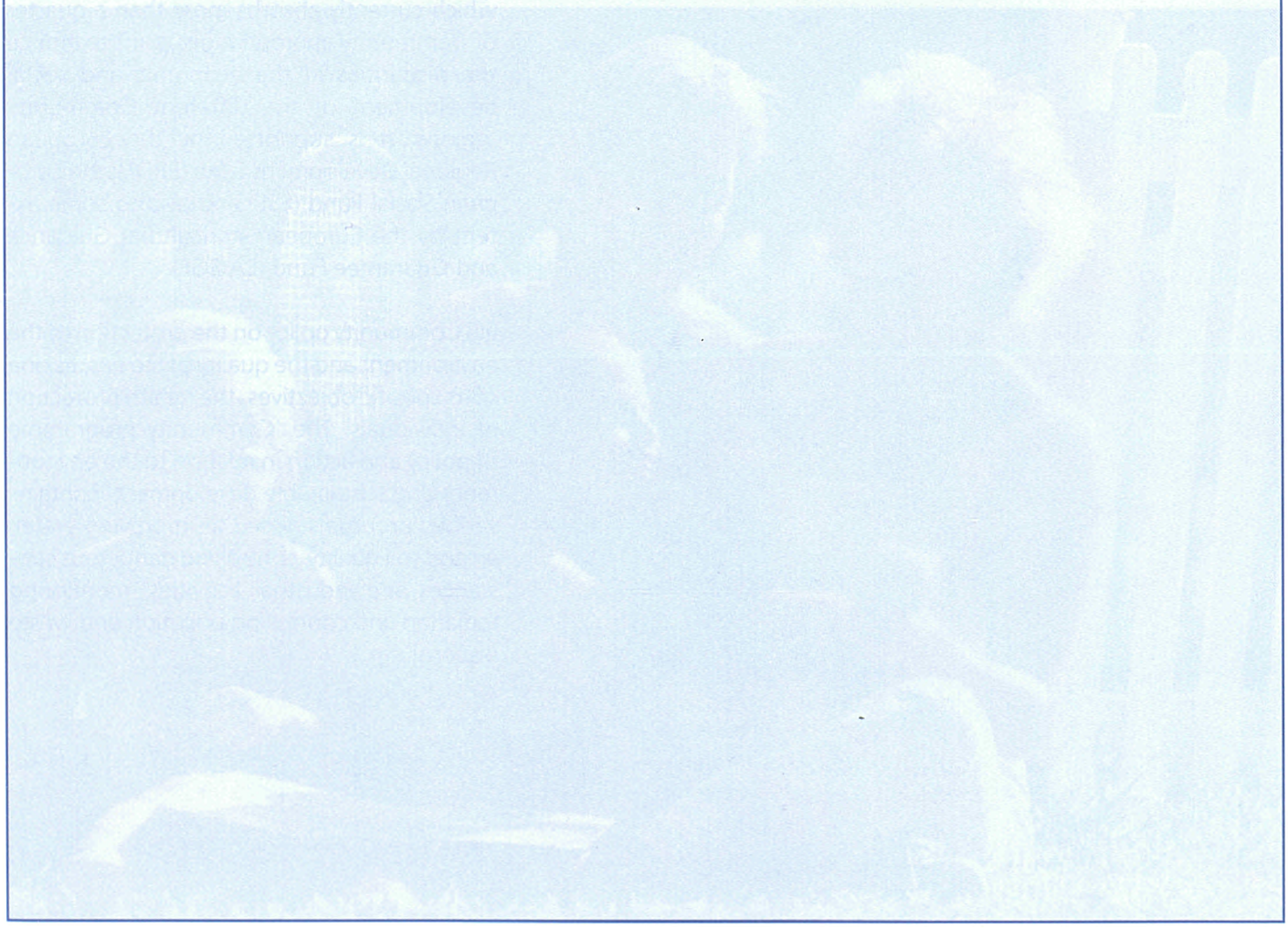
Evaluation of this project proved that the highly complicated tasks necessary for developing a self-care manual could be performed successfully by highly motivated organizations in the different Member States, cooperation and consultancy between them and a strong central coordination. Pan-European working not only proved to be possible, but also turned out to be highly effective.

It is worth mentioning once again that the manuals are culturally-specific. One model for all countries would not have done since the cultural, social and clinical circumstances vary considerably and the development of a self-care manual is complicated, costly and time-consuming: in this case it is clear that sharing experience and working together has enhanced the quality of the end-products, saved valuable time and money and, more importantly, helped to strengthen solidarity and social cohesion in the Community, lending support to HIV/AIDS sufferers.

Finally, this project also holds great potential for similar projects in countries outside the European Community, and for international self-care manual projects for other diseases. It would be very worthwhile indeed if, through similar, cost-effective programmes, persons with AIDS and other diseases could benefit from existing materials and experiences.

V

Health promotion



Health promotion: central to the Community's objectives and policies

In its broadest sense, health promotion, in other words the promotion of the right socioeconomic and environmental conditions to allow individuals and communities to opt for a healthy way of life, is one of the founding principles of the European Community. Indeed, it should always be borne in mind that the ideal of its founders was to ensure for the people of Europe a climate of peace, stability and exchange.

Article 2 of the Treaty of Rome (the EEC Treaty) assigned the Community the task of promoting throughout the Community a harmonious development of economic activities, a continuous and balanced expansion, an increase in stability and accelerated standard of living and closer relations between the States belonging to it.

The Community then gradually developed a series of sectoral policies, some of which have a considerable impact on health or are preparatory measures.

(i) Agricultural policy made it possible to guarantee Europeans a regular supply of good quality foodstuffs at socially acceptable market prices.

(ii) Economic and social cohesion policy, which currently absorbs more than a quarter of Community appropriations, aims to reduce the disparities in the economic and social development of the different Community regions. It is supported by the European Regional Development Fund (ERDF), the European Social Fund (ESF) and also to some extent by the European Agricultural Guidance and Guarantee Fund (EAGGF).

(iii) Community policy on the protection of the environment and the quality of life has, as one of its specific objectives, the health protection of individuals. The 'Community programme of policy and action in relation to the environment and sustainable development' contains various proposals aimed at improving water, air and soil quality, controlling dangerous substances and industrial activities, monitoring radiation and controlling pollution and waste disposal.

Protection and prevention measures and policies

In addition to the policies concerning the socioeconomic and environmental conditions necessary to ensure individual and collective health, the Community has introduced a series of health protection measures and policies.

The adoption of the Single European Act in 1986 was a considerable boost to the Community's efforts to improve the health and safety of workers and reduce the risks relating to exposure to carcinogens and other dangerous substances as well as the risk of industrial accidents.

In the field of consumer protection, a number of directives were adopted to improve the general safety of manufactured goods on the market and various aspects of the safety of foodstuffs, such as labelling, materials in contact with foodstuffs, additives.

As regards health care, the coordination of social security systems now means that under certain conditions insured persons can have access to it in other Community countries. Recognition of the right to benefit from human health protection systems, irrespective of personal resources, was established in a Council Recommendation on the convergence of social protection objectives and policies.

The framework research and technological development programme contains a specific programme on biomedical research, which includes public health research.

As regards medicinal products, the Community has adopted a series of directives on the approximation of the Member States' regulations on test protocols, manufacturing, marketing licences, the transparency of measures governing price fixing, classification, labelling and advertising.

One of the main objectives laid down in the Resolution on future action in the field of public health is 'to promote a healthy lifestyle and healthy physical and social environments'.

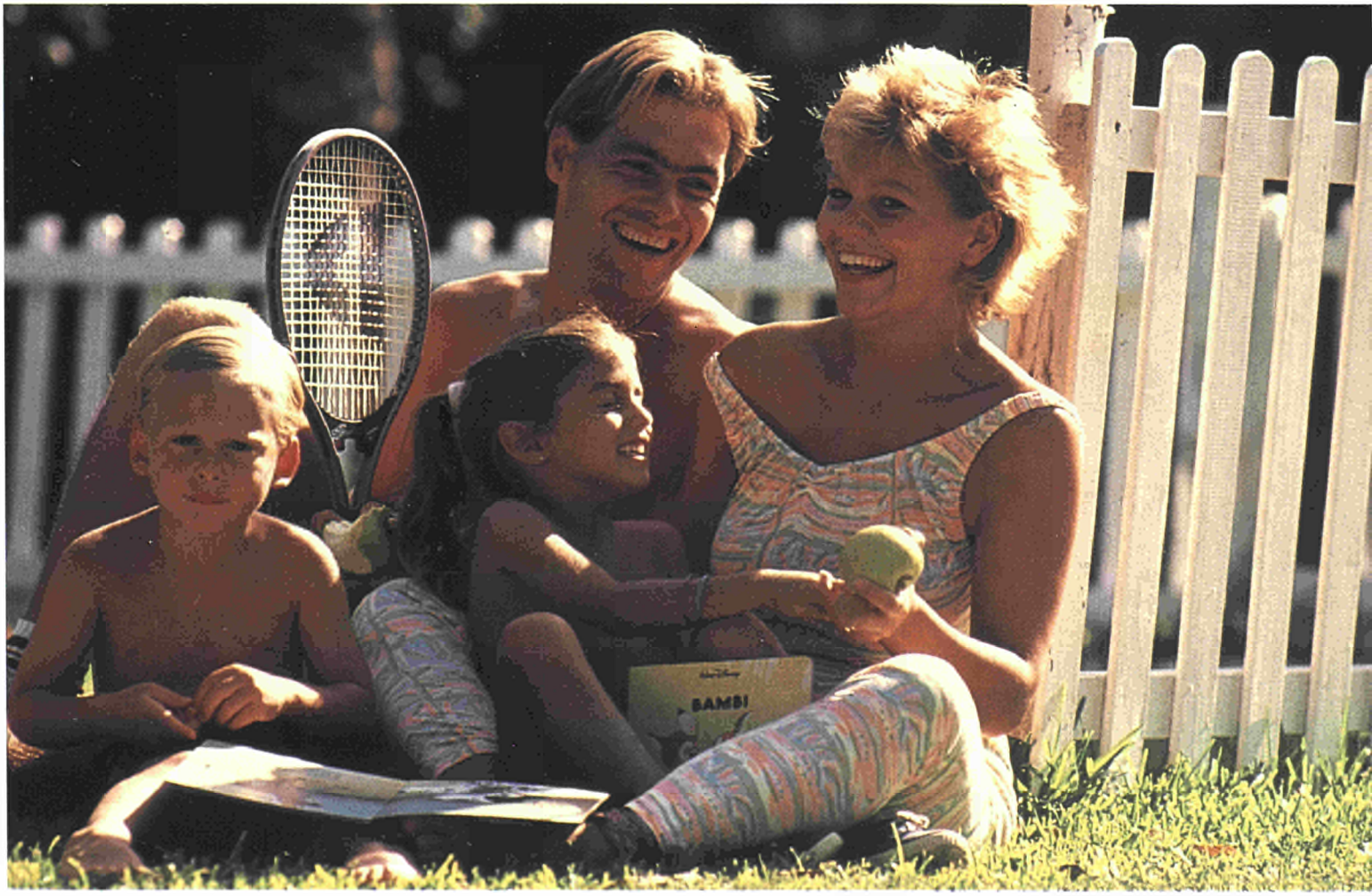


PHOTO © Isopress

From the mid-1980s, the Community began to introduce public health measures which went further than health monitoring and protection against the risks present in the environment and at the workplace, but which were aimed at encouraging and coordinating measures to combat diseases and promote health in a positive way.

(i) The Europe against cancer programme, in 1987, was the first major programme aimed at preventing disease; it was followed in 1991 by the Europe against AIDS programme and the European plan to combat drug dependence.

(ii) In response to the Resolutions of the Council of Ministers for Health and for Education and the European Parliament, the Commission supported various initiatives on health education in schools, in particular the European network of health-promoting schools, in cooperation with the World Health Organization and the Council of Europe.

The Treaty of Maastricht

With the entry into force on 1 November 1993 of the Treaty on European Union, the Community is given explicit competence in the field of public health. Article 129 of the Treaty specifies the scope of Community action in this field.

The Council of Ministers for Health, meeting on 27 May 1993, adopted a Resolution on future action in the field of public health. One of the main objectives laid down by the Ministers for Health was 'to promote a healthy lifestyle and healthy physical and social environments'.

In response to the objectives set by the Treaty and the Council of Ministers in the field of public health, the Commission, in its communication of 24 November 1993, identified priority areas which could be the subject of multiannual action programmes, and proposed a strategy.

In future, Community measures in the field of public health will focus on two types of complementary measures:

(i) programmes to combat specific diseases or 'scourges': these programmes, some of which will be a continuation of current measures, will cover cancer, AIDS and communicable diseases, drug dependence, accidents and suicides, rare diseases and diseases related to pollution;

(ii) in addition, the Community will introduce two horizontal programmes on:

- data, health indicators and the monitoring of diseases;
- health promotion, including health information, education and training.

This new health promotion programme was adopted by the Parliament and the Council of Ministers for Health on 16 February 1996.

The approach proposed by the Commission

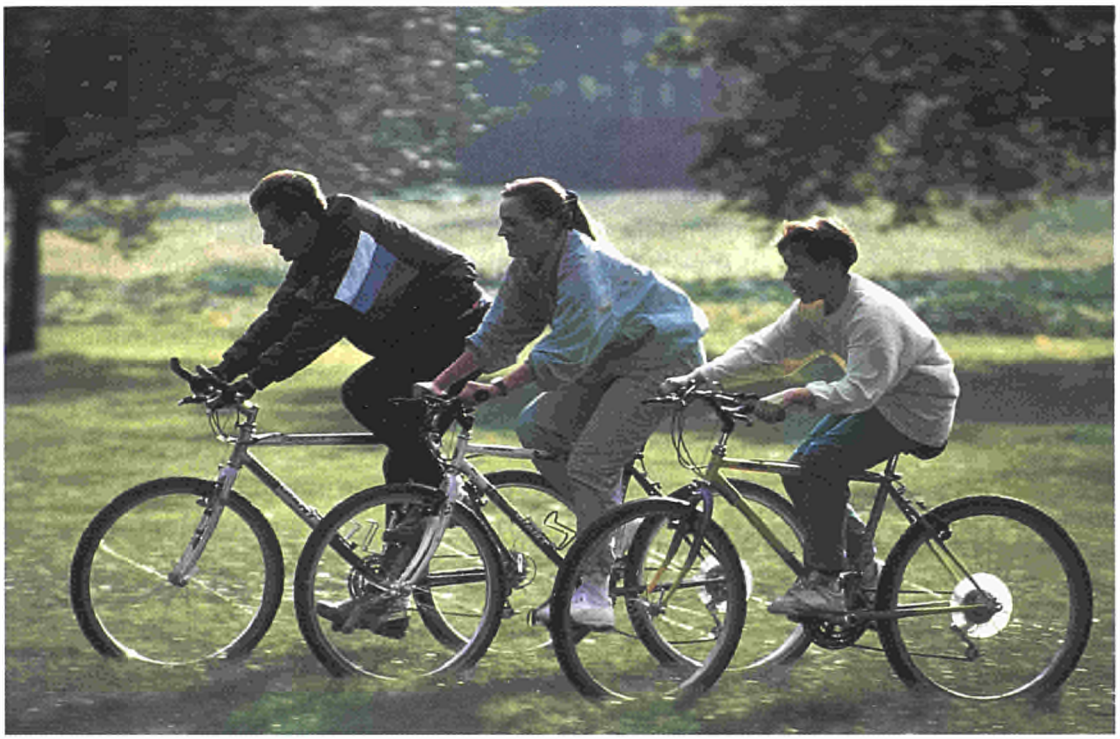
When drawing up its proposal for a health promotion programme, the Commission adopted a number of principles and concepts.

The health of an individual or group is determined by three groups of factors:

(i) environmental factors and socioeconomic conditions;

(ii) genetic factors, expressed as anatomical and physiological characteristics;

(iii) behavioural factors for which the individual is responsible (diet, alcohol, smoking, physical exercise, drugs, etc.), influenced by society, culture, education, training and information.



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The Community will support health education measures geared to young people in areas such as leisure and sports activities.

Within the Community, where the overall level of health is among the highest in the world, there are huge variations in life expectancy, morbidity and mortality in different population groups, depending on their socio-economic situation.

Improvements in the overall level of health in Europe have to take into account the unfavourable conditions of certain groups (such as the socially excluded, the poor, the elderly and immigrants) and certain communities (slum areas, suburbs, rural areas, etc.) because they are more exposed or more sensitive to certain risk factors, because their socio-economic conditions are unfavourable or because their behaviour and way of life make them more vulnerable.

The Commission also adopted the principle that health promotion should focus on health rather than illness. The promotion of health is not concerned directly with treatment or medical care; rather, by investing in health, it could help to reduce health expenditure and guarantee a high level of health for all. Great importance should be attached to the need to assess health promotion measures and programmes.

On the basis of these principles, the Commission believes that the main objective of the Community programme to promote health should be the development and encouragement of a 'health promotion' approach in the Member States' and Community's health policies.

There are five areas for action.

Health information

The first requirement for the adoption of a healthy lifestyle and behaviour is information on the dangers and benefits of a given factor or behavioural choice. Health information is an essential constant in health promotion.

The Community will help to improve understanding of the mechanisms for devising messages and assessing health information measures, by encouraging exchanges of information, skills and experience. In addition, the Community has an important role to play on a general level in promoting the exchange of information and documentation between reference centres at national level and between those responsible for public health and health promotion policies.

Health education

Health education is the cornerstone of health promotion policy. It is through education that the individual can move from simple awareness of a risk to a realization of what the risk means in terms of health and, ultimately, to the adoption of a responsible and positive behaviour and lifestyle.

The Community will support the efforts of the Member States to set up and implement health education programmes in schools and training programmes for teachers. It will encourage exchanges of experience and teaching materials and the implementation and evaluation of pilot education projects.

The Community will also support health education measures at the workplace and measures geared to adolescents and young people in areas such as leisure and sports activities.

Vocational training in public health and health promotion

In this area, the Community will try to develop and adapt training of the various types of players involved. Measures will concern understanding of what is available in public health and health promotion training at Community level, and will involve coordination between the Member States on the content of training.

Specific prevention and health promotion measures

These are aimed at particularly vulnerable or deprived groups (the poor, the socially excluded, communities of immigrants, the elderly, adolescents, etc.).

Health promotion structures and strategies

There is at present a fairly wide discrepancy between the Member States in the level of development and implementation of an overall health promotion strategy. The structures and resources used also differ considerably. By encouraging exchanges of experience and evaluation of the results of these policies, the Community can help to develop joint strategies.

The European network of health-promoting schools (ENHPS)

The European network of health-promoting schools is a concrete example of a health promotion activity that has successfully incorporated the energies of three major European agencies in the joint pursuit of their goals in school health promotion. Since 1991, the project has been a tripartite activity, launched by the European Commission (EC), the Council of Europe and the World Health Organization Regional Office for Europe (WHO/EURO).

Introduction

The joint planning and management of the ENHPS was one of the recommendations of the EC, the Council and WHO/EURO Conference on Health Education (Strasbourg, 20 to 22 September 1990). It builds on the collaborative work done in the 1980s under the pilot project 'Education for health'. This joint venture is in line with WHO's current priorities for health promotion and it is also in the spirit of the EC Council Resolution of 23 November 1988 on the implementation of health education in schools and the European Conference on Health Education and Prevention in schools organized by the EC and held in Dublin from 7 to 11 February 1990. On several occasions European Member States praised this collaboration between the EC, the Council and WHO/EURO in setting up this network. Such pragmatic collaboration is essential to avoid duplication and provide a framework within which to foster and sustain innovation, disseminate models of good practice and make opportunities for health promotion in schools more equitably available throughout Europe.

This innovative project has generated great motivation within Europe. This is demonstrated by the rapid nature of its development, from a small pilot activity involving four countries in 1991, to the project we see today, in which 37 countries participate, including all 15 Member States of the European Union and 22 other countries beyond the EU.

Countries committed to this pan-European initiative are addressing their energies in school health promotion towards the ultimate goal of creating in schools environments which are conducive to health. These are being pursued through the development, as part of the curriculum, of health and safety,

teaching and learning styles, and so on. The project will make schools better equipped to improve results. No doubt these are very ambitious goals, but the challenge facing a fast-changing Europe demands the type of change, innovation and the climate of care and support in schools which are embodied within the ENHPS.

What is a health-promoting school?

The health-promoting school aims at achieving healthy lifestyles for the total school population by developing supportive environments conducive to the promotion of health. It offers opportunities for, and requires commitment to, the provision of a safe and health-enhancing social and physical environment. A health-promoting school will, through its management structures, its internal and external relationships, the teaching and learning styles it adopts and the methods it uses to establish synergy with its social environment, create the means for all who live and work within it to take control over and improve their physical and emotional health. The health-promoting school, as an investment, is one that European countries cannot afford to delay.

The health-promoting school aims at fostering a healthy and happy school environment.

Photo: © Isopress

Background

The ENHPS is a timely project, given the challenges facing Europe in the 1990s. The aim of the project is to set up a network of demonstration site schools in countries to illustrate, through the development of good practice, the impact of health promotion in the school setting. Project schools will then be used throughout the health and education sectors to disseminate experiences and learning and influence policy and practice in school health promotion, nationally and internationally.

Since collaboration between the EC, the Council and WHO/EURO first began, the project has undergone rapid change. Beginning as a small pilot project, the network now includes over 500 schools with 400 000 students, in 37 countries. A further 2 000 schools are linked to the network through national or regional arrangements. All EU Member States are now members of the ENHPS. The network provides a unique platform for cross-country exchanges, partnerships and commitments.

The network is seen by the health and education sectors as a consolidating initiative. With partnership as both method and goal, the network provides a flexible framework in which project schools can determine their needs and work to meet them in their own ways. Participating pilot schools commit themselves to promoting health in schools by making them safe and health-enhancing social and physical environments in which to live, work and learn.

Management

The network is not run by the international organizations but is supported by them, morally and technically, as well as financially. It is run by the participating schools with the primary objective of improving and protecting the physical and emotional health and welfare of pupils, teachers, non-teaching staff and the wider community.

The network aims to be as decentralized as possible. The three sponsoring bodies (EC, Council, WHO/EURO) supporting the network have formed an International Planning Committee (IPC) with representatives from each of the organizations and a technical secretariat (hosted by the WHO Regional Office for Europe) as the technical supporting body. The IPC provides focus and ensures links and opportunities for all the parties in the network. These management arrangements have created a low bureaucracy and high result culture within the project.

Each country with pilot schools has a national coordinator. The group of national coordinators meets at least once a year to discuss experiences, needs and challenges. The technical secretariat provides back-up for the national coordinators by keeping track of ENHPS developments, giving technical guidance in countries, assisting in the organization of workshops, giving presentations at international and regional meetings, and arranging the annual business meetings for all national coordinators. The business meeting examines the future needs of members of the network. The technical secretariat also produces teaching and training aids and other material useful for the practical implementation and evaluation of the project.

Several case studies emerging from the network have now shown that through the commitment and eagerness of the projects, a considerable variety of programmes have been initiated. These have included: active collaboration between pupils, staff, parents and the community in the implementation of the health-promoting school concept; environmental improvements which have affected the ethos of the school; school policy development in specific areas and the creation of a supportive atmosphere for teaching and learning.

European dimension

Europe is made up of many cultures. An important part of the education process and the upbringing of young people includes the opportunity of developing a common understanding and recognition of this cultural diversity. Taking this into consideration, the project has from the very beginning aimed at including a European dimension where twinning projects at both national and local level are ways of sharing experiences and improving international understanding and mutual respect.

Several twinning programmes have started already, involving the sharing of information and the development of parallel health promotion activities with the help of tools such as electronic communication and video recording, as well as the exchange of teachers and students. These are monitored on a regular basis and results are published in the form of newsletters, technical articles, case studies, analyses, etc.

The role of the European Commission

By adopting the programme of Community action on health promotion, information, education and training within the framework for action in the field of public health, the Commission has created the environment for health promotion programmes up to the year 2000. The health-promoting schools programme is part of this programme and is aimed at the preparation and dissemination of school health education programmes and teaching materials and modules geared to different ages and different Member States; consultation between Member States (seminars, conferences, studies, programme assessments, etc.) with a view to including health education in school curricula; demonstration projects and innovative experiments aimed at promoting healthy lifestyles and responsible behaviour and involving the various partners concerned (children and young people, teachers and instructors, parents, the community, etc.); supporting the European network of health-promoting schools, in cooperation with WHO/EURO and the Council of Europe. The Commission's role has been instrumental in providing the added value which is much needed by such organizations and large-scale projects like the ENHPS.

Impact assessment and value added

The ENHPS is now a complex, large and truly European project. It has been hailed in documentation from the Commission, WHO/EURO and the Council as an exemplary model of collaboration between these three major European bodies and is now beginning to gather real evidence of success.

Examples are given below.

(i) The project has, from the outset, focused very strongly on the development of collaboration for all partners involved. At national level, the formal agreement on a joint commitment to the project from the Ministries of Health and Education has opened the way for a more effective approach to health promotion and education.

(ii) Several countries are already at the point of forming a national curriculum on health education based on the experience gained in the first phase of the project.

(iii) The mobilization of resources to provide technical support through specific tools and training has been increasingly successful.

(iv) Exchanges and cooperation between countries and schools have strengthened the network and brought about increased quality in health-promoting school-based initiatives.

(v) The project is reported to have an increasing impact on democratization in schools as well as in pre- and in-service teacher training.

(vi) International workshops have been held on a regular basis, including one for the German-speaking countries (Germany, Austria, Switzerland), where experience and good practice are exchanged.

(vii) An evaluation support system, funded by the EC, has just been completed. Its purpose is to provide appropriate tools for the evaluation of the various elements of this complex project. Through the process of building up an evaluation support system for the ENHPS, a wide range of school health promotion evaluation expertise from within Europe and several models of good practice in evaluation are now available.

(viii) Some countries are even reporting that the project has had an impact on policy development at national level.

(ix) In several countries, networks are now expanding to include more schools and thus the original idea of the pilot phase moving into the phase of dissemination and country-wide development is increasingly being fulfilled.

The funding for project activities demonstrates the advantages of accessing various sources of funding for particular aspects of the project. The Technical Secretariat receives funding from the Commission for the coordination of project activities in EU Member States. The Technical Secretariat is also funded by WHO/EURO. The Commission also gives EU Member States funding for national support. Other countries within the network receive funding from WHO/EURO. Additional sources of funding have come from the Council of Europe through the Demosthenes programme. This programme provides funding

An important part of the education of young people includes the opportunity of developing a common understanding and recognition of the cultural diversity in Europe.

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for training initiatives in Central and Eastern Europe. In some cases, funding has also been secured from the private sector. This has enabled the project to move forward at various levels, by pinpointing particular issues which have been prioritized by countries and have then attracted funding, by seeking support for countries in critical states of transition and by providing maintenance support funding for the development of long-term plans and strategies. Many countries also support project activities by setting aside money from both the national health and education budgets. National coordinators and project national support centres are frequently supported in this way.

The future

Countries participating in the ENHPS recognize that there is still a need for change. National coordinators, and their respective partners at national and local levels, carry substantial responsibility in strategic planning, coordinating activities and introducing changes into schools. It is essential, therefore, that they continue to be highly trained in all aspects of project management and innovation. However, particular problems are faced by national coordinators, trainers and teachers in introducing new methodologies and practices into education and health systems. Many classroom teachers are not used to introducing new teaching methods and feel unsure about using them. Many school administrators lack confidence in introducing change into school management structures. Trainers, although eager to learn new methods, require substantial training themselves, by competent group work experts. It is within this challenging context that the cooperation offered jointly by the EC, the Council and WHO/EURO is greatly appreciated by European countries.

Changes on the scale requested by a health-promoting school need skilful management in their introduction and adoption, and support in their final establishment as legitimate elements in school life. In the education environment which prevails in many European countries, the introduction and management of change is an enormously complex process. The opportunity to reflect upon and plan approaches to complex problems over an extended period of time is rare. The leaders of ENHPS national projects are now facing the most critical period in the project's life. The issues to be addressed are now: maintaining momentum, creating the sustainability so vital for the long-term future of health promotion in schools, and generating impact on local and national policies. At both international and national levels, the project requires careful attention to be paid to how the ENHPS can tackle the changes necessary within the education and health promotion services, in order to guarantee success.

The notion of whole school approaches to health promotion requires schools to consider, introduce, adopt and develop new approaches and methodologies in education. Based upon the very encouraging results of its first phase of development, the ENHPS is ready to consolidate and increase its impact on the whole school and its organization. This includes:

- ☐ the school environment
- ☐ teaching and learning methodologies
- ☐ the curriculum
- ☐ management practices
- ☐ democracy in the classroom
- ☐ relationships with the community
- ☐ research and evaluation.

Each of these components is now operationally taken into consideration in the development plan for the second phase of project activities.

Priority areas for action up until the year 2000

The first phase of ENHPS development highlighted the tremendous scope and potential for health promotion in schools. Able to address key issues at personal, social and physical levels, schools constitute an ideal setting for health education, and signal the way ahead for the health promotion strategies of the future.

Consequently, the network's original aim enabled schools to become more supportive, caring and healthier environments, integrating health promotion into the curriculum, introducing health-enhancing programmes and practices into the schools' daily routine, gain-

ing a greater awareness of working conditions, and fostering better relations within the schools themselves and a better rapport between the schools and their local communities.

While the first phase of development has proved that these aims are still valid for the future, the ENHPS is now ready to build and expand on them, tackling some new and ambitious goals, goals which will meet the growing needs of schools and coordinators, and respond to the new developments and changes within the project over the next four years.

Future development will take into account the transition into an established long-term project, allow for different approaches to project implementation, and recognize the need for an accurate means of measuring progress.

In the next phase the development of the project will continue to foster a fresh and democratic approach. It will not simply aim to prevent illness by influencing individual behaviour. Rather, it will seek to improve the whole quality of the school setting with health promotion as a device, ensuring that the environment of pupils, teachers and all those involved in everyday school life is safe and health-enhancing. This push towards more structural changes within the school settings will greatly facilitate the adoption of healthy lifestyles for the school population.

It will also seek to reduce inequalities in health and education, with the introduction of carefully targeted activities aimed at vulnerable groups and specific areas such as disadvantaged inner cities and rural districts.

At an international planning committee meeting, hosted by the EC in Luxembourg (November 1995), a new development plan including a working document setting out the strategy, aims and priorities for future development of the European network of health-promoting schools was endorsed by the three sponsoring bodies. 'The health-promoting school — an investment in education, health and democracy' is the title of the first international conference of the European network of health-promoting schools which took place in Greece in May 1997. A wide range of people, including key decision-makers and opinion formers working in the health and education sectors were invited.

Evaluation at international, national and local level is also a major issue at a time when several countries of the network are ending the initial phase of the project. Tools for evaluation have been developed and an evaluation report from the Technical Secretariat will be available in the middle of 1997. The report will cover a selection of countries who are members of the ENHPS and it will focus on illustrating the character of project implementation in different national contexts, investigating the support to the project at international, national and local level and drawing lessons for improved support and the management of change. Included in the report will be an audit methodology, which will allow for the continued monitoring of national projects.

The development of dissemination strategies has already started and the Technical Secretariat sees it as a major task to offer continuous support to the national projects in this area.

Europe deserves a stronger and ever-expanding network of health-promoting schools. It is an investment for our future and for our Europe.

European network for workplace health promotion

The European Commission, having acquired competence to take action in the field of public health, submitted a proposal for a health promotion action programme to the European Parliament and the Council. This was adopted on 16 February 1996 as a five-year programme with an overall budget of ECU 35 million. The tightness of the budget virtually rules out the possibility of financial support for national policies to promote health: only the launching of funding in priority areas can be considered. Projects which are to be subsidized, extended or set up with funds from the European Union must be of prime importance for the Community as a whole and the Member States, must extend beyond national interests and policies and must have a clear European dimension in the sense that they offer added value vis-à-vis *national health promotion policies.*

Article 129 of the EU Treaty does not specify that the institutions of the EU are to develop their own plan for health promotion — in addition to the health policies of the Member States — which embraces the various national plans, later replaces them and is then implemented as standard practice in the Member States. We can assume rather that the Member States have, in accordance with the principle of subsidiarity, long been operating comprehensive health policies catering for their own needs. These national programmes should remain in force, as in the past, and should be promoted only to the extent of being made known to the European public as well as to the regional or national population. This is precisely the aim pursued by Article 129 of the Treaty on European Union, which sets the Community the task of promoting cooperation between the Member States and coordinating Member State policies in liaison with the Commission. This means that any projects intended to achieve the aims of Article 129 of the EU Treaty must have a European dimension or offer benefits for Europe.

The place of work as a setting for health promotion

Health promotion is a process in the course of which working and living conditions are changed and people are taught how to play an active part in enhancing their health. The key questions are the following. What keeps people healthy? What aspects of the material and social working and living environment serve as resources? What experiences and learning processes enable and motivate people to make an effort to stay healthy?

The general aim of health promotion is a maximum increase in well-being with higher life expectancy, especially for groups of the population which hitherto have been disadvantaged in terms of health. Health promotion at work is intended to help healthier practices and behaviour at work to become easier and more rewarding for all concerned. Under a corporate policy geared to promoting health, employees, in-house health experts, managers and work councils should together design working conditions which are conducive to health and which enable and encourage the workforce to adopt healthy working practices and lifestyles (behaviour).

Primary prevention of specific diseases or hazards, secondary prevention for early detection and tertiary prevention for rehabilitation all make vital contributions to a comprehensive approach to health promotion. However, the key elements of a policy for health at work are as follows.

(i) A corporate culture and philosophy which accords the workforce's health the same priority as the enterprise's economic goals creates a good atmosphere for a comprehensive policy to promote health within the enterprise. In particular, this involves guidelines for cooperative and participative methods of management and management practice which accords high priority to the well-being of workers.

(ii) A health and safety policy which places the emphasis on prevention and is refined to produce forward-looking, health-conscious job design provides a good platform for overall health promotion at work. This means that the enterprise's technology and organization are designed to give its workforce maximum control over their own working conditions, scope for exercising their own options and opportunities for mutual support between colleagues in, for example, group projects. Health promotion can also include in-house agreements on hard- and software ergonomics and mixed tasking for people working on visual display units (VDUs).

(iii) Personnel deployment and development strategies enable the potential offered by these technical and organizational aspects of work to be exploited to the full. Ergonomic improvements and increased scope for action only enhance employees' sense of well-being if they are able, qualified and motivated to take advantage of them. Recruiting people who meet the enterprise's requirements and

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The enterprise's social policy in the wider sense also includes providing healthy food in a canteen where the atmosphere is conducive to chatting with colleagues and relaxing.

providing them with initial and further training thus make an important contribution to health promotion at work.

(iv) The enterprise's social policy in the wider sense can also be conducive to health, irrespective of whether the employer introduces the following measures in the spirit of a benevolent patriarch or at the suggestion of and in consultation with the representatives of the workers: cooperation with the health insurance scheme on all matters of health protection; expert advice for people suffering from psychosocial stress and addiction problems; information and courses on coping with stress for specific target groups; widening the range of sports available at or through work; an in-house agreement to protect non-smokers; tasty, cheap and healthy food in a canteen where the atmosphere is conducive to chatting with colleagues and relaxing.

(v) Arrangements on working hours which make it easier for people to reconcile family and working demands in accordance with their own inclinations and commitments help to avoid stress and can also reduce the effects on health of men's and women's different social roles. Important issues here are humane planning of shifts and arrangements to reintroduce normal working hours for shift workers and especially night workers.

(vi) Particularly health-conscious private enterprises or public services do not confine health promotion to internal matters. Environment- and health-conscious production methods, products and services are part of the comprehensive health policy of such enterprises which seek to enhance their image locally and amongst customers and consumers.

(vii) Finally, a health-conscious enterprise also takes an active part in municipal and regional health promotion, providing, for example, advice, practical help with premises or tools or sponsorship for municipal social and sports facilities.

In the sense of the WHO's Ottawa Charter, health promotion therefore means change — sometimes radical — in the structures and processes within an enterprise and its relations with its environment and, of course, assumes that experts, management and the whole workforce measure their decisions and their conduct against the yardstick of health promotion and make adjustments, if necessary.

Fields of action and means of communication

Health promotion concentrates on the factors which determine the health of the population and which an individual can alter at his own discretion. These factors mainly comprise diet, alcohol, tobacco, drugs, physical and mental health, and medication and its use.

In the enterprise these factors are an integral part of both practical action which the enterprises can initiate themselves and health promotion packages which public health institutions such as health insurance bodies can offer them.

Information, education and training have proved to be useful health promotion tools for imparting the necessary information on the risks of specific factors or types of behaviour and for increasing the awareness and motivation of individuals with a view to altering attitudes and behaviour. These are deployed in different ways in promoting health at work.

The place of health promotion at work in the action programme

Measures for promoting health pursue the following general objectives: to improve the standard of health in the community by informing people about the factors which jeopardize or promote health and by encouraging lifestyles and behaviour which are conducive to health, and to contribute to improving the socioeconomic conditions and environmental conditions which are a prerequisite for the health of the individual and the community. According to the Commission, health promotion and health education can be regarded as general areas of activity which cover many lifestyle-induced diseases and accidents in a variety of environments (such as work) and seek to mitigate high-risk behaviour, especially by supporting measures to devise approaches and activities incorporating information, education and training — the three main instruments of health promotion.

The action programme sees the place of work as a suitable environment for a health education drive. This can take the form of information on diet as part of in-house catering, on prevention of excessive drinking and smoking and on stress factors and stress avoidance. The following measures are intended to contribute to achieving the action programme's aims:

(i) general health education measures at work, especially regarding diet and prevention of excessive drinking and smoking;

(ii) measures targeting specific groups such as young people, older workers and women;

(iii) preparation and dissemination of teaching material, dissemination of 'model practices' arising from experiments, etc. Such initiatives complement action in other EU programmes.

The action programme provides for more general measures in the field of health education: information methods and techniques, exchanges of experience, cost-effectiveness analysis, preparation and assessment of campaigns, and cross-border networks.

The action programme states (point 104) that health promotion has an intersectoral dimension, which means that legal instruments in other areas of policy which also affect health can contribute to the promotion and protection of health. Working conditions are also mentioned in this context. This opens up the possibility of linking measures for safety and health with those for promoting health at the place of work.

Successful workplace health promotion: an overview

Once the reasons for a health drive at work have been clarified, the next question is how health promotion can be launched and implemented successfully. The main conditions for this are:

- cooperation within and between enterprises
- analysis of the initial situation (health report)
- setting priorities and goals
- involving workers
- health-related communication
- identifying and overcoming obstacles
- observation and analysis of measures taken.

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Providing initial and further training for personnel makes an important contribution to health promotion at work.

The foundations and key characteristics of health promotion at work can be summarized as follows:

(i) Health promotion is a process in the course of which healthy and health-inducing practices and types of behaviour are made more rewarding for everyone in the enterprise.

(ii) Health promotion combines strategies for work-orientated and behavioural prevention, organization and personnel development, healthy job design and reinforcement of personal responsibility for health.

(iii) Health promotion is intended to reduce and eliminate disadvantages for individual groups of workers permanently.

(iv) Humanitarian company aims and a participatory management style create a positive atmosphere for promoting health.

(v) Clear-cut areas of responsibility and arrangements for interdisciplinary cooperation make it easier to cooperate on health.

(vi) Weak points and needs must be analysed before priorities can be set.

(vii) The aims of health promotion are to be set out in terms which are geared to action, i.e. are practical, target specific groups and promote an overall concept of health.

(viii)The aims of health promotion in an enterprise become more focused and are more readily accepted when workers are actively involved in all phases.

(ix) Health promotion can be put into practice quickly once clear budget rules and agreement on its goals have been established.

(x) Health promotion benefits from timely and comprehensive information to all those involved and from attractive public relations work.

(xi) Constant monitoring and regular assessment of the costs and benefits of health promotion provide arguments in favour of a permanent in-house health policy and efficient customization of individual measures.

The more sophisticated these arrangements are in an enterprise, the higher the quality of health promotion will be in practice and the closer it will get to being a health-promoting enterprise in the sense of the WHO's Ottawa Charter.

Quality and health promotion

Quality is a concept which is difficult to pin down, as it can be interpreted differently and is ultimately defined in terms of its goals. The formal definition in accordance with DIN ISO 8402 is: 'All the properties of a product or a service which relate to the ability to meet various explicit or tacit requirements'. A better definition (Haist and Fromm) is: 'Compliance with the customer's requirements with respect to function, price, delivery period, safety, reliability, environmental friendliness, value, cost, guidance, etc.'.

The DIN ISO 9000 series of standards, which has been in existence since 1989, examines the need for enterprises to introduce methods and processes to prevent errors (quality assurance systems). Such systems are understood to comprise conformity specifications, internal testing systems and design, operation and process documentation, which is kept in the enterprise's quality management file.

An important requirement of ISO 9000 is for evidence of a quality assurance system, demonstrating an enterprise's ability to develop, produce and deliver a product or a service (health promotion measures).

Key features of quality assurance in organizing health promotion programmes are listed below.

1. A basic consensus between all the parties concerned
Health promotion can only be implemented if all the parties concerned can agree on its aims. Ideally, health promotion at work expresses the parties' conviction that goods and services may not be produced at the expense of human health.

2. Organizational development
Health promotion is a horizontal task which can affect all areas and ought to be incorporated in organization development projects. It can thus become part of the quality assurance system for total quality management and an instrument in change management.

3. Participation of workers
Health promotion must involve the employees and/or all parties concerned. Premises, time and training must be made available in order to secure their cooperation in achieving common health aims. The representation of interest bodies are also called upon to support them.

4. Work-related measures
Measures to promote health at work should relate to general and individual working conditions and should meet the needs of the workers. One of their tasks is therefore to identify pathogenic and health-promoting aspects of work.

5. Interdisciplinarity
An interdisciplinary approach to promoting health at work should be adopted in order to meet the specific requirements of this area of activity. Psychologists, sports teachers and nutritional scientists, etc. must cooperate in this field to extend the traditional scope of health and safety at work.

6. Long-term prospects and institutionalization
Health promotion should be institutionalized as a long-term systematic process comprising analysis, planning, implementation and assessment phases. This can be achieved with the help of a working party on health for one or more enterprises or an extended safety and health committee.

7. Customization
Health promotion at work is to be tailored to each enterprise, reflecting circumstances and the specific culture of each one; there is no one best way.

Specific quality assurance elements are to be developed for the individual fields of activity. Individual plans (for Adipositas in Germany) already exist.

The working of the network

The network is designed to be an information network, in which the Bundesanstalt für Arbeitsschutz acts as an intermediary between the Commission and the 15 Member States.

The tasks of the European coordination office include distributing the resources for the national contact points, gathering and circulating information on all significant activities undertaken in this field in Europe, ensuring the transfer of information, compiling the annual European status report on the basis of the national status reports, and, through public relations and publications, encouraging multilateral cooperation and circulating important findings. To this extent, the coordination office has an organizational role.

The national contact points will be expected to conduct a stocktaking of all important activities in the field of health promotion at work, organize and exchange information and experience, organize an information day in their own country, find new network partners, help project groups to set up, and organize transfers of information, chiefly via electronic media.

All 15 Member States have expressed an interest in participating in the network and in setting up national contact points.

As far as the national stocktaking of activities in the field of health promotion at work is concerned, the Bundesanstalt für Arbeitsschutz will produce a catalogue of specifications to help Member States in producing their status reports. Using summaries, the national reports should describe clearly the backgrounds to workplace health promotion and the different structures in place. Each national status report will be made available to all Member States.

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Commission communication on the framework for action in the field of public health

Contents

Annex

Executive summary

This communication sets out the Commission's proposals for taking forward the Community's work on public health to meet the objective introduced by the Treaty on European Union that 'the Community shall contribute towards ensuring a high level of human health protection' (Article 129). It defines a framework for action by the Community, and describes the role of the Community institutions and the Member States. It sets out a strategy for action, identifies the means available to the Community to accomplish its aims and establishes the procedures for evaluation, review and consultation. Finally, key areas of action are selected for the next five years.

The communication is divided into two parts. The first part sets out the background to public health policy, and the second describes the European Community approach.

Part A

Background to public health policy

Chapter I of the document provides an overview of the main health-related problems and challenges facing Member States today. These problems relate to:

(i) the ageing population of the Community;

(ii) increasing population mobility in the Community and between Member States;

(iii) changes in the environment and in the work setting;

(iv) rising expectations about what health services can and should deliver; and

(v) the general socio-economic problems of the Community, notably social exclusion.

As a result of these problems Member States have been facing increasing pressures on the provision of health services and these are likely to grow in the future.

The scope of public health policy is then set out and how it involves activities aimed at individuals' immediate environment and the more general context in which they live.

Annex I to the communication summarizes the Member States' prevention and health promotion policies.

Chapter II presents a description of the major trends in health status in Member States based on available mortality and morbidity data. The figures show that in recent decades there has been a substantial improvement in overall health status, with people living longer, and that cancer and cardiovascular diseases, and for young people accidents, are the major causes of death in the Community. Other conditions producing significant morbidity and mortality are listed. Annex V presents more detailed statistical data.

Chapter III sets out the basis for Community action on public health. It describes the application of the principles of subsidiarity, transparency and proportionality to this area, emphasizing that questions of the finance and delivery of care and treatment services are for each Member State to determine.

The legal bases for Community activities in health are outlined (the policies, programmes and instruments giving effect to them are set out in Annexes II and III). The provisions and significance of Article 129 are then set out in detail. The main elements of this Article are the focus on prevention of diseases, particularly the 'major scourges', including drug abuse; the stress that health requirements must be considered in developing other Community policies, and the obligation on the Commission to liaise with the Member States in the coordination of their policies and programmes.

The chapter finally outlines the work undertaken by the European Council, the Council, the European Parliament and the Economic and Social Committee in the development of Community public health policy.

Part B

The European Community approach

Chapter IV first sets out the scope of possible Community action in public health and the objectives of such Community action. It then describes the means of undertaking Community action in this field, including the establishment of common objectives and of networks, exchange of information and personnel, improvement of data systems, financial support to programmes and projects, production of an annual Community health report, and assistance to cost reduction efforts.

Principles for identifying diseases or health threats for Community action are given. The selection involves consideration of both diseases' effects on the health status of the Community population and whether preventive action can appropriately be taken at Community level (Annex IV lists important health scourges and their impact).

On this basis cancer, cardiovascular diseases, accidents, AIDS and communicable diseases, drug dependence and rare diseases are deemed to be appropriate targets for action.

Chapter V on causation of diseases makes the point that for effective disease prevention, it is vital that their underlying causes are addressed by a mixture of measures. Important causal factors, such as smoking and alcohol, are set out together with data on their trends in the Community.

Chapter VI on the nature and extent of Community involvement explains the broad mechanisms that the Commission will use in taking forward the objectives of policy. It will give priority to large-scale, wide impact projects and will keep a 'health watch' on other Community programmes and policies as they develop.

The kinds of general mechanisms to be used are described in detail.

(i) *Consultation and participation.* Appropriate mechanisms will be set up to give advice to the Commission on formulating and implementing activities.

(ii) *Promotion of programme and policy coordination.* Comparisons and evaluations of prevention policies and cost-effectiveness analyses will be made and networks to monitor diseases set up.

(iii) *Cooperation with international organizations and third countries.* Existing cooperation with relevant international bodies such as WHO will be increased e.g. by commissioning specific work from them, conducting joint programmes or supporting their programmes. With regard to third countries, existing assistance schemes will be stepped up and consideration will be given to undertaking further cooperation with particular countries notably in Central and Eastern Europe.

(iv) *Information, education and health promotion.* A coordinated programme of health education and promotion measures will be developed aiming both at causal factors and specific diseases. This will take forward the work already being carried out in certain areas e.g. AIDS and cancer.

(v) *Research.* Steps will be taken to strengthen links with the Community research programmes, as defined in the fourth research and development framework programme, to ensure that the research needs of public health are met, to establish a strategy for public health research and to ensure that the results are properly disseminated.

(vi) *Training of health professionals.* To increase the effectiveness of health professionals' role in public health, existing courses will be evaluated, collaboration on new ones promoted, and exchanges of experiences and information on teaching and training will be fostered.

Chapter VII on future action in the field of public health sets out, on the basis of the arguments in the preceding chapters, the priority areas for Community action in public health. The areas proposed cover 'horizontal' activities and diseases — specific ones. They are:

(i) health promotion, education, information and training;

(ii) health data and indicators, and monitoring and surveillance of diseases;

(iii) cancer;

(iv) drugs;

(v) AIDS and other communicable diseases;

(vi) accidents and injuries;

(vii) pollution-related diseases;

(viii) rare diseases;

(ix) other health threats (if circumstances require).

This communication is only a first step towards a continuing effort of developing policies, programmes and individual actions designed to give full effect to Article 129, and to other articles in the Treaties of relevance to health protection. It would be followed by a series of programmes on each of the identified topics above. The Commission hopes that it will stimulate debate, help concentrate attention on health prevention and promotion, as has been the case in Member

States concerning health care and treatment, and build lasting partnerships and networks in the common endeavour to bring about a high level of health protection in the European Community.

Part A

Background to public health policy

I — Introduction

1. This communication sets out the Commission's proposals for a framework for action in the field of public health in the light of the ratification of the Treaty on European Union, which introduced Articles 3(O) and 129, with explicit provisions on public health, in the Treaty establishing the European Community.

2. In essence the communication does four things. First it sets out the major issues in relation to health which confront the Community. Second, it explains how priorities for Community action can be established. Third, it describes the kinds of actions that are possible and how they fit together with what has been done so far on public health by the Community and by Member States and also with other Community programmes. Finally a number of specific programmes of actions are proposed.

3. The proposed framework set out in this communication is intended to build upon the important contributions made by the Council, the European Parliament, and the Economic and Social Committee in this area, as well as the work of the Commission. It takes full account of all the principles for Community action laid down in the Treaty on European Union and in the other Treaties.

(a) Current health challenges in the Member States of the European Community

4. The wide cultural, social and economic diversity of the European Community means that the different Member States are confronted with a variety of health protection problems. But there are also several important common issues which bear on health matters across the Community as a whole. Such issues include the following.

(i) Ageing population. The proportion of people of 60 or over in the Community is rising. From only 17.5% in 1980 one scenario depicts that it will reach 24% by 2010. This increase will mean that progressively there will be both larger numbers of elderly people who are disproportionate users of health services, and the burden of paying for them will fall on a relatively smaller working population. Thus the need for medical care threatens to outstrip society's ability or willingness to provide it. In addition, whether countries spend a larger or smaller amount on medical care, studies show that the impact of treatment on the population's mortality rates is outweighed by the power of the factors affecting the incidence of diseases such as cancers and cardiovascular diseases, and that the decline in old-age mortality is accompanied by a rise in the untreatable disabilities now common among the old. Studies also suggest that recently the average number of years that people spend disabled has grown faster than the number of years they spend healthy.

(ii) Increasing population mobility. Migration into the European Community, the coming into effect of the single market and the general increase of travel and tourism are producing an ever-larger intermingling of populations. The health implications of this trend include the propensity for spreading communicable diseases more rapidly, the potential for increased drug abuse and the potential difficulties of providing for the specific needs of migrant communities.

(iii) Diseases arising from environmental changes and workplace environments. A number of health problems are being produced by changes in the environment resulting from economic and technological developments. The increased levels of respiratory illnesses and certain forms of cancer can, for example, be linked to such changes. Moreover, the introduction of new working methods and modern machinery and computers into the workplace environment can also lead to physical and psychological health problems. Conditions related to stress and musculoskeletal problems are also increasing significantly.

(iv) Rising expectations concerning health. The factors above which are leading to growing demands for health services are accompanied by people's concomitant rising expectations of what the health services can provide. The continuing development of powerful technologies for diagnosis and treatment has fostered this expectation of more and better provision and the desire of everyone, and especially the disadvantaged groups and poorer regions, to have access to it. The economic costs of this are increased by the fact that many new procedures rely on sophisticated and more costly drugs and equipment.

(v) Socio-economic problems, in particular social exclusion. Slow economic growth and high levels of unemployment are leading Member States to apply tight constraints on public spending. This limits both the amount available for health services and what can be spent on social assistance. Moreover, unemployment, inequalities, discrimination, poverty and social exclusion can themselves lead to health problems.

5. As a result of the health-related issues outlined above which confront the Member States, their health spending has risen rapidly in the last two decades. As shown in Figure 1 (Annex V), during the 1970s and 1980s, health expenditure increased significantly in relation to gross domestic product (GDP), partly reflecting the slowdown in the rate of economic growth. In the latter part of the 1980s, however, the figures for certain Member States stabilized and even declined as growth picked up. Nevertheless, cost containment remains a topic of major concern in the 1990s especially in the context of the present recession and the budget constraints on public expenditure growth. Member States have been acting vigorously to contain costs, and cost containment has been achieved only by taking steps both to limit provision, as, for example, by controls on drug prescribing and medical recruitment, and to hold back demand, including the imposition of charges for drugs and tests.

6. The underlying pressures on services have not disappeared and are likely to intensify, despite the fact that there is little correlation between the main health indicators and health spending. Furthermore it has been established that lower service spending has disproportionate effects on the poor, sick and old. Hence there is a need for well-balanced responses to the inevitable pressures to adjust health spending, such as public health initiatives (e.g., smoking cessation, diet and exercise, air pollution controls, etc.), better structuring and financing of health systems to minimize costs, cutting out ineffective treatments and evaluating medical equipment and medicines in cost/benefit terms.

7. The difficulties involved in taking the right decisions in health protection under severe economic constraints prompted the Council to agree, *inter alia,* the Resolution concerning fundamental health policy choices of 11 November 1991 (OJ C 304, 23.11.1991). This Resolution, and indeed the Treaty on European Union, make it plain that Member States accept an obligation to ensure that their citizens enjoy a high standard of health. This ethical and legal obligation to protect the health of the public is reinforced by the economic benefits, for specific age groups and activity sectors (e.g. in perinatal care), of taking health promotion, protection and preventive measures.

8. By taking effective action, premature deaths among the productive population can be prevented, as can disablement and chronic illnesses with the consequent effects of absenteeism and unfitness for work; health can be improved and demands upon health care and treatment services can be controlled. In short, the Community's productive capacity can be maximized and simultaneously the costs of ill health reduced. Finally, and most important, safeguarding health, as well as producing economic advantages can also improve the quality of life, which will have inestimable benefits both for the individual and for society as a whole.

(b) Scope of public health policy

9. Against this backdrop the scope of public health activities can be delineated by a consideration of the risks to the health of the members of a community, and of the steps needed to protect individuals within the community from those risks and to increase the likelihood of their living a full and healthy life. Apart from risks to health related to individual genetic, physical and mental make-up, risks to health derive both from one's chosen lifestyle and one's immediate surroundings, in particular at home and work, and from the local environment — the combination of social, economic and cultural conditions that provide the general context for people's lives. Thus the steps required to protect individuals' health must address both of these 'environments'.

10. While the actions and programmes of the public authorities have dominated the development of public health strategies, in the last three decades public health interest has focused increasingly on the responsibility of the individual for his own health and the modifications he can make to his own behaviour to prevent the onset of disease. Such considerations have been applied to diet, the taking of sufficient exercise, the avoidance of dangerous and toxic substances, including drug abuse, and the prevention of accidents.

11. International control of disease first appeared in the form of national quarantine schemes in Europe and the Middle East to contain the spread of epidemic disease from one country to another. These efforts first demonstrated the need for international cooperation for health protection. A permanent international health organization was established in Paris in 1907 to receive notification of serious communicable diseases from participating nations, to transmit this information to the member nations, and to study and develop sanitary conventions and quarantine regulations on shipping and train travel. This organization was ultimately absorbed by the World Health Organization (WHO) in 1948.

12. The WHO undertakes both short- and long-term projects to control or eradicate diseases on a world scale and maintains close relationships with other United Nations specialized agencies, also dealing with health issues, particularly the United Nations Children's Fund (Unicef), the Food and Agriculture Organization (FAO), and the International Labour Organization (ILO).

13. The Community has, from the outset, made health and well-being one of its primary goals; health concerns underlie the economic objectives of the EEC Treaty, the safety provisions of the ECSC Treaty and the protection requirements of the Euratom Treaty. It is for

these reasons that the Treaty on European Union (TEU) makes health protection one of the centrepieces of the quest for ever closer union of the peoples of the Community, and enjoins upon the Community and the Member States' Governments to contribute to the attainment of a high level of health protection.

II — Health status and trends in the Member States

(a) Mortality

14. The last decades have been characterized by two major trends in the health status of the population in the European Community. First, on the basis of mortality indicators, there is clear evidence of a considerable and continuing improvement in overall health status. People are living longer and fewer infants are dying in all Member States. Between 1960 and 1989 life expectancy for men across the 12 Member States rose from 67.3 to 72.8 years, and for women, from 72.7 to 79.2 years. Moreover, while the Member States with the best records have continued to improve, those with lower rates have been catching up. The range between the Member States has thus narrowed, halving between 1970 and 1988. Even more striking, the lowest life expectancy figure in 1988 for the whole population of a Member State (74.3 years) was better than the best in 1970 (73.8 years).

15. A similar but even more dramatic picture emerges from the figures on infant mortality in the Community. This figure has dropped by a factor of more than four from 34.8 per 1 000 in 1960 to 8.2 in 1989. As with life expectancy there has been a substantial narrowing of the range between best and worst, and again the worst Member State in 1989 (12.18 per 1 000) was better than the best in 1970 (12.75 per 1 000).

16. The second trend is that of a significant shift in the causes of death, with communicable diseases (AIDS excluded) decreasing considerably in importance thanks to better hygiene and living conditions, preventive measures, such as vaccination programmes, and the availability of effective treatments. They have been replaced to a large extent by other diseases, notably cancer and cardiovascular diseases. Whereas just over one half of the 2.9 million deaths in the Community in 1960 resulted from these latter diseases, by 1990 the proportion had risen to two thirds. Of the 3.3 million deaths, 1.4 million were from cardiovascular diseases and 0.8 million from cancer. These diseases are not only the primary cause of death among the over-65s, but also among the population between 35 and 65 years of age, thus contributing significantly to premature death, as do accidents for the 5 to 34-year-old group. The patterns of mortality are continuing to change, however. There is, for example, evidence of a recent decline in mortality from cardiovascular diseases and an increase in deaths from previously rare diseases such as Alzheimer's disease. Such developments reflect demographic changes, advances in therapy, and the launch of large-scale preventive programmes.

(b) Morbidity

17. Mortality rates provide only an incomplete picture of the overall health status of a population. For a full picture, information is also necessary on morbidity i.e. the numbers of people with a particular illness or other medical condition. Such information reveals not only which are the most prevalent illnesses in the population, but it is also an indication of the demands made upon the health-care system. Unfortunately, although individual Member States have morbidity data, owing to substantial differences in collection methods and definitions, few comparable morbidity data exist at present for the Community as a whole.

18. One notable exception is for traffic accidents where information is available both for deaths and for injuries

Table 1 — Relative importance of different diseases measured by hospital admissions and bed days[1]

	France (1985-87)		Denmark (1990)	
	Admissions	Bed days	Admissions	Bed days
Injuries	13.2	11.7	7.7	13.9
Digestive system disorders	12.7	12.0	7.1	6.7
Cardiovascular	11.6	15.5	24.9	21.9
Cancer	10.2	12.5	11.7	8.9*
Respiratory conditions	6.9	5.8	10.4	8.8
Musculoskeletal conditions	6.3	7.0	14.8	15.5
Other diseases	39.1	35.5	23.4	24.3

[1] Indicative data, provided by the Ministries of Health, not directly comparable due to differences in definitions, classification and periods of reference.

* Danish figures for cancer include lung and breast cancers only.

in the Community. Overall, these figures show a decline in the death rate in the Community from traffic accidents in the period 1970 to 1990 and a smaller and patchier decline in the rate of injury. Younger age-groups are predominantly involved. In the light of the discussions on the White Paper on the development of transport policy, the Commission has published a communication on an action programme on road safety (COM(93) 246 of 9 June 1993) and a proposal for a Council decision on the establishment of a database on road accidents (COM(593) of 23 July 1993). Some information is also available on cardiovascular disease as seven Member States are participating in the Monica study run by WHO which collects mortality and morbidity data in this field. The data indicate that just as cardiovascular diseases are the major cause of mortality in the Community, so they are a cause of serious morbidity in the middle- and old-aged population.

19. Comprehensive comparative data do not exist for other conditions. However, national statistics do provide pointers to the relative importance of the various diseases in terms of morbidity. Table 1 gives figures for the principal diseases in Denmark and France according to their percentage of total hospital admissions and bed days. These show that despite some differences, the overall patterns in both countries are not dissimilar, with the same kinds of diseases being important in both countries.

20. The data that exist confirm that cardiovascular diseases are the most important contributions to Community morbidity, just as they are to mortality, but they indicate that cancer is of less importance in morbidity than in mortality and that there are several non-fatal diseases which are of considerable significance in morbidity, notably respiratory and musculoskeletal diseases. Taken together the mortality figures and the information available on morbidity make it possible to draw up a list of those diseases which produce high mortality and/or high morbidity. Table 2 gives those diseases which pose particularly serious health problems for the Community as a whole.

21. In addition, some communicable diseases, which were in the past a major cause of mortality, are now once more on the increase. This is due in particular to the advent of AIDS and to the resurgence of certain important communicable diseases such as tuberculosis which had been thought no longer to represent a serious problem. They all have the potential to pose serious problems if no action is taken. Finally, the list must include drug dependence because of the substantial social and health problems to which it is linked, and the ever-increasing numbers of individuals involved in drug abuse.

22. Together then these diseases account for most of the deaths, most of the illness and most of the demand for health services in the Member States of the Community. But it must be emphasized that the figures presented above relate only to general trends. It is certainly the case that in some ways the differences and the gaps between best and worst Community States are narrowing. However, comparing national figures can give a rather distorted picture, one reason for this being the different sizes of the Member States. Moreover, national figures themselves tend to disguise significant differences between the regions within each Member State.

Table 2 — Diseases producing high mortality and/or morbidity

Accidents
Cardiovascular diseases
Cancer
Mental illness, including suicide
Musculoskeletal conditions
Respiratory diseases, including asthma

23. In the case, for example, of the mortality rate from lung and bronchial cancer, in 1988 the overall EC mortality rate was 48.8 per 100 000. The UK had the highest rate (70.5) and Portugal had the lowest rate (20.6). But within the UK the rate varied nearly twofold between the north of England (92.4) and Northern Ireland (49.2). Italy's national rate (51.1) came closest to the Community average, but that masks the fact that the rate in northern Italy was three times as high as that in the south. Similar large variations within States can be identified for other major diseases. Such variations reflect cultural, social and economic differences between regions and also the significant impact that environmental factors such as air pollution can have on health.

24. Similarly, studies have shown significant variations of morbidity and mortality between different socio-economic groups within Member States. In 1987, for example, the perinatal and infant mortality rates in England were more than 50% higher for people with unskilled occupations than for professional groups, and in Denmark unemployed and unskilled men in poor accommodation had an 'excess mortality rate' of 6.2% compared with the best ranked group. It is important, therefore, that full account is taken of the variations not only between but also within Member States as well as the general patterns for the whole Community when looking at the overall status and trends in the Community.

25. Moreover, in considering specific diseases as possible targets for Community action, information about their mortality and morbidity is not by itself sufficient. It is also necessary to look at the key factors associated with their causation, at the more general social and economic context which bears on health protection and

policy choices and at the efforts already undertaken by Member States to respond to these health challenges. An overview of the policies and measures taken by the Member States to prevent disease and promote health, against the aforementioned background, is given in Annex I.

III — The basis for Community action

(a) Subsidiarity

26. The manner in which these activities by the Community and the Member States have to be conducted is governed by the principle of subsidiarity. Subsidiarity, the attributes of which are laid down in Article 3b of the Treaty establishing the European Community, implies that in matters not under its exclusive competence, the Community intervenes when action, by reason of its scale or effects, may better be carried out at Community level. Moreover, irrespective of whether a matter comes under its exclusive competence or not, action on it by the Community must be proportional to the objectives to be achieved.

27. The following considerations apply in particular to the field of public health.

(i) In coordinating policy, the Community's role is to forge constructive relationships at all levels, assist in closing identified gaps, formulate and improve strategies for effective implementation of policies and measures, and ensure that transfers and flows of knowledge, expertise and materials occur to the mutual advantage of the parties concerned.

(ii) In accordance with the principle of proportionality, the Community intends to focus on the implementation of larger rather than smaller projects, which for the most part will involve more than one Member State. This will maximize impact and avoid becoming involved with narrow issues and concerns which may be perceived as an interference with matters already dealt with by the authorities of the Member States, or as heavy-handedness in resorting to means out of proportion to the objective being pursued.

(iii) Diversity in and among the Member States in diet, culture, weather conditions, land use, and the type and concentration of economic activity, is such that, in general, no detailed prescription will be handed down from the Community, even regarding problems which are identical or similar from Member State to Member State, region to region, locality to locality. In matters of health, it is up to the individual and the family to consider alternatives and take decisions on matters that directly affect them; and up to society, through the democratic process, to create an environment conducive to the best decision being made by the individual, and to the right collective decisions being made in all matters where the individual cannot, alone, determine or bring about the desired health outcome.

(iv) The Member States in partnership with their health professionals and individuals involved are concerned with the financing and delivery of care and treatment. However, the Commission may assist the Member States in improving their collaboration on health-care matters, as for example on fundamental health choices,[1] and may provide assistance to them in actions designed to improve the quality of health care and treatment.

(b) Legal bases

28. Prior to the Treaty on European Union, there was no specific legal basis or competence vested in the Community in the field of public health. That is not to say that the Treaties did not contain provisions of direct relevance to the protection of health and welfare. Thus, health and safety at work was given from the outset a prominent place in the EEC Treaty (Articles 117, 118 and Article 118A of the Single European Act) and in the ECSC Treaty, whereas the health protection provisions for both workers and members of the public contained in the Euratom Treaty (Articles 30 to 39) soon became the cornerstone for regulatory action in this field in all Member States.

29. Other provisions in the EEC Treaty also directly or indirectly concern health: Article 2 sets out the duty of the Community to raise the standard of living; Article 36 allows restrictions on imports, and goods in transit, in order to protect the health and life of humans; Article 43 deals with agricultural policy which can have an impact on human health; Article 48 ensures freedom of movement for persons, including patients and health workers; Articles 52 to 58 are of relevance for the right of establishment, and in Article 59, the free movement of services, including health services, is guaranteed. Article 100A has a major impact on health since all proposals for directives establishing the internal market for products (e.g. blood products), services, capital and persons must have by virtue of this Article, a high level of health protection as a basis; Articles 130f to 130q cover research including health research. In addition, the protection of human health as the ultimate goal of environmental protection measures is enshrined in Articles 130r and 130s of the EEC Treaty as amended

[1] See paragraph 7 on page 106.

by the Single European Act. Finally, Article 155 serves, *inter alia*, to issue recommendations also in matters related to health protection, and has been used in the past for issuing recommendations on a European list of occupational diseases, and Article 235 for proposals for decisions and regulations for various health-related issues, such as information to the general public and training of members of the health professions in the framework of the Europe against cancer programme, the setting up of a Health and Safety at Work Agency, and the creation of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

30. The policies, programmes and instruments (see Annexes II and III) to give effect to these Articles played a determinant role in transforming the health scene of the Community and in raising the quality of life of its citizens. The Treaty on European Union not only maintained these provisions but also reinforced them. Consumer protection has been given a clear mandate to protect the health and safety of consumers in Article 129A. Article 130 on the environment requires the Community to contribute to the pursuit of the objective of protecting human health. In addition, in Article 126, the Community has been given the duty to contribute to the development of quality education, which plays an important role in health protection and promotion. Moreover under Article K.9 of the Treaty on European Union, the Council, acting unanimously on the initiative of the Commission or a Member State, may decide to undertake action aimed at combating drug addiction.

31. Above all, public health has, by reason of Articles 3(o) and 129, been accorded its own explicit provision. The Community has been given responsibility to contribute to the attainment of a high level of health protection with due regard to the principles established by the European Council in Edinburgh (subsidiarity, openness, transparency and proportionality), and vested with powers to discharge this responsibility in a manner that ensures respect and support for Member States' policies and activities, prevents unwarranted intrusion and interference, and leaves room for adjustment and choice of the means for their implementation. In doing this, the experience gained hitherto in public health actions carried out by the Community serves both as a guiding light and as a base on which to build. In particular, the Europe against cancer programme, launched in 1986 by the European Council, has demonstrated the value of identifying common objectives and goals. It has paved the way for the adoption by the Council of other programmes and initiatives dealing with AIDS, drug demand, alcohol abuse, and health education in schools, and has shown what can be achieved by partnership, cooperation, and use of instruments in other Community policies. In implementing the Europe against cancer and Europe against AIDS programmes, the Commission adopted a method which predated the principle of subsidiarity and involved a systematic attempt to generate Community added value, by promoting cooperation between the Member States in the field of studies and research, and the spread throughout the Community of the most successful national practices, in particular by bringing together the responsible partners in the Member States. The achievements of these programmes and the need for their continuation were underlined during the recent evaluation of their effectiveness by the Council.

32. In initiating action under Article 129, the Community has to address itself to preventing disease. Prevention in all its facets thus becomes the focus of Community action, whether primary, to ensure good health and to minimize exposure to risk factors implicated in the causation of diseases; secondary, to avert the onset of diseases in those so exposed, for example by screening, vaccination and preventive medication/prophylaxis; or tertiary, to avert the progression or recurrence of disease. Prevention can be distinguished from treatment as the latter may be described as an intervention to correct congenital defects, or to restore an individual to a previous (better) level of health. Treatment, as opposed to prevention, is therefore a matter of Member States' cooperation and not an area in which the Commission can or should take initiatives on behalf of the Community.

33. Preventive activity by the Community must address itself to the question of major scourges. Major scourges or health threats may be determined in relation to a host of factors, both objective (health data and indicators) and subjective (perception, ethical, cultural and political questions). Consideration of these issues is to be found in Chapter IV. However, one point must be stressed here: Article 129 specifically requires public health action on the scourge of drugs.

34. Article 129 implicitly recognizes the dichotomy between action addressed on the one hand to the individual to enhance his/her potential for health gain, healthy lifestyle, and non-risk or low-risk behaviour, such as health information and education, and, on the other hand to societal action, involving research into the causes and transmission of disease. This research may be fundamental, and also behavioural, social, and environmental, and could concern the immediate, local, and even remote environment, over which the individual has little, if any, control.

35. Of primary importance is the provision of Article 129 that health protection requirements shall form a constituent part of the Community's other policies. In

the future, elaboration of policies and measures with an impact on health must from the outset take account of, and be coherent with, public health policy. This means that other policies, despite their having different legal bases, will also serve the objectives of health protection.

36. Central to the Commission's role in the implementation of Article 129 is the obligation to liaise with the Member States in the coordination of their policies and programmes concerning prevention, including drug prevention, investigation and analysis of causes and modes of transmission of health scourges, health information and health education. The Commission will, in close collaboration with the Member States, take appropriate initiatives to promote such coordination, particularly in areas in which the Member States have already demonstrated a need to cooperate, notably disease surveillance and control, health data and indicators, health information and health education, and in the fight against the major scourges of drugs, cancer and AIDS.

(c) Past consideration of health matters by the Community institutions

(i) European Council

37. In 1986, the representatives of the Governments of the Member States, meeting within the Council, adopted a resolution on a programme of action of the European Communities against cancer (86/C184/05)[1] which set the objectives of this programme and listed the priority actions to be considered. It also agreed on declaring 1989 as a year of information on cancer. Moreover, it called upon the Member States to draw from their experience in the treatment and rehabilitation of drug addicts in order to collaborate in informing teachers, parents, and young people about the risks related to drug addiction and in preparing a report and recommendations on measures that can be taken at Community level. This serious preoccupation with drugs was reflected in the declarations of subsequent meetings of the European Council, notably in London in 1986, in Dublin and Rome in 1990, in Luxembourg and Maastricht in 1991, and in Lisbon in 1992. The London meeting in 1986 also stressed the importance of coordinating national campaigns against AIDS with a view to raising awareness and better informing the public on this disease. These resolutions and declarations by the European Council paved the way for the Community action against the scourges of cancer, drugs, and AIDS.

[1] OJ C 184, 23.7.1986.

(ii) Council

38. Council and Ministers of Health's interest and debate concerning public health issues began in 1977 and started to grow in the early 1980s. Efforts at setting an agenda in this field at the Community level began to revive in 1982 when the European Parliament asked for a clarification of what exactly had been done in the public health field since 1978, the year in which a second research and development programme was adopted by the Council in the sector of medical and public health research. The Commission's communication on Community-level cooperation on health-related problems finally initiated activities in 1984.

39. The informal meeting of Health Ministers in November 1984 discussed the increase of health spending, the combating of drug and tobacco addiction and health education for the young. The next (formal) meeting of the Health Council was held in May 1986. Resolutions and decisions were adopted on the action programme to fight cancer, on the introduction of a European emergency health card, on measures to fight against AIDS and on ways of decreasing the consumption of tobacco and alcohol. This and subsequent meetings of the Health Ministers, in which various health issues were discussed and important initiatives launched, raised hopes for a Community-wide health policy.

40. The signing of the Treaty on European Union on 7 February 1992 gave rise to heightened expectations concerning the potential for improving health protection in a Community where cooperation and coordination of policies and programmes, which had long been the dream of a few, could become a reality. This culminated during the second half of 1992 in the examination by the Health Council of fundamental questions concerning the future course of Community action in the field of public health. Discussion took place on the need for breaking with the past and looking forward to greater continuity, coherence, and prioritization in public health work, and to constructing an appropriate framework comprising the successful Community programmes on cancer and AIDS and actions in specific areas, such as drugs and health education in schools. In this, the Council was assisted by a Commission staff working paper, entitled 'Public health', which reviewed and took stock of the achievements of Community efforts so far, and acknowledged the need for a coherent approach based on prevention, health promotion, health protection through other Community policies, coordination between Member States, and cooperation with third countries and international organizations.

41. On 27 May 1993, the Council and the Ministers for Health meeting within the Council adopted an impor-

tant resolution on future action in the field of public health which dealt with all the main aspects of the public health framework in which the Community will be working in the future. The resolution reaffirmed the need for close cooperation and for consideration of the weight to be given to health requirements in other policies; and set out a number of guidelines concerning the fundamental objectives of action, namely adding life to years and years to life, the need for multiannual planning to ensure coherence and continuity, the criteria for selecting areas of activity with reference to amenability to preventive action, and complementarity with other policies with a health component, the methods of cooperation and consultation, and, finally, the relations with third countries and international organizations. These guidelines have been studied carefully by the Commission and taken into account in this communication.

(iii) European Parliament

42. The European Parliament has been in favour of a Community health policy since the early 1980s and has put forward several resolutions in the field of health, notably:

health policy in the European Community (OJ C 128, 16.5.1983. p. 86)

European charter of rights of hospital patients (OJ C 46, 20.2.1984)

Community programme of research into AIDS (OJ C 46, 20.2.1984)

children in hospital (OJ C 148, 16.6.1986, p. 37)

women in childbirth (OJ C 235, 12.9.1988, p. 183).

43. Members of the European Parliament have always shown a keen interest in health matters, as is evident from the very large number of Parliamentary questions raised on the subject. Its various committees, in particular the Committee on Environment, Public Health, and Consumer Protection, the special Committee on Drugs, and the Committee on Youth, Culture, Education, the Media and Sport, have prepared several reports on health-related subjects, including reports on AIDS, health education and drug abuse, bioethics, organ transplantation, and blood self-sufficiency.

44. A recent report of the Committee on Environment, Public Health and Consumer Protection, concerning public health policy after Maastricht (1993 — PE205.804), was prepared following a public hearing on 3 June 1993. The report lays particular stress on Article 129's call for coordination of Member States' policies and programmes and on integration of health requirements into other policy areas, and provides a comprehensive overview of current public health issues, including demography and health needs, comparable/compatible health data and indicators, healthcare costs, and research and health policy. The Committee made several proposals for Community action, including calls to the Commission to provide for wide-scale consultation procedures; establish an epidemiological investigation service; collect, analyse and disseminate data on notifiable diseases; encourage exchange schemes for health professionals; develop the exchange of information between national health systems; report on the health status of the Community; investigate the feasibility of encouraging greater use of generic pharmaceuticals and coordinate the use of all pharmaceuticals; indicate the minimum levels of health care; develop and execute activities on health promotion and education, including vaccinations and screening; and intensify its activities against cancer and AIDS, and with regard to the problems of the elderly. The report and a pertinent resolution will give an added impetus to the ongoing efforts to endow the Community with a much needed public health dimension.

45. Reference should also be made to the important work carried out by the European Parliament's intergroup on health, and to its STOA group (Science and technology option assessment).

(iv) Economic and Social Committee

46. During the past 10 years, the Economic and Social Committee has regularly given its opinions on health matters such as occupational medicine; dangerous substances and preparations; the Community system of information on accidents involving consumer products; occupational cancer; an action programme on toxicology for health protection; prevention of asbestos pollution; cancer prevention action programme; and the transparency of medicinal product prices. More recently, the Committee approved Community initiatives in the social field, such as The European Year of Older People; the Europe against cancer programme and the Europe against AIDS programme, and the creation of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

47. It is against a background of an expression of the will of the Community institutions, and also of the desires of numerous health professionals, medical and patient associations, interest groups and ordinary people in the Community, that the Commission, having given thorough consideration to the timeliness and feasibility of action on the one hand, and the available means, on the other, seeks with this com-

munication to establish a coherent and comprehensive framework for Community public health action which will give expression to the new provisions in the Treaties.

Part B

The European Community approach

IV — Selection of activities

(a) Scope of possible activity

48. The Council and the Member States have identified a large number of areas for possible action, at Community level, which demonstrates the range and diversity of expectations, and underlines the need for the establishment of priorities in order to match resources to demands:

- the continuation of existing Community programmes on cancer and AIDS
- cardiovascular diseases
- communicable diseases
- mental diseases
- hereditary diseases
- asthma and allergies
- migration and health
- health and environment
- prevention of accidents and violence
- prevention of drug abuse
- improved data and their comparability
- nutrition
- tobacco
- alcohol
- exchanges of information on Member States' policies
- pilot projects in prevention and early diagnosis
- establishment of centres of excellence
- exchange visits for health personnel
- public health research
- cost containment
- fundamental health choices
- self-sufficiency of blood
- toxicology
- health and young persons
- use of pharmaceutical products
- renal dialysis
- emergency health card.

49. Chapter II identified on the basis of information on mortality and morbidity those groups of diseases and conditions which currently or potentially pose the most serious threats to the Community. This chapter looks at these diseases separately in order to ascertain their suitability for Community action. In order to do so it is necessary to establish broad objectives for Community action and operational criteria based on those objectives for selecting diseases.

50. There are essentially four interlinked objectives for Community action;

(i) to prevent premature death which particularly affects the young and working population;

(ii) to increase life expectancy without disability or sickness;

(iii) to promote the quality of life by improving general health status and the avoidance of chronic and disabling conditions;

(iv) to promote the general well being of the population particularly by minimizing the economic and social consequences of ill health.

51. To attain these objectives and maximize the impact of its action, the Community needs to identify those diseases to be tackled as a matter of priority. Such identification starts with the examination of data which help to establish which are the major health threats, including data on mortality, morbidity, harm potential in the absence of intervention, amenability to preventative measures, perception by the public, and costs, both social and economic. On the basis of the Community criteria of subsidiarity and added value those major health threats for which it can be demonstrated that action by the Community is cost-effective, readily available and appropriate, can then be selected for Community action. Moreover, other diseases, which cannot be considered major, can also be selected for Community action provided that it can be shown that the fight against them would benefit from the involvement of the Community.

52. Action and measures by the Community, must be relevant, transparent, and explained in such a way that they can be understood by the Community citizens; they should be addressed, nevertheless, only to decision-takers and practitioners in several Member States. Otherwise, the risk is that the more visible the action of the Community becomes, the greater the risk of a fragmentation of effort and resources, and the less the associated impact and degree of satisfaction.

(b) The means of Community action

53. Community action against diseases will in particular focus on encouraging cooperation between Member States, lending support to their action, promoting in close contact with the Member States coordination of their policies and programmes, and making better use of Community policies where these relate to public health. Particular attention has to be devoted to the following activities: health information, health promotion, health education, health training, cooperation with international organizations and third countries, and research. Action by the Community can take, in particular, the following forms.

(1) Establishment of a general framework for supporting Member States' policies and programmes (networks, joint actions, information exchange systems). It is true that Member States already cooperate in certain areas, but this cooperation can now be strengthened. Increased cooperation could involve, for example:

- establishment of common objectives, in particular areas, or for new health threats and problems;
- programmes for exchange of experiences and of health professionals, and for dissemination of the most effective practices;
- standardization and collection of comparable/compatible data on health, and the promotion of systems of health monitoring/surveillance;
- creation of information networks for the evaluation of different treatments and new technologies applied to health, *inter alia,* by disseminating the results of research carried out under the Community's framework programmes;
- compilation of an annual progress report on the health situation within the Community, based mainly on reports from each Member State, in order to evaluate activities undertaken and make decisions for the future;
- financial assistance for programmes and pilot projects;
- assistance to the efforts of Member States to reduce health costs by reducing obstacles to free movement of patients between Member States, and by developing the health aspects of the use of medicinal products, whilst respecting the Member States' competences in these fields.

(2) Better use of Community policies and instruments where these relate to public health. More attention will be paid in this respect to the implications for health protection and disease prevention when new Community initiatives are introduced in areas other than health.

(c) Selection of areas of activity

(i) Selection criteria

54. Based on the considerations above, the following criteria for identifying diseases (or health threats) for Community action can be set out:

1. diseases that cause, or are likely to cause in the absence of intervention, significant premature death (years of life lost) and/or have overall high death rates;
2. diseases that cause, or are likely to cause in the absence of intervention, significant ill health by having a high prevalence of morbidity or with the potential to cause high morbidity and/or serious disability (years of disability-free life lost);
3. diseases having significant implications for the quality of life as well as major socio-economic effects, such as high health-care and treatment costs, or considerable absenteeism and unfitness for work;
4. diseases for which practicable measures of prevention exist;
5. diseases for which there would be added value from the Community undertaking actions, particularly through economies of scale.

55. Whereas application of criteria 1 and 2 may be relatively straightforward, the importance and difficulties in using the third criterion must be stressed. In fact 'quality of life' is a very subjective criterion used to provide descriptions of degrees of disability, distress or pain, or the capacity to carry out normal activities. Certain studies have suggested that people consider some health states as 'a fate worse than death', and such concerns have been taken into account in valuations of the global burden of diseases by using concepts such as the quality-adjusted life year.

56. The selection procedure involves two distinct steps. Firstly, by applying the first four criteria, diseases that are of major importance throughout the Community can be identified; these are not necessarily the major diseases which the Community should deal with. The latter can only be determined as a result of a second selection step involving the attainment of Community added value. Finally, those diseases, from among those identified following the two-step procedure, which should be tackled as a matter of priority, can be determined by seeking to maximize the Community added value in terms of health gain obtained by providing the necessary coherence and continuation with Community activities already undertaken against certain diseases, and by trying to aim, with a given action, at as many diseases as possible.

57. The first step in the procedure involves the examination and analysis of the available data concerning a number of important diseases from those listed in the International Classification of Diseases. The table in Annex IV contains a list of diseases which have been evaluated according to the above criteria. Annex V contains statistical data used in the analysis and discussion on trends that follow. The following paragraphs indicate those diseases, which on the basis of the criteria should be the focus of Community action, and discuss trends. In addition, Community actions in the field of preventing drug dependence, already selected as a priority in Article 129, are described.

(ii) Major health scourges other than drugs

Cancer

58. The major lifestyle-related cancer is cancer of the respiratory passages and of the lungs. Epidemiological evidence shows that this is linked mainly to smoking. In recent decades there has been an increase in cancers related to tobacco and alcohol (mainly upper respiratory and digestive tract and lungs).

59. In Figure 2 of Annex V the trends towards a Community average prevalence of lifestyle-related health threats and a levelling out of prevalence between males and females (due to increasing female smoking) are clearly evident. The most rapid developments are shown in the cases of Denmark and the Netherlands but the trend is visible in all countries except Spain which, in contrast, has shown a fall in prevalence among females. As far as other forms of cancer are concerned, the trends are not quite so clear and, in some cases, do not follow the same pattern. This has to do with two factors: first, changes in lifestyle, and, second, the improved capacity for making an early diagnosis and, thereby, early intervention. Improved capacity for making an early diagnosis (combined with improved sexual hygiene) means, in the case of cervical cancer, that a downward trend can be identified. However, for breast cancer, the opposite trend is evident: in almost all Member States the numbers are increasing. It is difficult to give a simple explanation for this development since breast cancer cannot be linked easily to lifestyle-related risk factors, although diet is suspected to play a role. There is similarly a rise in the overall number of cancers of the digestive organs. Here, however, a link to nutrition and changed eating habits is widely seen as a major explanation. This and the link between breast cancer and diet are being investigated by the Europe against cancer programme, by means of a major survey of eating habits in seven Member States.

Cardiovascular diseases

60. There is a general trend towards a decrease in mortality from cardiovascular diseases, though in Greece and Spain the figures are not so clear-cut as for the other Member States, for reasons possibly relating to changes in diet. No unequivocal explanation for this development has been produced so far, but there seems to be a certain correlation between reduced prevalence and changes in lifestyle. Generally speaking, mortality has dropped the most in countries with the biggest decline in the number of smokers, the best blood pressure controls, decline in serum-cholesterol levels and the biggest increase in physical activity. Moreover, introduction of more efficient methods of treatment has had an influence on mortality as well.

Accidents

61. Since 1970 the overall death rate from all kinds of accidents (including poisoning) in the Community has declined. With regard to traffic accidents, there has been a significant fall in the death and injury rates in most Member States. For example, the mortality rate in France declined by one third between 1970 and 1990, that in Italy by one half and that in the Netherlands by two thirds. On the other hand, in Portugal the injury rate went up considerably after 1985, and in Spain the death and injury rates have both increased over the same period, though they are still at a relatively low level. Moreover, it must be stressed that traffic accidents, as shown in Table 5 (Annex V), remain the leading cause of death for young people in the Community.

Suicides

62. The overall number of suicides in the Community has shown a rising trend over the last 20 years. A comparison between the first and the last years available (1970 and 1989) shows that Germany is the only country with a significant drop in the number of suicides. The other Member States show either a stable pattern or an increase. No definite explanation for these developments can be given although societal changes obviously play a role. But differences between political, cultural and historical tradition tend to be of importance as borne out by the fact that suicide has generally been less common in southern Europe than in certain northern European countries.

AIDS and other communicable diseases

63. Communicable diseases have to a large extent ceased to be a prevalent cause of death in the Community, though they still cause significant morbidity. However, the advent of AIDS in the early 1980s has somewhat changed this picture. The last decade has seen a rapid increase in the number of people with this disease in the Community. In 1982, just 86 people were reported as being diagnosed with AIDS. By 1990 this number had risen to just under 14 000. The numbers are still continuing to increase, though the rate of increase has slowed down. By 30 June 1992 over 69 000 cases had been reported and by 30 June 1993 the number had risen to nearly 89 000. Making allowances for delays in reporting cases, it is estimated that the cumulative total at the end of June 1993 was over 95 000. Although all Member States are affected, three, namely France,

Spain and Italy, account for 71% of all Community cases. In northern Member States the largest number of AIDS cases are among homosexual men and in southern States among injectable drug users. But the proportion of AIDS cases among heterosexuals is continuing to increase throughout the Community. No precise figure is available for the number of people in the Community infected with HIV, the virus which leads to AIDS. But the WHO has estimated that about 500 000 people are infected.

64. The recent resurgence of tuberculosis, often associated with AIDS, points also to the need to continue to take action against communicable diseases.

Other important diseases

65. As pointed out in Table 2 above, several other diseases, notably mental illness, musculoskeletal conditions and respiratory conditions, produce substantial morbidity in the Community. The ageing of populations is likely to increase the prevalence of these conditions. Community action against these diseases, though not of the highest priority, will need to be kept under consideration in the future.

(iii) Drug dependence

66. Drug dependence is the only health threat specifically mentioned in Article 129, making it automatically a priority for Community public health action. Action on drugs benefits already from coordination at Community level; the extent of this multifaceted problem, with its links to major social scourges such as social exclusion and unemployment, and the difficulties encountered by Member States in combating its severe effects on society, has led to a series of initiatives being taken at Community level over the past few years. The wide range of initiatives adopted by the Council and the European Parliament has demonstrated the great importance that they attach to this problem and their view that actions to tackle it are needed at the Community level. This has been reinforced by the singling out of drugs in Article 129 as a major scourge to be given priority by Community public health action.

67. Important initiatives on drugs include the Council Resolution of October 1986, and the European plan against drugs drawn up by the European Committee to combat drugs (CELAD) adopted by the European Council in December 1990 and prolonged by the European Council in December 1992. These documents set out a wide range of activities to be undertaken. Moreover, the Council adopted in February 1993 a regulation setting up the EMCDDA, which is charged with data collection, analysis, comparison and evaluation in the field of drugs, with special emphasis, in its initial three-year work programme, on demand and reduction of demand for drugs. The Community will in the future be able to consolidate its achievements in the field of drug prevention, build on the work already carried out, and propose a forward-looking programme for public health action on drugs and drug dependence.

(iv) Rare diseases

68. By definition, rare diseases have less of an impact on society and are responsible for relatively little mortality and morbidity. Nevertheless, experience shows that by the very fact of their rareness and the consequent lack of information available about them, they can produce significant problems for individual countries. Legionnaires' disease, Creutzfeldt-Jakob disease and genetic disorders like haemophilia, are obvious examples. There could thus be benefits in Community initiatives aimed at such diseases to complement the efforts of Member States and maximize the exchange of information and experience, so that all Member States are assisted in taking appropriate action when confronted with an unfamiliar threat. There are other diseases which may be rare in some Member States but not in others. One typical example is thalassaemia, which is rife in the south of the Community. With regard to rare illnesses, therefore, the Community will have to cooperate closely with Member States to draw up initiatives likely to generate economies of scale and create solidarity between Member States.

V — Causation of diseases

69. The groups of diseases mentioned in the previous chapter are those to which Community measures should be directed. But for preventive action to be as effective as possible, it is not enough to direct it just at particular diseases and groups of diseases; it is even more important to aim it at their underlying causal factors. In considering, therefore, what kinds of measures might be appropriate and what priority to give them, it is necessary to look at the key factors associated in the aetiology of these conditions.

70. Of course, as the significant variations of morbidity and mortality between different socio-economic groups within the Member States would indicate, adverse socio-economic conditions (e.g. poor housing, low access to health care, long-term unemployment) constitute a threat to public health. This linkage has been recognized in the recently-launched programme on social exclusion (COM(93) 435) which seeks to assess through selected projects the impact of a range of socio-economic conditions on social exclusion and promote solidarity. Combating these conditions, while at the centre of other Community policies, constitutes nevertheless one of the main preoccupations of the Community in pursuing its objective to contribute to preventing risks to certain groups, and in designing an effective strategy of health protection.

71. Without attempting to be comprehensive, Table 3 sets out major factors associated with the previously identified major health threats.

72. It is clear from this table that, quite apart from genetic inheritance, there are a number of other common factors, both specific and more general, associated with these diseases. Of the specific factors, smoking and alcohol are implicated directly and nutrition also plays a role. More generally, environmental problems are directly implicated or to some extent are associated with all of them. Some factors are also associated with other significant conditions; nutritional problems, for example, are a central factor in diabetes, rickets and osteoporosis; alcohol produces cirrhosis, and smoking by pregnant women increases the risk of infant mortality.

73. In terms of designing an effective strategy of prevention of disease and health protection, the fact that several key factors are common to a variety of conditions has important consequences. It means, for instance, that measures aimed at preventing people taking up smoking have a significant impact on the rates of morbidity and mortality from a range of different conditions, thus greatly enhancing their impact.

74. Measures aimed at eliminating or reducing the impact of particular causal factors related to several diseases, employing for example actions in health information, education, and promotion, addressing issues such as nutrition, tobacco and alcohol, and aimed at the general public or at particular groups such as children or the elderly, can play a key role in the overall strategy and help direct limited resources to maximum effect. Such 'horizontal' measures form a key part of the strategy set out in Chapter VII. However, as well as addressing those factors which are implicated in several

Table 3 — Factors implicated in disease causation

Disease	Factors
Accidents	Drink-driving, unsafe behaviour, defective or poorly-designed products and services, environmental problems
Cancer	Smoking, alcohol abuse, nutrition, genetic factors, exposure to radiation and carcinogenic substances
Cardiovascular diseases	Smoking, alcohol abuse, nutrition, genetic factors, stress, lack of exercise
Communicable diseases, including AIDS	Poor hygiene, unsafe water, unsafe sexual behaviour, drug abuse, nutrition, contaminated blood
Drug abuse	Socio-economic problems, psychological disorders, stress
Mental illness, including suicide	Socio-economic problems, genetic factors, stress
Musculoskeletal conditions	Poor working environment, physical stress, nutrition, lack of exercise
Respiratory diseases, including asthma	Environment problems, including pollutants, smoking genetic factors

conditions, the specific features of each disease must not be overlooked. Generally speaking, it is difficult to be totally precise about the cause of many diseases. The evolution of microbiology has gradually enabled the identification of the micro-organisms responsible for most infectious diseases, but it will be necessary to wait for the mapping of the human genome to know which genes are responsible for certain clinical conditions. Moreover, the means of fighting against these illnesses will certainly adapt in the future as their precise causation is discovered.

75. As is the case for the information on the prevalence and effects of the diseases themselves across the Community, so information on the major causal factors is also patchy. However, on three of the most important ones, nutrition, smoking and alcohol consumption, some information is available from WHO figures which provide a picture of trends across the Community.

76. On nutrition, figures are available on the proportions of fat and proteins in people's diets. In 1989, the amount of fat as a percentage of total energy intake ranged from 34% in Portugal to 47% in Belgium and that of protein from 10% in Greece to 14% in France. Of more significance, however, are the trends which show that while the percentage of protein in diets has not varied much since 1970, there has been a considerable rise in fat intake in several countries, notably France, Italy, Portugal and Spain.

77. On smoking there are figures showing total cigarette consumption per capita in the Member States on a yearly basis. These show a marked divergence between the trends in the northern and southern States. In the period 1976 to 1990, the total consumption decreased in six northern States by between 13.4% in Denmark (from 1 801 to 1 560 units per year) and 25.5% in the Netherlands (from 2 086 to 1 555 units per year), on the other hand there were considerable increases in the southern States with, for example, Spain showing a rise of 87.8% (from 1 122 to 2 109 units per year). This north-south divide tends to be borne out by Eurostat data on expenditure on tobacco as a proportion of total household expenditure.

78. The trend of alcohol consumption is virtually a mirror image of that for cigarette smoking. In the period between 1970 and 1988 the northern States saw a considerable increase in alcohol consumption per head; for example, in Denmark there was an increase of 45.6% (from 6.8 to 9.9 litres of pure alcohol per capita per year) in the Netherlands of 46.4% (from 5.6 to 8.2) and in the UK of 43.4% (from 5.3 to 7.6). At the same time, in the southern States consumption was falling; in Italy it fell by 36.5% (from 13.7 to 8.7) and in France by 21.6% (from 16.2 to 12.7).

79. It must be emphasized that such data have to be interpreted very cautiously since the baselines for Member States vary considerably. The WHO data on alcohol as a percentage of total energy intake, for example, show that in 1989 there was a considerable range between Member States from 3% in Greece to 8% in Germany. The main value of such figures is in indicating trends which in turn can reveal current and potential problems and highlight areas for intervention.

VI — The nature and extent of Community involvement

(a) General approach

80. The health sector is a broad domain of organized activity, the workings and effects of which directly and profoundly influence one of the most cherished possessions of the individual, namely his or her health. Traditions, practices and the legal and administrative organization of public health services and systems are so varied as to render meaningless any talk of unification or harmonization of policies in this domain.

81. The role of the Community is to underpin the efforts of the Member States in the public health field, assist in the formulation and implementation of objectives and strategies, and contribute to the continuity of health protection provision across the Community, setting as a target the best results already obtained in a given area anywhere in the Community.

82. Needs in the field of public health across the Community are vast and there is no question of the Community seeking to meet them all. Rather, the Community will carry out actions that yield the highest possible added value from the limited resources available, using instruments and measures that are deemed to have the greatest impact. The Commission will seek to ensure that actions at the policy and strategy level, aiming at as many selected diseases as possible, are given top priority, sufficient means, and clear objectives. The Commission will accord priority to large-scale, wide-impact projects involving as much as possible governmental organizations and non-governmental organizations with a proven record in their respective fields. The Commission will also ensure that instruments in other policies are used for, or contribute to, health protection, and any adverse impact from other policies is eliminated by keeping a 'health watch' at all stages of drafting of pertinent instruments and programmes. Finally, the Commission will be ready to respond to Member States' requests for contributions to cooperation between them, and will enlist, when it is appropriate, the aid of international organizations competent in health matters.

83. Table 4 shows, in a matrix form, the kind of action that can be undertaken at Community level for a range of identified health threats expressed either as a disease or group of linked diseases or as a causal factor. Of special importance are activities to support Member States' actions and promotion of coordination of their policies and programmes, cooperation with international organizations and third countries, information, education, health promotion, training and research, which are further discussed below.

(b) Consultation and participation mechanisms

84. Article 129 provides for the consultation of the Economic and Social Committee and of the Committee of the Regions. Moreover, Community instruments of binding character provide for consultation and participation mechanisms in relation to programmes and measures adopted by the Community in the field of public health. Apart from these mechanisms, the Commission intends to obtain additional expertise in order to ensure that the best possible consultation and participation machinery is available to give guidance and feedback as regards Community activity on health protection, whilst streamlining and consolidating the existing structure of committees and working groups.

85. The Commission will provide for the establishment of appropriate consultation and participation mechanisms in the context of the implementation of this public health framework. In this regard the respective roles of health professionals and non-governmental organizations will be recognized.

(c) Support to Member States' action and promotion of coordination

86. The Commission intends to base its support for Member States on specific actions, which it alone is able to implement, in particular by promoting the exchange of experience and views and the preparation of actions that can be implemented through a variety of instruments in different sectors.

87. With regard to areas of activity in which the Commission believes there is value in launching new and innovative actions, the following considerations apply.

(i) The comparison and evaluation of prevention policies against health threats though difficult, is essential in order to avoid an uncoordinated approach which can have an adverse impact on the choices and decisions of public health authorities. The Commission can play a decisive role in this respect by undertaking large-scale cost-effectiveness analyses, based in particular on models and tools made available to it by epidemiological science, and by formulating proposals for measures and programmes aimed at strengthening the defences against diseases.

(ii) The Commission will seek to assist Member States in improving standards of health promotion and disease prevention. Some Member States have undoubtedly attained a high level of protection in some areas, and since the aim is to achieve levels of protection at the best level existing in the Community, the Commission should try to provide the information necessary to correct shortcomings, taking as its reference point those Member States' pol-

Table 4 — Possibilities for Community action

Type of action Health threats and diseases	Health data indicators	Surveillance, monitoring	Health of public	Information on specific groups	Health education/ promotion	Training of health professionals	Cooperation between Member States	Policy coordination	Strategy formulation and implementation	Use of instruments in other policies	Financial support	Surveys, studies	Cooperation with international organizations and third countries	Other specific preventive actions
Tobacco consumption	****	*	***	**	***	*	****	****	****	****	***	*	**	*
Drug abuse	****	***	**	***	****	****	****	****	****	****	****	***	****	***
Alcohol abuse	****	*	***	**	***	**	***	**	**	****	***	***	**	*
Lack of exercise	**	*	**	**	**	*	*	*	*	*	**	**	**	*
Poor diet	****	*	***	***	***	**	***	**	**	****	***	****	**	*
Cancer	****	**	***	****	****	***	***	***	****	****	****	****	****	****
Diseases of the circulatory system	****	**	***	****	****	***	***	**	***	***	**	***	***	***
Respiratory diseases	***	***	**	***	**	***	****	****	****	****	***	***	***	**
Congenital abnormalities	***	**	**	***	**	**	***	*	*	*	**	**	**	**
Perinatal conditions	***	**	**	***	**	**	**	**	*	*	**	**	***	*
Accidents	****	***	****	***	****	***	***	***	***	****	**	****	**	*
Musculoskeletal problems	**	*	***	***	**	**	**	*	*	**	**	**	**	*
Visual problems	**	*	**	**	**	**	**	*	*	**	**	**	**	*
Auditory problems	**	*	**	**	**	**	**	*	*	**	**	**	**	*
Mental disorders, suicides	****	*	*	**	**	**	**	*	*	**	**	***	**	**
Nutrition-related disorders	**	*	*	**	**	**	**	*	*	**	**	***	**	*
AIDS	****	****	**	****	****	****	****	****	****	***	****	****	****	****
Other communi cable diseases	****	****	**	****	**	****	****	****	****	**	****	****	****	***
Rare diseases	***	***	*	***	*	***	****	***	**	*	**	***	***	**
Food borne diseases	***	***	**	**	**	***	***	***	**	***	**	***	**	**

**** = High *** = Medium ** = Low * = None

icies and programmes which are the most advanced in this respect. A primary aim in this area will be the establishment of interconnected networks of competent centres for the monitoring and control of diseases, using appropriate data, criteria and methods. Efforts towards this goal are already under way concerning communicable diseases, and appropriate initiatives will be taken concerning other diseases, for example, cancer, building on systems and arrangements already existing.

(iii) Member States' attitudes towards persons from non-member countries vary considerably with regard to health protection requirements and to the health protection afforded to them. Policies in this area need to be coordinated and the Commission intends to launch appropriate initiatives on this subject. In order to achieve these objectives there is a need for the greatest possible transparency and the Commission will need to have recourse to appropriate advice and to consult widely in order to plan effectively, to communicate its messages, and to promote dialogue on the issue of migrants and health.

(d) Information, education and health promotion

88. Activities directed towards the general public and specified sub-groups can be categorized as health information, health education or health promotion. It has become clear over the years that the precise meaning of each of these terms varies according to the particular cultural and linguistic context.

89. Health information involves the communication, often to the general public, but also to specified groups, of information on health-related matters. The content will normally be relatively general rather than personal, since it is unlikely that the recipients can be identified precisely. The medium may be paper (leaflets etc.), print (advertisements and articles), audiovisual (television and radio) or, less often, personal (talks and lectures by health experts, for example).

90. Health education implies the provision of a body of knowledge concerning health to a defined target group, using learning opportunities. The process will include interaction with and feedback from the recipients and the process cannot be said to be completed until the target group has demonstrated a change in awareness which should include, and go beyond, the knowledge of a number of factual elements. The critical point is that the educator undertakes to deliver a certain set of information and knowledge, and will adopt various approaches to ensure that it is achieved. It should be noted that while this process is typically associated with school-based education of children, it is not confined to this group. Responsibility in this field depends on the administrative structures in the individual Member States: both health and education departments may be involved, and other ministries may also have a say.

91. Health promotion has been described as applied health information. In other words, where health information and health education attempt to provide the target with the information and tools necessary for a healthy lifestyle, health promotion will actively seek to modify attitudes, behaviour, and environments, to enable the pursuit of a healthy lifestyle. Techniques may include legislation, economic incentives, modifications in various ways of the environment of the target group in order to promote healthy lifestyles. Health promotion measures and those leading to the long-term improvement of social and economic conditions, have to go hand in hand, as health promotion is a complex task interwoven with the entire social and political situation. It is not sufficient to act unilaterally on health-related problems, nor to limit efforts to people at high risk; rather, the whole community has to be involved in a joint effort that gives a continuing sense of collaboration and participation to everybody and leads to the long-term improvement of general living conditions.

92. Health promotion and health education can be considered as general subjects which are taking place in a large and diverse area (family, school, work, community), cover many lifestyle-related diseases (cancer, AIDS, drugs, cardiovascular diseases, etc.) and accidents, and aim to change risk behaviour (smoking, alcohol, nutrition, drug abuse, lack of physical exercise, etc.). The social and cultural differences between and within Member States have to be carefully assessed in undertaking Community health promotion and health education activities, particularly as regards nutrition and drug abuse.

93. The different approaches needed in a diverse and complex society such as the European Community should, however, never lead to a scattered approach. On the contrary, the various approaches should reinforce each other in order to ensure the maximum effectiveness of all the health promotion and health education actions. This can be done by linking the various approaches at the different levels (European, national, regional, and local). An effective organization and coordination of health promotion and health education actions at all levels, as well as careful planning and evaluation of the actions, within the context of an overall plan, is a prerequisite to ensure maximum benefits from the efforts expended in the promotion of health. The Commission, therefore, is reviewing existing programmes to ensure that where there are actions of a similar nature, such as health promotion and health education, these will be regrouped together so as to avoid duplication of effort and to improve efficiency.

94. In implementing health promotion and health education the role of the Commission will be to:

(i) facilitate the exchange of information and models of good practice by networking, preparation of information packages, manuals, and workshops;

(ii) lend support by providing appropriate incentives;

(iii) initiate, generate, and coordinate, as necessary, activities at Community level.

95. An appropriate use of the resources and expertise available in the Member States will be made in order to increase the effectiveness of health promotion and health education actions.

(e) Research

96. Apart from Articles 130f to 130q on 'research and technological development' which cover all research activities, Article 129 gives the Community a clear mandate for research in the field of disease causation and transmission. Actions under this public health framework should make full use of the results obtained under the Community's framework programmes for research.

97. Research on biomedicine and health (Biomed) in the context of the current Community programme of research and technological development runs until 1994 with a budget of over ECU 130 million.

98. Current research covers four main areas:

(i) coordination of research on prevention, care and health systems;

(ii) major health problems and diseases with an important socio-economic impact;

(iii) human genome analysis;

(iv) medical ethics.

99. AIDS figures prominently among the major health problems. The other major health problems covered by this programme are cancer, cardiovascular disease, mental illness and neurological disease and the ageing process and age-related health problems. In all these areas links with action-oriented activities are being strengthened.

100. Discussions are currently under way concerning a fourth framework research programme on the basis of a formal Commission proposal (COM(93) 276). The Commission published on 6 October 1993 a working document (COM(93) 459) concerning the scientific and technological content of the specific programmes implementing the fourth framework programme. It is now being considered by the European Parliament and the Council, and it proposes the following headings for research in biomedicine and health during 1994-98:

(i) AIDS, tuberculosis and other infectious diseases;

(ii) cancer;

(iii) pharmaceutical research;

(iv) neurosciences and brain research;

(v) prevention, occupational health, risk factors, and public health research;

(vi) epidemiology of illnesses with a major socio-economic impact;

(vii) cardiovascular diseases;

(viii) human genome analysis;

(ix) health services research;

(x) biomedical technology and engineering;

(xi) biomedical ethics.

101. Another area where significant developments in Community research over the next few years are expected is that of the telematics programme for health care (formerly AIM). The activities in AIM, with a budget of nearly ECU 100 million for the period 1991 to 1994, are intended to improve the quality and cost-effectiveness of health services through the use of 'telematics', that is the combination of informatics and telecommunications.

102. In order to ensure that a coordinated effort is made and that existing and future Community research programmes cover adequately the subjects of health promotion and disease prevention, the following conditions should be met:

(i) the identification based on clear priorities agreed at Community level of those aspects of public health that need stimulus and promotion through research;

(ii) coherence between public health actions and research activity;

(iii) a clear strategy covering those matters relevant to public health topics;

(iv) the step by step establishment of appropriate structures, for example, networks;

(v) the proper dissemination of research results and their impact on decisions at Community level and Member State level.

(f) Training of health professionals

103. Health professionals in different settings (general practice, hospitals, schools, occupation, leisure) have a key function in the transmission of health education and health information messages to the Community. This has already been demonstrated in the case of the fight against cancer and AIDS, with important activities being undertaken in the framework of the relevant Community programmes. It is the intention of the Commission to pursue work in this area in order to:

(i) increase the awareness of health professionals about the important role they can assume and about how they can contribute to the prevention of major diseases;

(ii) increase their grasp of issues relevant to the prevention of diseases with a multicultural dimension, for example, the role of nutrition, migration (for instance, related to thalassaemia and HIV), and their knowledge of conditions that are gaining in importance (for example, tuberculosis).

104. To this end, taking into account both the Community's guidelines on education and training, as set out by the Commission in May 1993 (COM(93) 183) and the experience acquired through Community action programmes, such as Erasmus, FORCE and Comett, the Commission will undertake, where appropriate under these action programmes, the following:

(i) promotion of exchange of information between Member States on current training courses and schemes notably in relation to toxicodependency, but also including alcohol and medicines, nutrition, and sexually transmitted diseases;

(ii) coordination and recommendations on training programmes for health professionals, in close collaboration with the competent authorities, learned institutions, and the committees and associations concerned;

(iii) encouragement of exchanges of experiences on teaching methods and didactic materials in relation to the prevention of major health scourges and on the evaluation of effectiveness of those teaching methods and materials;

(iv) inventory and evaluation of existing methods and practical applications on how to improve accessibility and availability of information and materials aimed at health professionals, in relation to the prevention of major health scourges;

(v) information and promotion of awareness of doctors, nurses and social workers on specific conditions uncommon in their respective Member States, but which, as a result of growing migration and travel, are becoming increasingly important in the Community, such as tuberculosis in migrants, HIV and STDs in tourists, and thalassaemia in people of Mediterranean origin.

(g) Cooperation with international organizations and third countries

105. Whilst cooperation with third countries and international organizations is specifically mentioned in relation to public health in Article 129, cooperation in general has already been undertaken by virtue of Article 228 of the EEC Treaty which provides for the conclusion of agreements between the Community and one or more States or an international organization. The Treaty also states that the Commission has to ensure the maintenance of all appropriate relations with the organs of the United Nations, of its specialized agencies, and shall also maintain such relations as are appropriate with all international organizations (Article 229). The EEC Treaty also provides in Article 230 for the establishment of all appropriate forms of cooperation with the Council of Europe and in Article 231 for cooperation with the Organization for Economic Cooperation and Development (OECD).

106. The Commission has already long-standing collaboration with third countries and with several international organizations in the field of public health. In the future the onus must be on increasing the cooperation with them such that maximum benefit can be drawn for all the parties involved. To foster cooperation of the Community with third countries and international organizations in the field of public health it is necessary to have good knowledge of ongoing and planned cooperation between Member States and third countries and international organizations. This will help to avoid duplication of efforts and lend support to the actions undertaken by Member States.

(i) International organizations

107. A relatively large number of organizations, both governmental and non-governmental have health on their agenda. The main organizations concerned are WHO, the Council of Europe, the International Organization for Migration (IMO), Unesco, the International Atomic Energy Agency (IAEA), the Organization for Economic Cooperation and Development (OECD), the International Labour Organization (ILO), the Food and Agriculture Organization (FAO), the United Nations international drug control programme (UNDCP), the International Federation of Red Cross and Red Crescent Societies (IFRC), and the International Council on Alcohol and Addictions.

108. Agreements in various forms have been established with most international organizations, and in one instance the Community became a full member of an international organization (FAO, 1991). With the exception of WHO, whose activities encompass all health matters, other international organizations only deal with specific health issues as they relate to their objectives. However, in the case of the Council of Europe, which has links in many areas with the Community, there has been an expansion of its role in the public health field, particularly since a number of countries of Central and Eastern Europe have become members of that organization.

109. The object of fostering cooperation is two-fold:

(i) to strengthen the public health actions within the Community, as well as those undertaken outside the Community but which have an impact on it;

(ii) to ensure that the Community plays an increased role in the public health field at the international level.

WHO

110. Cooperation with WHO is based on two exchanges of letters with the Commission (1972 and 1982). This cooperation covers the Organization as a whole, as well as its regional offices, and in particular the European office, and the International Agency for Research on Cancer (IARC). At operational level, intensive working relations have been developed between the Commission and WHO in different areas. These include the organization of joint activities in specific areas. Of particular importance is technical expertise provided by WHO to the Commission services, to help to reply to specific demands, such as development assistance and the provision of humanitarian emergency aid. Cooperation in the cancer field with IARC is already extensive. A review of the current WHO-EC collaboration has been transmitted to the Council (COM(93) 224 final). It is the Commission's intention to arrange a further exchange of letters with WHO in order to update, improve and expand cooperation on specific issues.

Council of Europe

111. With the Council of Europe, cooperation is based on the EEC Treaty and has been amplified by a 1987 agreement. In the public health field, cooperation covers matters such as blood, organ transplantation, health education, youth and health promotion issues and health and sports, in particular, doping. There is also close involvement in the workings of the European Health Committee and the European pharmacopoeia and, especially, in action on drugs where close cooperation exists between the Commission and the Pompidou Group and which will be further extended through the establishment of the EMCDDA. In addition, enhanced collaboration with the Council of Europe in the health field, appropriately directed, could promote cooperation with Central and Eastern Europe thus contributing to the fulfilment of the objectives of paragraph 3 of Article 129.

112. The Commission is carrying out an examination of its cooperation with the Council of Europe in public health, and will be making the results of this examination available in due course. Consideration will be given to proposing the introduction, into the draft Council of Europe conventions on health, of clauses permitting the European Community to become a party to these conventions, without the need for the negotiation and ratification of specific protocols.

Other international organizations

113. IOM: Cooperation is ongoing on the issue of migration and health.

Unesco: AIDS and drug education are covered and will be further developed.

ILO: Joint activities are being undertaken on drugs and alcohol at the workplace. Initiatives are being developed on smoking, health education and promotion also involving workers' families.

FAO: A joint conference on nutrition and health has been organized and more joint activities are envisaged to implement its results.

UNDCP: Cooperation on drug demand reduction is being stepped up.

Red Cross: Humanitarian health assistance has been provided through the International Federation of Red Cross and Red Crescent Societies and will continue in the future on such issues as blood supply and quality, AIDS prevention, etc.

OECD: Cooperation is ongoing in the field of the health aspects of the environment, (chemical safety in particular) and will be further developed on the subject of health statistics.

IAEA: Close cooperation exists in the field of radiation protection.

Nature of increased cooperation

114. The nature of increased cooperation with international and non-governmental international organizations could take three forms.

(i) In matters of Community competence, the Commission could ask international organizations to carry out specific tasks for the Commission in areas where these organizations have a mandate and proven expertise (joint projects).

(ii) In areas reserved for cooperation between the Member States, the Commission can enlist the help of such organizations, in conducting joint programmes and actions which benefit some or all of the Member States.

(iii) In areas where the international organizations conduct their own programmes or actions, which are not priority matters for the Commission or the Member States, the Commission may provide assistance, if such programmes and actions are of interest to the Community.

(ii) Third countries

115. Cooperation with third countries will take into account the present and future links existing between these countries and the European Community. There are a number of countries having formal agreements with the Community, in some of these agreements health protection is specifically covered. It is intended

to examine with these countries what emphasis will be accorded to health matters under these agreements.

116. According to the conclusions of the European Council of Copenhagen (1993) Community programmes should be opened up to the countries of Central and Eastern Europe having association agreements with the Community. This should lead to the development of practical links with these countries to complement the assistance already provided by the Community. The possibility of opening action programmes for their participation will be jointly considered with these countries. Similarly cooperation with countries that have applied for Community membership should permit the identification of topics of mutual interest, and their gradual involvement in a number of ongoing activities.

117. In the framework of its relations with developing countries, the Community participates in cooperation programmes in the field of public health. Emphasis is placed on supporting, by means of various financial instruments, health system reform and actions aimed at satisfying basic needs of the populations concerned, in particular the most vulnerable groups. Assistance is also extended to the fight against major endemic diseases, and in particular sexually transmitted diseases and AIDS. Collaboration, in the context of public health programmes, present and future, will be stepped up in order to share experiences and adopt coherent strategies on health issues of importance both to the Community and the developing countries, such as AIDS and drug dependence.

VII — Future action in the field of public health

118. The strategy chosen for selecting health threats for action at Community level, in addition to what is and shall be undertaken in the research area, points to the pursuit by the Community of a mix of (i) actions of a general nature benefiting the fight against many diseases, for persons of different age groups, socio-economic categories, sex, etc. such as health data and surveillance, health information, education and promotion; (ii) actions that are disease-specific and need, for maximum efficacy, to be narrowly focused, ensuring at the same time a sensible continuation of major current programmes which have proved their worth and have brought together public authorities, many interest groups and individuals across the Community in the best demonstration of the principle of subsidiarity.

119. Category (i) above directly responds to the challenge of undertaking action against all the major health scourges previously identified, in a way that promises to yield maximum health gain from the involvement of the Community, and stands to benefit both those who shape and take decisions, and the citizens of the Community. Category (ii) will help to facilitate the imput of interest groups and experts and better enlist and organize them in the fight against specific diseases.

120. Annex IV shows for each identified health threat and disease what, in qualitative terms, is expected to be the impact of involvement by the Community. Community programmes with actions of a general nature, listed, among others, in Table 4, will not only yield added value in respect of these health threats and diseases, but also, in respect of other threats and diseases. This is the case, for example, of health information and nutrition and on smoking in relation to cancer and to cardiovascular disease. Finally, specific actions in the context of programmes for particular threats and diseases will complement and reinforce the previous actions and will ensure that no opportunity is lost in tackling the selected diseases in a comprehensive and coherent manner. Both disease specific and 'general action' programmes will be introduced by using the legal instruments foreseen by Article 129, and their aims will be furthered by measures based on Article 129, or indeed other appropriate articles of the Treaties.

121. In terms of major health scourges, the above considerations lead the Commission to conclude that a number of them can sufficiently be addressed at present by existing programmes and instruments, and by future actions of a general nature. These are cardiovascular and cerebrovascular disease, mental disease, congenital defects, perinatal conditions, and musculoskeletal disorders. The Commission intends to keep the situation as regards these diseases under review, so as to be able to undertake specific actions if this appears to be appropriate. Moreover, for those programmes and measures that have been selected, the Commission intends to introduce more systematic evaluation mechanisms, involving substantive as well as management measurements. The former will include estimation of decreases in the occurence of risk factors and alteration in risk behaviours and attitudes; the latter will enable the drawing up of conclusions on whether preset goals have been achieved and what modifications are needed, to identify the causes of success or failure, and to define ways by which goals can be achieved with minimum costs, and maximum results obtained with given resources.

122. The areas singled out as a matter of priority for future Community action in the field of public health can now be determined. These areas may be the subject of Commission proposals for comprehensive multiannual programmes which set clear objectives and will respect the principles already outlined in this document, including subsidiarity. These programmes would be introduced over a three-year period, and on the basis of experience gained, would last for five years. The programmes would be on the following topics:

- health promotion, education and training
- health data and indicators, and monitoring and surveillance of diseases
- cancer
- drugs
- AIDS and other communicable diseases
- intentional and unintentional accidents and injuries
- pollution-related diseases
- rare diseases.

In the light of experience and developments in the incidence of diseases in the Community, the Commission may propose programmes on other health threats.

Annex I

Overview of prevention and health promotion policies in the Member States

1. Belgium

(French community)

Present priority areas are: AIDS, drugs, elderly people, immigrants and vulnerable groups. The preventive actions include health education, school health services, actions against drugs, AIDS and mental health problems. Moreover, long-existing programmes on vaccination, hygiene and sports injuries continue to be pursued.

(Flemish community)

A comprehensive health promotion and prevention strategy has been elaborated, the key elements of which are:

(i) mid-term priority setting;

(ii) coordination of local and regional initiatives which fit well with the overall, national and Community context;

(iii) integration of sectoral approaches into a general health promotion frame, for example, school health, mental health, drug prevention, and child and family issues;

(iv) implementation of legal provisions (e.g. early notification of diseases, vaccinations);

(v) provision of adequate resources for specific preventive action, notably in the field of AIDS, cancer, cardiovascular diseases, perinatal mortality, accidents, transmissible diseases and mental health;

(vi) action by the authorities assisted by other partners such as the Flemish Health Promotion Institute which, since 1991, constitutes an important forum for all organizations concerned with health promotion and education;

(vii) other coordination mechanisms have also been set up in specific fields, such as AIDS, tobacco prevention, alcohol and drugs, cancer, etc.;

(viii) monitoring, surveillance and quality control work in public health including data collection and analysis of trends.

2. Denmark

Apart from a number of preventive services carried out by the established health-care system, the Danish prevention policy is based on the document *The health promotion programme of the Government of Denmark*. This document, published in 1989, gave priority to programmes on cancer, cardiovascular disease, accidents, psychological problems and musculoskeletal diseases. In addition to these priorities, Denmark has specific programmes on drugs and AIDS as well as on asthma and allergic diseases.

The Ministry of Health is the coordinator of all actions in this area taken by government agencies, and strives to integrate prevention considerations into other policies being implemented in Denmark.

To this end, a number of coordinating bodies have been set up, all chaired by the Ministry of Health.

As regards funding, preventive issues are financed from tax revenues.

3. Germany

Responsibility for health issues lies almost entirely with the *Länder* and apart from Federal programmes on cancer, AIDS, and drugs, all other health prevention actions as well as all other health-related activities are carried out in a decentralized manner by the *Länder*. In support of the above activities the Federal Government launched in 1993 a programme on health research called 'Health research to the year 2000'. This programme deals with lifestyles, nutrition and the environment as well as care for groups at special risk namely children, young people, women and the elderly.

A number of Federal advisory bodies have been set up to deal with health and prevention issues, foremost of which is the Bundesgesundheitsrat (Federal Health Council). The Council of professionals advises on concerted actions and the Federal Health Research Council on research. Other advisory and expert groups exist for specific diseases.

Preventive activities are financed from tax revenues at the federal, *Länder*, and municipality level, from health insurance contributions, as well as from contributions from companies and from various other sources.

4. Greece

Prevention policy in Greece follows the orientations of WHO's 'Health for all by the year 2000', with emphasis being placed on the selection of priorities and on the

involvement and cooperation of public and private bodies. Current areas of priority include cancer, AIDS, cardiovascular disease, blood and blood products supplies, blood-related hereditary diseases, accidents, drugs, mental diseases, infectious diseases.

Action on cancer, aided by the Community, focuses on nutrition, tobacco and screening programmes, and on developing a national cancer register. The fight against AIDS is carried out mainly through special programmes of information research and social assistance. Particular efforts are made for encouraging voluntary blood donations, with compulsory controls being made on donated blood for hepatitis B and C and for HIV, and on the prevention of thalassaemia and haemophilia. Increasing attention is directed towards the collection and utilization for prevention purposes of information on accidents on the road, home, and during leisure activities, and programmes of health education have been launched using in particular the concept of the health-promoting school. Action against infectious diseases includes systematic vaccination and compulsory notification, as well as *ad hoc* measures, for example on tuberculosis and malaria. The elderly benefit from a range of health information and education actions, and from measures designed to provide assistance at home. Finally, training of health professionals on prevention and on the problems of migrants is gaining importance.

Policy is formulated by the Ministry of Health and Social Security, following advice from the Central Health Council which comprises experts from across the health professions. Specialized quasigovernmental agencies and bodies exist for the implementation of measures and programmes against certain diseases and health threats.

Financing of action programmes and research is mostly provided by the Ministry of Health budget, but there are also contributions from tobacco taxation and nationwide donation campaigns.

5. Spain

The general health objectives fall into three categories: promotion of healthy lifestyles, prevention of environmental risks to health and improvements to the health-care system.

Concerning the promotion of healthy lifestyles, public health measures are aimed at reducing tobacco consumption and its harmful effects on health, encouraging physical exercise, reducing the harmful effects of alcohol, reducing drug abuse and dependency on harmful substances and developing diets suited to individual needs. The measures for the prevention of environmental risks are aimed at reducing biological, physical and chemical risks as well as preventing hazards at work and accidents. Finally, improving the health-care system includes the extension of public health care, developing primary health care, special care, maternal and infant care, development of oral hygiene, mental health care and the rehabilitation and geriatric care systems. Specific disease prevention programmes include programmes on cardiovascular diseases, cancer, AIDS, accidents and zoonoses. In addition to these programmes, two horizontal programmes are being carried out on health promotion and health education.

Responsibility for the execution of prevention policies lies at all administrative levels: the national, regional and the local levels and a number of advisory bodies assist in the formulation and implementation of the various policies. Legal provisions regulate areas like vaccinations, notifiable diseases, food hygiene, atmospheric protection, protection against physical agents and protection against hazards at work. Additionally, a comprehensive set of legal instruments regulates tobacco: a ban on advertising, health warnings, nicotine and tar contents, a ban on sales to children and restrictions or bans on consumption.

6. France

The national prevention policy contains three elements: (i) action directed at all determinant issues affecting health; (ii) medical prevention (vaccination, screening and prophylaxis; and, (iii) action directed at specific target groups (school children, the old, pregnant women, the disabled, and young people with adaptation difficulties).

In 1991, a high-level committee on public health was established by the Minister for Health in order to give advice on public health questions and policy. This committee is at present reshaping public health policy on the basis of WHO's health for all strategy. Besides that committee, prevention and health promotion activities are carried out by specific advisory bodies and by local authorities.

Legal obligations cover the following areas: vaccinations; medical examinations before marriage, during pregnancy and post-natal for mother and child; drug use; tobacco and alcohol advertisements; and declaration of communicable diseases.

Prevention programmes on specific diseases and health threats concern AIDS, drugs and drug abuse, tobacco and alcohol, use of pharmaceuticals, STDs, cancer screening prevention and dental problems. General prevention programmes are directed towards elderly people, women, young people, the handicapped and also concern the integration of health aspects in urban development and schools.

As regards funding, prevention activities are financed from a combination of tax revenues and health insurance contributions.

7. Ireland

The objectives of the national prevention policy include: prevention of infectious diseases, early detection of health defects in children, achieving significant improvements in the level of oral health, and reducing the incidence of disease attributable to smoking, alcohol abuse and other lifestyle-related factors.

The Irish Government in 1988 adopted a policy aimed at health promotion, and established new health promotion structures including a Cabinet sub-committee on health promotion to provide an effective mechanism whereby decision-making in areas of public policy with an impact on health can be made on the basis of a health perspective. Preventive actions in Ireland include immunization programmes, notification, diagnosis and hospital services for infectious diseases, monitoring of tuberculosis, cervical screening, maternity, infant care and child health, dental care, AIDS, drug abuse and tobacco.

Towards the end of 1993 the Ministry of Health proposed a national health strategy which, in particular, included a strategic plan for health, promotion, mapped out the current Irish health status and set out national goals and targets for specific improvements, along with a strategy for achieving them.

8. Italy

Preventive activities in Italy are mainly concentrated on four issues. Environment and health, lifestyle-related problems, health protection at work and the prevention of infectious diseases.

As regards environment and health, activities are increasingly being carried out by the European Centre of Environment and Health which was set up by mutual agreement between the regional office for Europe of WHO and the Italian Government. On lifestyle-related diseases, Italian policy concentrates on nutrition, smoking, drugs, and AIDS. Concerning health protection at work, the basic law (No 46 of 5 March 1990) governs health and safety at technical installations, equipment, substances and buildings, and has been supplemented by decrees transposing EC Directives based on Article 118a of the EEC Treaty. For the prevention of infectious diseases, Italy has over the last two years introduced a new system for the prevention of and reporting on such diseases. The new system means that such diseases can be identified better and more quickly ensuring a rapid flow of information to and from the Ministry of Health so that, where appropriate, immediate action can be taken and information exchanged with international health organizations.

Responsibility for the prevention activities lies with a number of institutions, notably the Ministry of Health, the National Health Service, local health authorities and the drugs addiction services.

9. Luxembourg

Since the 1970s, preventive action has been an integral part of the overall health policy in Luxembourg. This was reflected in the reorganization of the Government Health Department in 1980 whereby special divisions were set up for prevention. The most important programmes are the programmes on drugs, tobacco, alcohol, on cardiovascular diseases, and on cancer. In addition to this, a special programme has been launched to promote healthy nutrition and healthy lifestyles.

Activities on prevention are coordinated by the Ministry of Health, with the other ministries taking part in the overall effort as well. Activities on prevention have since June 1992 been the object of the revised law on health insurance and the health sector. Apart from the provisions contained in this law, Luxembourg has not yet developed a separate and comprehensive programme on prevention.

10. The Netherlands

Prevention policy in the Netherlands is based on a number of programmes. Disease prevention consists of national vaccination programmes, screening programmes, cervical and breast cancer screening programmes, and counselling services for mothers and young children. Systematic training on prevention is currently being introduced notably for general practitioners. Action on health promotion covers a wide range of activities such as national health education campaigns, school and workplace health education conferences, mental health education especially for groups at risk, such as the elderly, divorced couples, children, etc. Health education also focuses on alcohol, tobacco and drugs. Intersectoral actions are carried out in the work environment, notably for safety and health at work, and so on.

Preventive activities are carried out by national specialized institutions, municipal public health services, regional mental health services, regional addiction services and primary health-care professionals.

Disease prevention is financed by the insurance schemes.

11. Portugal

The medium-term objective for the Portuguese strategy on prevention is to improve the standard of public health by means of campaigns against cancer, drugs, AIDS and by the prevention of stroke and cardiovascular disease, the prevention of accidents in general, the prevention of suicide and by improving assistance to the elderly, to children and to young people. Moreover, the overall strategy seeks to improve conditions and the functioning of the health-care system by increasing the number of beds for the chronic sick, by improving or

replacing facilities providing health care, and by taking steps to rationalize existing human resources and promote a better distribution of medical health-care personnel. The Ministry of Health is carrying out specific programmes on the control of diabetes mellitus and hypertension, vaccination, infant and juvenile health care, maternal health care, oral health, health at school, health education, a national cancer project, drug prevention, and AIDS.

The prevention policy in Portugal is coordinated by the Ministry of Health and is laid down in the Portuguese National Health Service Law. The Ministry of Health is advised by the National Health Council which comprises representatives from all parties concerned with health protection. The National Health Council formulates recommendations on the overall health strategy and in this work it is assisted by a large number of consultative bodies.

12. United Kingdom

Prevention policy in the UK is made up of four parts.

(i) Screening and immunization programmes include breast and cervical cancer screening, and immunization of all children for diphtheria, tetanus, whooping cough, polio, measles, mumps, rubella, BCG and HIB.

(ii) Specific health initiatives exist, such as the 'Health of the nation' initiative for England launched in July 1992 which identified five national priorities and set 27 targets. The priority areas concern coronary heart disease and strokes, cancers, mental illness, accidents, and HIV/AIDS and sexual health (including family planning). The implementation of this initiative is to be based on the commitment of all Government departments, on building health alliances at national and local level, on acting through appropriate settings, and on improved health monitoring and impact evaluation.

(iii) Health promotion and education activities are another part. For England, under the 'Health of the nation' strategy, priorities were established for activity by the Health Education Authority, both at national and local level, for health promotion as an explicit element in general practitioners' contracts and for widespread health promotion throughout the health service. Other preventive actions specifically concern smoking, alcohol, drug misuse, nutrition, family planning and dental health.

(iv) Environmental health and public health actions include actions on the safety of medicines, consumer products and the environment, promotion of food hygiene at national and local level, and finally control and surveillance of communicable diseases.

Annex II

Community policies and instruments of direct relevance to health protection

1. Overview of activities

Health and the environment

The close link between the environmental aspects of public health and the necessity of governmental intervention was well established throughout Europe by the end of the last century and by then international activity had already begun. The efforts of the European Community 'to preserve, protect and improve the quality of the environment' and thus 'to contribute towards protecting human health' are a continuation of this international activity made more influential and effective by EC powers to legislate and EC funds to assist implementation. The latest comprehensive expression of the Community's environmental activities is to be found in 'Towards sustainability', a European Community programme of policy and action in relation to the environment and sustainable development (COM(92) 23 final, Volume II) adopted by the Council on 1 February 1993. This programme contains further proposals for improving the quality of water, air and soil, for controlling dangerous substances and industrial activities, and for monitoring radiation and controlling pollution and the disposal of waste.

Health and safety at work

The adoption of the Single European Act (1986) and inclusion of Article 118a gave a great boost to the Community's efforts to improve the health and safety of workers and reduce the risks from carcinogens and other dangerous substances and accidents at work. The Community's involvement in this area originated in the concern to improve working conditions in the Treaty establishing the Coal and Steel Community (April 1951), reinforced by the social provisions (Title III) of the EEC Treaty and the health protection measures in the Euratom Treaty. Important measures were adopted from 1977 onwards, notably in 1980, but a significant step in Community involvement was taken in 1989 when a framework Directive (89/391/EEC) was adopted on the improvement of the safety and health of workers at work. A large number of subsequent Community measures have been adopted within this framework, establishing the Community as the driving force in occupational safety and health matters. Some of these measures are closely linked with the Community's public health measures in the field of toxicology and poison centres.[1]

[1] Resolution of the Council and Ministers for Health of the Member States on improving the prevention and treatment of acute human poisoning (90/C 329) of 3 December 1992.

A healthy population requires healthy food

The need for food products to be safe, uncontaminated, and wholesome led to phytosanitary and veterinary controls, as well as to requirements for the composition of foodstuffs, the use of preservatives, additives, etc. and for informative labelling requirements. These matters are the subject of a number of internal market measures in the Community dating back as far as 1962. More recently (mid-1980s onwards) interest has been growing in the nutritional value of foodstuffs and additives for the promotion of health. Current public health concerns are to avoid foodstuffs which have an association with major diseases such as cancer and cardiovascular disease and to help people to choose sensibly what to eat through health education and by clear labelling of the components of food products. To this end, the Commission has instituted a major nutritional study under the Europe against cancer programme.[2]

Consumer protection

The population also needs protection from other products and from the potentially harmful effects of some services. The products include not only medical products such as pharmaceuticals[3] and medical devices[4] but also the whole range of potentially dangerous items available on the market. The Community's internal market measures to ensure a high level of health protection in these matters include 'new approach' directives relating to medical devices, personal protective equipment, machinery, toys,[5] etc., as well as directives and measures relating to consumer information general product safety and the monitoring of accidents.[6]

Research and information technology

Basic to developments in public health policy are the findings of research into the causes and transmission of diseases and ways to prevent them, including the use of modern techniques of information technology. The Community's successive medical and health research programmes have, since their start in 1978, contained

[2] European prospective investigation of cancer, nutrition and health (EPIC) 1998.

[3] Council Directives 65/65, 75/318 and subsequent legislation.

[4] Council Directive 90/385/EEC of 20.6.1990 (OJ L 189, 20.7.1990) and Council Directive 93/42/EEC of 14.6.1993 (OJ L 169, 12.7.1993).

[5] Council Directive 88/378 of 3.5.1988 (OJ L 187, 16.7.1988).

[6] Council Directive 92/59.

an important element concerned with the prevention of disease. The current Biomed programme contains similar provisions. Community information technology and telematics programmes and pilot schemes, often carried out in cooperation with WHO and the Council of Europe, have included elements concerned with the monitoring of congenital disease, the use of informatics in medicine (AIM), care systems (statistics, early warning, food safety and pharmacovigilance), and epidemiology.

Social security

The coordination of social security systems gives insured people access under certain circumstances to health care in all other countries of the Community by means of Regulation (EEC) No 1408/71 and form E111.

The recognition of a right to benefit from systems for protection of human health regardless of personal resources is laid down in Council recommendation 92/442/EEC on the convergence of social protection objectives and policies. Access to systems for the protection of human health, regardless of an individual's resources, can be guaranteed either through a system of health insurance, which is open to persons of all income levels irrespective of their individual risk profile, or through the free provision of health care and prevention within a public health service.

The health professions

The health professions and staff of governmental and non-governmental organizations responsible for the provision of health services have a key role to play in the provision of advice and information for the promotion of public health and the prevention of disease. The Community's measures for the mutual recognition of professional qualifications between the Member States and for the development of cooperation and training in higher education and training institutions make an important contribution in this context. Elements of the Community's programmes to combat cancer and AIDS are designed to promote improved training for health staff involved in the fight against those diseases.

Disease prevention and health promotion

The Community's public health activities since the mid-1980s have gone beyond control of and protection from environmental and workplace health hazards to the encouragement and coordination of measures to combat major diseases and to promote health in a positive way.

The Community's programme to combat cancer (1987–89) was the first major disease prevention programme. The Europe against cancer programme focused on actions in particular areas such as tobacco and alcohol consumption, dietary habits, exposure to carcinogens and to the sun. It encouraged appropriate screening programmes and information on early detection and promoted a 10-point European code against cancer for the general public. The Community, using internal market provisions, adopted legislative measures on tobacco to improve and control the labelling of tobacco products and the tar content of cigarettes. A recommendation on smoking in public places was adopted and a proposal for a directive to ban the advertising of tobacco products is currently under consideration. A further programme to combat cancer was adopted to continue the activity from 1990 to 1994, which demonstrated its value and effectiveness, its power in agenda setting, and its impact, through its partners at all levels, on raising awareness.

Other major public health programmes soon followed as political pressure and health developments demanded Community action. The Europe against AIDS programme (1991–93) has 10 main action areas. As with cancer, some actions concerned the raising of public awareness, improved health education and cooperation with the Community's research programme. Other new elements were also introduced to suit the particular nature of the disease, including social support and counselling, estimates of the costs of managing HIV infection and efforts to combat discrimination against HIV-positive persons. Following the evaluation by the Council of the action under the programme, and in anticipation of the coming into force of the Treaty on European Union, the Council and the Ministers for Health have sought to prolong the programme to the end of 1994.

The European plan to combat the abuse of drugs has a particular element concerned with public health actions to reduce the demand for drugs. Information exchanges, the raising of public awareness, and assistance for pilot projects on prevention are features of the plan. A European drug prevention week is an important means of fostering cooperation and raising awareness.

For the public to know about and respond to such guidelines as the European code against cancer, a sustained programme of health promotion and education and the provision of relevant information is necessary. The WHO's programme 'Health for all by the year 2000' stressed this approach and the Community's initiatives on health education, instituted by both the Education and the Health Ministers, are concerned with the subject. Campaigns to persuade people to change their behaviour have also been launched in the context of the Community's programmes to combat cancer and AIDS and actions on drug abuse.

Other aspects

There are, of course, other aspects of the Community's public health activities. Actions to promote

the attainment of self-sufficiency in human blood or plasma derived from voluntary non-remunerated donations and to develop the production of blood products coming from these donations are a good example. There have also been actions in the field of toxicology for health protection, on improving the prevention and treatment of acute human poisoning, in the development of the European emergency health card and in a number of other areas, not only in the sphere of public health, but also as part of other Community policies.

2. List of Community instruments of direct relevance to health protection

EEC Treaty

(1951—57): implicit recognition of public health concepts by reference to 'accelerated raising of the standard of living' — many articles indirectly relevant to health protection.

Euratom Treaty

(1957): provides for:

(i) basic safety standards to be laid down within the Community for the protection of the health of workers and the general public against the dangers from ionizing radiations (chapter III);

(ii) safeguard inspections and training of inspectors (chapter VII);

(iii) conclusion of agreements or conventions with international organizations, third countries (chapter X).

With the adoption of the Single Act

(1986): a specific legal basis concerning health, safety, environmental protection and consumer protection was established: Article 100a(3); Article 118a (protection of workers' health and safety); environment (Articles 130r, 130s, 130t).

Health and safety at work

(1977—78): adoption of the first Council Directive concerning safety signs and the Directive concerning vinylchloride monomer (based on Article 100 of the EEC Treaty).

1980: Council Directive concerning the protection of workers against chemical, physical and biological agents (Article 100).

1989: adoption of the framework Directive 89/391/EEC concerning main apsects of health and safety at work (Article 118a) and 12 other directives on particular aspects of occupational safety and health.

Environment

EEC Treaty (Articles 100r, 100s, 100t)

(1) Dangerous substances, industrial risk, biotechnology. Examples include:

1967: Council Directive 67/548/EEC relating to classification, packaging and labelling of dangerous products (OJ L 196, 16.8.1967, p. 1);

1976: Council Directive relating to restrictions on the marketing and the use of certain dangerous substances and preparations (OJ L 262 27.9.1976, p. 201);

1982: Council Directive on the major accident hazards of certain industrial activities (OJ L 230, 5.8.1982, p. 1);

1993: Council Directive on principles for assessment of risks to man and the environment of substances.

(2) Air. Examples include:

1970: Council Directive concerning air pollution by emissions from motor vehicles (OJ L 76, 6.4.1970, p. 1);

1982: Council Directive on a limit value for lead in the air (OJ L 378, 31.12.1982, p. 15);

1985: Council Directive on air quality standards for nitrogen dioxide (OJ L 87, 27.3.1985, p. 1).

(3) Directives on waste (OJ L 194, 25.7.1975, p. 39), waste water treatment (OJ L 135, 30.5.1991, p. 40), waste prevention of air pollution from waste incineration plants (OJ L 163, 14.6.1989, p. 32; OJ L 203, 15.7.1989, p. 50).

(4) Noise (motor vehicles, aircraft, construction plants, household appliances, etc.) (OJ L 42, 23.2.1970, p. 16).

(5) Water (drinking water quality, bathing water) (OJ L 347, 17.12.1973, p. 1).

Consumer protection

Foodstuffs

Since 1962 Council Directives concerning additives used in foodstuffs intended for human consumption

have been adopted (based on Article 100 of the EEC Treaty). In 1969 a Standing Committee for Foodstuffs was set up. The Scientific Committee for Food which sets up lists of additives and the conditions for their use was set up in 1974.

1985: Council Directive concerning certain substances having hormonal action.

1989: Council Directive on the official control of foodstuffs and Council Directive on the approximation of laws of the Member States relating to foodstuffs for particular nutritional uses (based on Article 100a (3) of the EEC Treaty).

1990: Council Directive related to quick-frozen foodstuffs for human consumption.

Council Directive on nutrition labelling for foodstuffs.

Council Directive relating to plastic materials intended to come into contact with foodstuffs.

Other

1989: Council Decision on a Community system for the rapid exchange of information and the dangers arising from the use of consumer products (Article 235).

1988: Council Directive concerning safety of toys.

1991: Council Directive on control and acquisition of weapons.

1992: Council Directive on general product safety.

Pharmaceuticals

In 1965, the Council adopted the first Directive on the approximation of the provisions relating to proprietary medicinal products, based on Article 100 of the EEC Treaty.

1975: Setting up of a pharmaceutical committee: the Committee for Proprietary Medicinal Products, Council Directive relating to standards and protocols in respect of the testing of proprietary medicinal products.

1987: Council Directive concerning the approximation of national measures relating to the placing on the market of high-technology medicinal products, and Council Directive concerning tests relating to the placing on the market of proprietary medicinal products.

1989: Council Directives 89/342/EEC on vaccines, 89/343/EEC on radiopharmaceuticals, 89/381/EEC on blood derivatives, and 89/105/EEC on the transparency of the pricing and reimbursement of medicinal products for human use (Article 100a).

1991: Commission Directives on pharmaceutical goods manufacturing practice (91/356/EEC) and on testing requirements for medicinal products (91/507/EEC).

1992: Council directives on wholesale distribution, legal classification for the supply, labelling and advertising of medicinal products for human use (Article 100a).

1993: Council Regulation (EEC) No 2309/93 (Article 235 of the EEC Treaty) and Council Directives 93/39/EEC and 93/40/EEC (Article 100a) creating a European Agency for the Evaluation of Medicinal Products and establishing new Community procedures for the registration of medical products for human and veterinary use.

Free circulation of persons

1964: Council Directive 64/221/EEC on the coordination of special measures for foreign nationals on grounds of public order, public security or public health, concerning their movement and residence (Article 56(2) of the EEC Treaty).

Medical and paramedical activities

1975: Setting up of a committee of senior officials on public health concerned with the:

Directive on the mutual recognition of diplomas of doctors (Articles 49, 57 and 66 of the EEC Treaty);

Directive on the coordination of provisions in respect of activities of doctors (Articles 49, 57, 66 and 235 of the EEC Treaty).

Followed by the:

Council Directive concerning the mutual recognition of diplomas of nurses (1977); of dentists (1978); of midwives (1980); of pharmacists (1985) and of general practitioners (1986).

Medical devices

The Council has adopted several directives concerning protection of health and safety of persons with regard to placing medical devices on the market:

Directive 84/539/EEC on electro-medical equipment used in human or in veterinary medicine;

Directive 90/385/EEC on active implantable devices;
Directive 93/42/EEC on medical devices.

Annex III

Health protection requirements as a constituent part of other Community policies

Cooperation in the fields of law and internal affairs

Control of persons at external frontiers, immigration, drugs, and European Monitoring Centre for Drugs and Drug Addiction.

Citizens' rights

Accession to the European Convention on Human Rights.

Protection of personal data.

External affairs

PHARE and TACIS; UN drugs.

Relations with international organizations: Council of Europe, WHO, FAO, OECD, IOM, Unesco, UNDCP, IAEA, UN.

Acceptance of the European Pharmacopoeia.

Cooperation with third countries: EFTA, CEEC, Mediterranean countries, Latin America, North America, etc.

Negotiations with ASEAN on the illicit manufacture of drugs and psychotropic drugs.

Monitoring of intra-Community and international traffic in drugs and psychotropic drugs.

Internal market

Quality, safety and hygiene of food products, warning system, labelling, additives, colouring agents, contaminants, interaction between diet and health, packaging.

Medical equipment standardization, e.g. *in vitro* diagnosis, pharmaceutical products, cosmetic products, drugs and precursors.

Substances and dangerous preparations, classification and labelling; fertilizers, biocides.

Regulation of qualifications of (health) personnel.

Competition

Price of medicinal products; social security systems.

Social affairs

Women and health, social protection, disabled persons, the elderly, migrants, poverty, health protection of workers, European Social Fund.

Education and training

Erasmus, activities intended for young people and health professionals.

Agriculture

Quality and health of plants, animals and specialized crop species (fruits and vegetables, wine, alcohol, tobacco, etc.); hygiene related to fish, shellfish, milk, dairy products.

Promotion of consumption of olive oil, dairy products, fruits and vegetables.

Veterinary and phytosanitary controls within and outside the Community.

Fisheries

Quality of products from fishing and aquaculture.

Promotion of consumption of products from fishing and aquaculture.

Promotion of sanitary conditions of production, consumption and commercialization of products from fishing and aquaculture.

Transport

Transport safety; prevention of accidents, in particular road accidents associated with alcohol, accident database.

Development

Cooperation actions concerning health systems reform, and programmes and projects of support to the development of health.

Campaign against AIDS.

R&D programme in the field of science and technology for development, subprogramme on medicine, health and nutrition in tropical and sub-tropical areas.

Culture communication and information

People's Europe: activities aimed at young people, in the fields of drugs, AIDS, sport, for example.

Environment

Nuclear safety and health protection (Euratom; protection against other physical agents: noise, low frequency electromagnetic waves).

Control of dangerous chemical substances and preparations; dangers associated with biotechnology and genetically modified organisms.

Control of emissions from industrial installations; waste management.

Quality of the air, soil, water, drinking water.

Civil protection.

Research

Community Reference Bureau.

Nuclear safety; radiation biological and health effects; assessment of risks of natural and medical radiation.

Biotechnology: neurosciences.

Biomed I: human genome analysis; biomedical ethics, research on health services and technologies and diseases associated with lifestyle: AIDS, cancer, drugs, ageing, quality control. Fourth R&TD programme: preventive and epidemiological research on diseases with major socioeconomic impact and genetic diseases. Research on health systems, on evaluation of needs, and on education and information on health matters. European brain research.

Telecommunications and telematics programme

Telematics programme for health care (AIM), improved quality assurance and effectiveness of therapeutic and social measures and primary health services, resource management medical images, health records, rehabilitation patient data cards, etc. via results of several specific projects, concerted action and accompanying measures: RACE, Esprit, Impact, TIDE.

Telematics programme for administration (ENS) CARE project: rapid, efficient access to health statistics; pharmacovigilance, etc.

Legal protection of data (Council of Europe recommendations).

Indirect taxation

Distilled and fermented beverages, processed tobacco.

Tourism

Consumer protection

General safety of products and services and liability; Ehlass project; system for the rapid exchange of information; consumer information and education.

ECHO

Emergency humanitarian aid for non-member countries.

Social and health statistics

Annex IV

Identification of major health scourges in the European Community

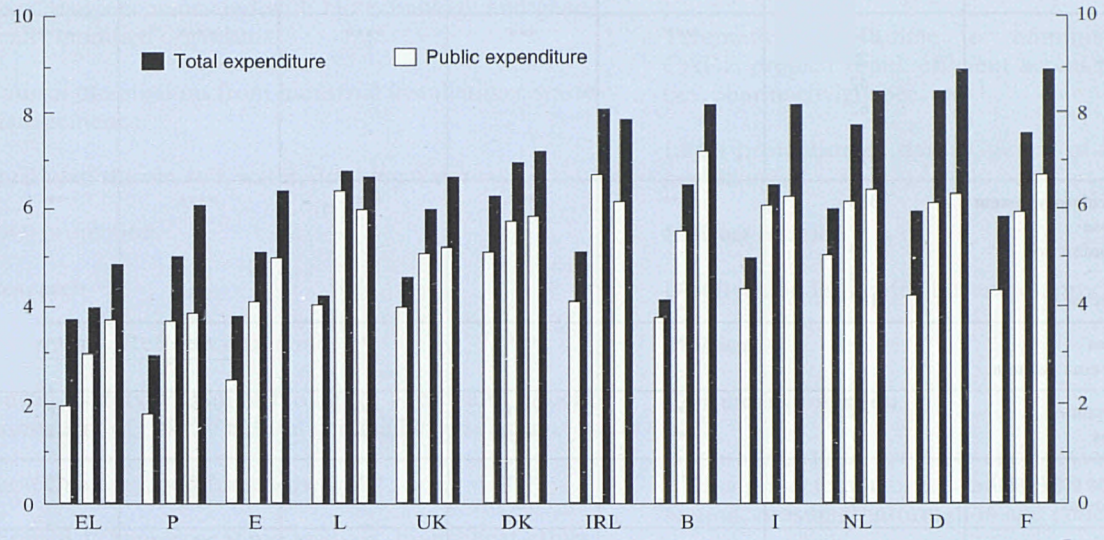
Disease I health problem	Standardized death rates per 100 000 or incidences per 100 000 (estimates)	Costs for health services (and other costs, e g. absenteeism)	Practical possibilities or prevention	Community added value (opportunities for intervention)	Major scourge (major health problems)	Previous Community health action
Cancer Cancer of colon Lung cancer Digestive organs Breast cancer Prostate cancer	337 29 42 62 33 19	***	***	****	****	****
Diseases of the circulatory system Hypertensive disease Acute myocardial infarction Cerebrovascular Ischaemic heart disease	338 16 90 90 137	****	***	****	****	**
Respiratory diseases Bronchitis, emphysema, asthma	17	***	***	***	***	**
Congenital abnormalities Perinatal conditions	5 5	*** ***	**** ****	*** ***	* *	** **
Accidents (including poisoning) Motor vehicle accidents	51 15	****	****	****	****	**
Drug and alcohol abuse		***	****	****	****	***
Musculo skeletal problems		****	***	***	***	**
Visual problems		**	**	*	*	*
Auditory problems		*	**	*	*	*
Mental disorders Suicides	13	****	**	*	***	*
Nutrition-related disorders, including diabetes, dental caries		***	***	***	**	***
AIDS Other communicable diseases, e.g. sexually-transmitted diseases and tuberculosis	2.41 (incidence)	*** ***	**** ****	**** ****	*** ***	*** ***
Childhood infections, e.g. Measles Rubella Other childhood infections	51 (incidence) 26 (incidence)	**	****	****	*	*
Rare diseases, e.g. Thalassaemia, sickle-cell anaemia, rickets		*	***	***	**	*
Food borne diseases, e.g. Salmonella poisoning		**	****	****	***	*
**** = High	*** = Medium	** = Low	* = None			

Annex V

Statistical data

Figure 1 — Total and public expenditure on health care in relation to national expenditure in the Community, 1970, 1980 and 1991

Percentage of national expenditure (GDP less exports plus imports)



Public expenditure in 1990 for EL, L, P.

Figure 2 — Temporal distribution of causes of death (EUR 12)

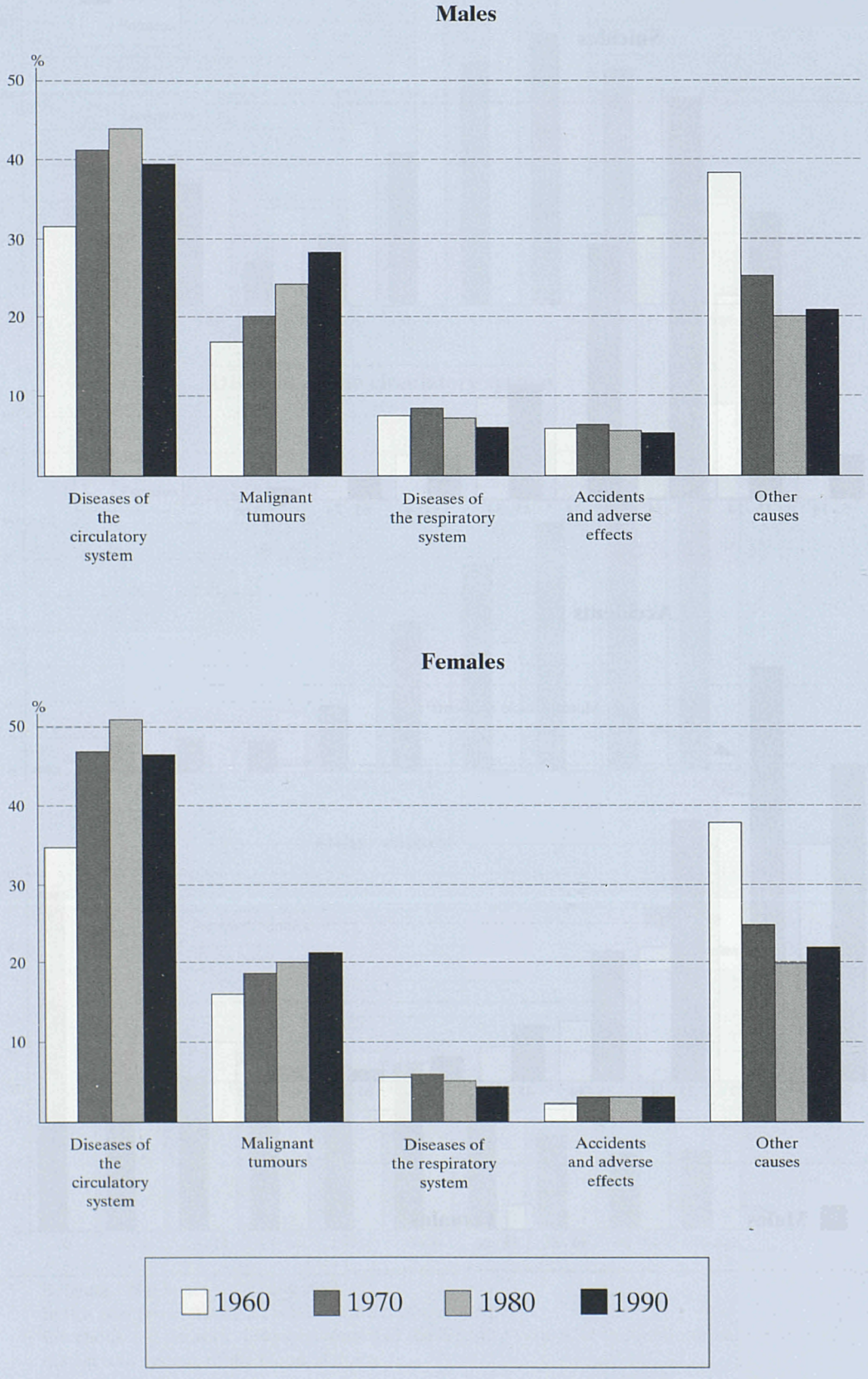
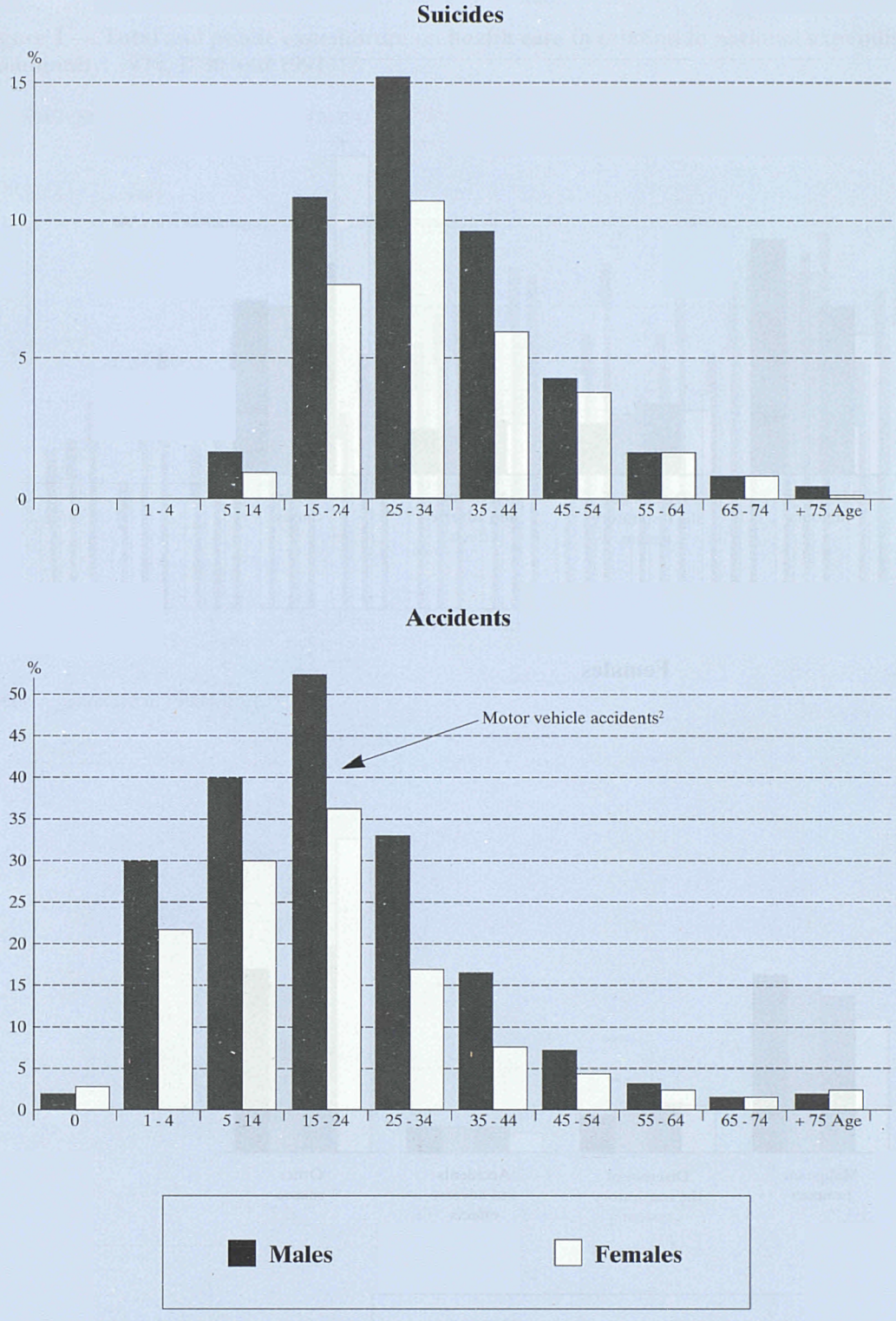
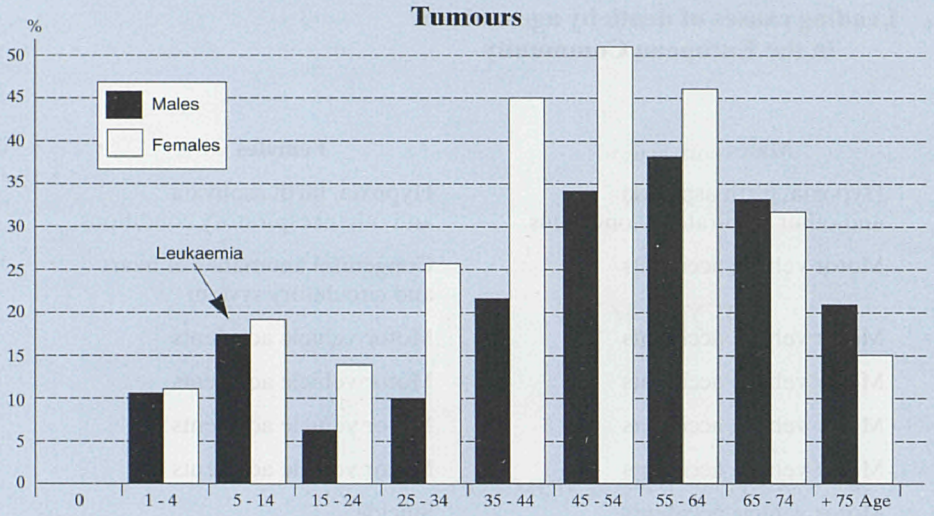
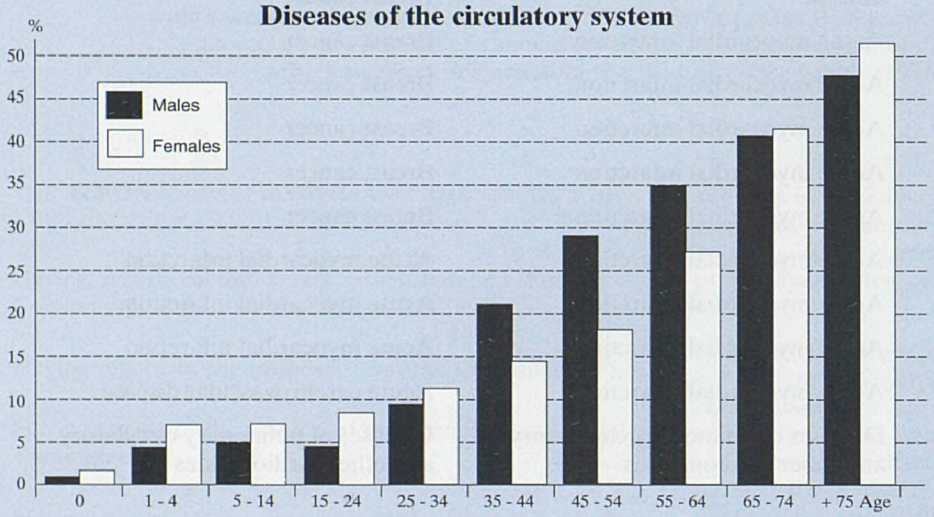
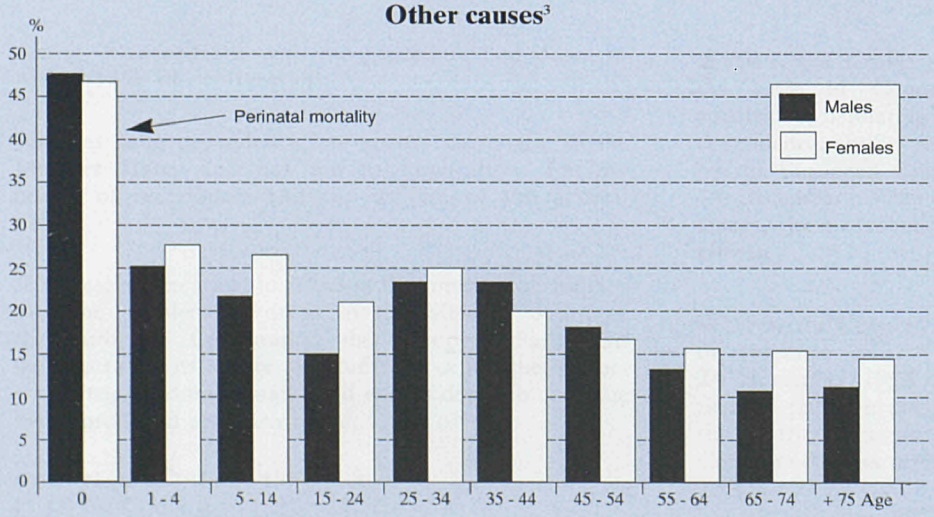


Figure 3 — Causes of death by age group (EUR 12) in 1989[1]









1 Belgium 1986; Spain 1987; Italy 1988.

2 In this year group nearly all accidents are traffic-related.

3 Infectious and parasitic diseases, diseases of the digestive system, of the genito-urinary system, of the nervous system, of the blood, skin, etc.

Leading causes of death by age and sex in the European Community

Age in years	Males	Females
under 1	Hypoxia, birth asphyxia and other respiratory conditions	Hypoxia, birth asphyxia and other respiratory conditions
1—4	Motor vehicle accidents	Congenital anomalies of heart and circulatory system
5—9	Motor vehicle accidents	Motor vehicle accidents
10—14	Motor vehicle accidents	Motor vehicle accidents
20—24	Motor vehicle accidents	Motor vehicle accidents
28—29	Motor vehicle accidents	Motor vehicle accidents
30—34	Motor vehicle accidents	Suicide
35—39	Suicide	Breast cancer
40—44	Acute myocardial infarction	Breast cancer
45—49	Acute myocardial infarction	Breast cancer
50—54	Acute myocardial infarction	Breast cancer
55—59	Acute myocardial infarction	Breast cancer
60—64	Acute myocardial infarction	Breast cancer
65—69	Acute myocardial infarction	Acute myocardial infarction
70—74	Acute myocardial infarction	Acute myocardial infarction
74—79	Acute myocardial infarction	Acute myocardial infarction
80—84	Acute myocardial infarction	Acute cerebrovascular disease
over 85	Diseases of pulmonary circulatory and other cardiopathies	Diseases of pulmonary circulatory and other cardiopathies

Source: World Health Organization.

I

(Information)

COUNCIL

COMMON POSITION (EC) No 1/96

adopted by the Council on 20 December 1995

with a view to adopting Decision 96/. . ./EC of the European Parliament and of the Council, of . . ., adopting a programme of Community action on the prevention of drug dependence within the framework for action in the field of public health (1996 to 2000)

(96/C 37/01)

THE EUROPEAN PARLIAMENT AND THE COUNCIL OF THE EUROPEAN UNION,

Having regard to the Treaty establishing the European Community, and in particular Article 129 thereof,

Having regard to the proposal from the Commission [1],

Having regard to the opinion of the Economic and Social Committee [2],

Having regard to the opinion of the Committee of the Regions [3],

Acting in accordance with the procedure laid down in Article 189b of the Treaty [4],

Whereas drug dependence has grown alarmingly in the Member States and has serious implications for the health of individuals and the welfare of the general public;

Whereas, in creating in 1985 a Committee of Inquiry into the problem of drugs in the Member States of the European Community, the European Parliament demonstrated its desire to study in depth the factors which trigger drug demand and enable drugs to continue being produced and distributed;

Whereas in its resolutions [5] concerning this problem the European Parliament formulated a series of proposals with a view, in particular, to Community action on the prevention of drug dependence;

Whereas the European Council, at its meeting in Dublin on 25 and 26 June 1990, stressed that it was the responsibility of each Member State to develop an appropriate drug demand reduction programme and considered that effective action by each Member State, supported by joint action of the Twelve and the Community, should be a main priority over the coming years;

Whereas the actions undertaken at Community level on the basis of Council resolutions, declarations and conclusions relating to the prevention of drug dependence, and in particular subsequent to the adoption by the European Council, meeting in Rome on 13 and 14 December 1990, of the European Plan to Combat Drugs, have helped to sustain the Member States' efforts;

Whereas the Council, in its resolution of 2 June 1994 [6], in response to the Commission communication of 24 November 1993 on a framework for action in the field of public health, included drug dependence among the priority areas for Community action for which the Commission was invited to bring forward proposals for action;

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(1) OJ No C 257, 14. 9. 1994, p. 4.
(2) OJ No C 110, 2. 5. 1995, p. 8.
(3) OJ No C 210, 14. 8. 1995, p. 88.
(4) Opinion of the European Parliament of 20 September 1995 (not yet published in the Official Journal), Council common position of . . . (not yet published in the Official Journal) and Decision of the European Parliament of . . . (not yet published in the Official Journal).

(5) OJ No C 172, 2. 7. 1984, p. 130.
OJ No C 283, 10. 11. 1986, p. 79.
OJ No C 47, 27. 2. 1989, p. 51.
OJ No C 150, 15. 6. 1992, p. 42.
(6) OJ No C 165, 17. 6. 1994, p. 1.

Whereas Regulation (EEC) No 302/93 [1] established a European Monitoring Centre for Drugs and Drug Addiction to provide the Community and the Member States with reliable and comparable information concerning drugs and drug addiction;

Whereas the declaration on the occasion of the entry into force of the Treaty on European Union adopted by the European Council, meeting in Brussels on 29 October 1993, emphasized that the Treaty provides 'a structured institutional framework, so that in particular greater control can be achieved over those of society's problems that run across frontiers, such as drugs (. . .)';

Whereas the problems associated with the drugs phenomenon are such that they require a fully coordinated and global strategy, as stated by the European Council, meeting in Brussels on 10 and 11 December 1993;

Whereas drug dependence is the only scourge expressly mentioned in the provisions of the Treaty dealing with public health and is therefore a priority for Community action within the framework for action in the field of public health set out by the Commission;

Whereas this programme is one of the essential components of the Commission communication to the European Parliament and the Council of 23 June 1994 on a European Union action plan to combat drugs (1995 to 1999), on which the Council commented in its conclusions of 2 June 1995;

Whereas, by reason of its scale and effects, Community action to encourage support for the prevention of drug dependence will make a better contribution to achieving the desired objectives, which come within the framework of Article 129 of the Treaty, in particular the second subparagraph of paragraph 1 thereof;

Whereas cooperation with the competent international organizations and with non-member countries should be strengthened;

Whereas a multiannual programme should be launched with clear objectives for Community action, and priority actions selected with a view to preventing drug dependence and the associated problems, as well as appropriate evaluation mechanisms;

Whereas the programme should have as its objective to help combat drug dependence by preventing dependence linked to the use of narcotics and psychotropic substances and associated use of other products for the purposes of drug addiction;

Whereas there is a need to improve knowledge of the phenomenon of drugs and drug dependence and their consequences, and of the ways and means of preventing drug addiction and the associated risks;

Whereas there is a need both for general preventive action and for preventive measures focusing on specific target groups, particularly the young and marginal groups, while avoiding stereotypes of drug users;

Whereas it is important that the Commission ensures that this programme is implemented in close cooperation with the Member States; whereas, to that end, provision must be made for a procedure to ensure that Member States are fully involved in implementing the programme;

Whereas agreement on a *modus vivendi* [2] between the European Parliament, the Council and the Commission concerning measures implementing acts adopted in accordance with the procedure laid down in Article 189b of the Treaty was reached on 20 December 1994;

Whereas, from the operational point of view, the investment made in previous years should be safeguarded and developed;

Whereas, however, possible duplication of effort should be avoided by the promotion of exchanges of experience and by the joint development of basic information modules for the general public, for health education and for training members of the health professions, which may be targeted on specific groups;

Whereas the objectives of this programme and of the measures carried out for its implementation form part of the health protection requirements referred to in Article 129 (1), third paragraph, of the Treaty and are thus a component of other Community policies;

Whereas, in order to increase the value and impact of the programme, a continuous assessment of the measures undertaken should be carried out, with particular regard to their effectiveness and the achievement of objectives both at national level and at Community level, and, where appropriate, the necessary adjustments made;

Whereas this Decision lays down, for the entire duration of the programme, a financial framework constituting the principal point of reference, within the meaning of point 1 of the Declaration by the European Parliament, the Council and Commission of 6 March 1995, for the budgetary authority during the annual budgetary procedure;

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[1] OJ No L 36, 12. 2. 1993, p. 1.

[2] OJ No C 293, 8. 11. 1995, p. 1.

Whereas this programme should be of five-year duration in order to give sufficient implementation time to allow actions to achieve the objectives set,

HAVE DECIDED AS FOLLOWS:

Article 1

Establishment of the programme

1. A programme of Community action on the prevention of drug dependence, hereinafter referred to as 'this programme', shall be adopted for the period 1 January 1996 to 31 December 2000 within the framework for action in the field of public health.

2. The objective of this programme shall be to help in combating drug dependence, in particular by encouraging cooperation between Member States, supporting their action and promoting cooperation between their policies and programmes with a view to preventing dependence linked to the use of narcotics and psychotropic substances and associated use of other products for the purposes of drug addiction.

3. The actions to be implemented under this programme and their specific objectives are set out in the Annex under the following headings:

A. Data, research, evaluation

B. Information, health education and training.

Article 2

Implementation

1. The Commission shall ensure the implementation, in close cooperation with the Member States, of the actions set out in the Annex, in accordance with Article 5.

2. The Commission shall cooperate with the institutions and organizations which are active in the field of drug demand reduction.

3. The Member States are called upon to take the measures they judge necessary to coordinate and organize the implementation of this programme at national level.

Article 3

Budget

1. The total appropriation for the implementation of this programme for the period referred to in Article 1 shall be ECU 27 million.

2. The annual appropriations shall be authorized by the budgetary authority within the limits of the financial perspective.

Article 4

Consistency and complementarity

1. The Commission and the Member States shall ensure that there is consistency and complementarity between actions to be implemented under this programme and other relevant Community programmes and initiatives, including the 'Socrates', 'Leonardo da Vinci' and 'Youth for Europe (III)' programmes and the biomedical and health research programme under the Community's framework programme for research.

2. The Commission shall also ensure that in the activities undertaken account is also taken of the work of the European Monitoring Centre for Drugs and Drug Addiction (EDMC). It shall also ensure, together with the Member States, that the Community's priorities and needs are taken into due account in the EDMC's programmes.

3. The Commission and the Member States shall ensure consistency with the European Union's action plan to combat drugs.

Article 5

Committee

1. The Commission shall be assisted by a committee consisting of two members designated by each Member State and chaired by the representative of the Commission.

2. The representative of the Commission shall submit to the committee draft measures concerning:

(a) the committee's rules of procedure;

(b) an annual work programme indicating the priorities for action;

(c) the arrangements, criteria and procedures for selecting and financing projects under this programme, including those involving cooperation with international organizations competent in the field of public health and participation of the countries mentioned in Article 6 (2);

(d) the evaluation procedure;

(e) the arrangements for dissemination and transfer of results;

(f) the arrangements for cooperating with the institutions and organizations referred to in Article 2 (2).

The committee shall deliver its opinion on the draft measures referred to above within a time limit which the chairman may lay down according to the urgency of the matter. The opinion shall be delivered by the majority laid down in Article 148 (2) of the Treaty in the case of decisions which the Council is required to adopt on a proposal from the Commission. The votes of the representatives of the Member States within the committee shall be weighted in the manner set out in that Article. The chairman shall not vote.

The Commission shall adopt measures which shall apply immediately. However, if these measures are not in accordance with the opinion of the committee, they shall be communicated by the Commission to the Council forthwith. In that event, the Commission shall defer application of the measures which it has decided upon for a period of two months from the date of such communication.

The Council, acting by a qualified majority, may take a different decision within the time limit referred to in the previous subparagraph.

3. In addition, the Commission may consult the committee on any other matter concerning the implementation of this programme.

The representative of the Commission shall submit to the committee a draft of the measures to be taken. The committee shall deliver its opinion on the draft within a time limit which the chairman may lay down according to the urgency of the matter, if necessary by taking a vote.

The opinion shall be recorded in the minutes; in addition, each Member State shall have the right to ask to have its opinion recorded in the minutes.

The Commission shall take the utmost account of the opinion delivered by the committee. It shall inform the committee of the manner in which its opinion has been taken into account.

4. The Commission representative shall keep the committee systematically informed about:

— financial assistance granted under this programme (amounts, duration, breakdown and beneficiaries),

— Commission proposals or Community initiatives and the implementation of programmes in other areas which are directly relevant to the achievement of the objectives of this programme, with a view to ensuring the consistency and complementarity referred to in Article 4.

Article 6

International cooperation

1. In the course of implementing this programme, cooperation with non-member countries and with international organizations active in the field of public health shall be encouraged and implemented in accordance with the procedure laid down in Article 5.

In particular, the Commission shall cooperate with the Council of Europe's Pompidou Group, with international intergovernmental organizations such as the World Health Organization (WHO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the International Labour Organization (ILO) and with the United Nations International Drug Control Programme (UNDCP).

2. This programme shall be open to the participation of the associated countries of Central and Eastern Europe (ACCEE) in accordance with the conditions agreed to in the additional Protocols to the Association Agreements, to be concluded with those countries, concerning participation in Community programmes. This programme shall be open to the participation of Cyprus and Malta on the basis of additional appropriations in accordance with the same rules as apply to the EFTA countries following procedures to be agreed with the countries in question.

Article 7

Monitoring and evaluation

1. The Commission, taking into account the reports drawn up by the Member States and with the participation, where necessary, of independent experts, shall ensure that an evaluation is made of the actions undertaken.

2. The Commission shall submit to the European Parliament and the Council an interim report halfway through this programme and a final report on its completion. The Commission shall incorporate the results of the evaluations into these reports. It shall also send them to the Economic and Social Committee and the Committee of the Regions.

Done at . . .

For the European Parliament
The President

For the Council
The President

ANNEX

PROGRAMME OF COMMUNITY ACTION ON THE PREVENTION OF DRUG DEPENDENCE

A. DATA, RESEARCH, EVALUATION

Objective

To improve knowledge of the phenomenon of drugs and drug dependence and its consequences and of means and methods of prevention of drug dependence and the risks relating thereto, in particular by using the information supplied by the EDMC and the possibilities offered by existing Community programmes and instruments.

Actions

1. Help identify the data to be collected, analysed and disseminated for the purposes of this programme, including data on polysubstance dependence.

2. Exploit the most useful data for implementing this programme, on the basis in particular of a regular communication of the work of the EDMC.

3. Help develop a strategy for research on the prevention of drug dependence, in particular for improving knowledge as regards the impact in the public health sphere of policies targeting drug users and on the effects of drugs and the use of appropriate techniques for preventive purposes.

4. Support studies and pilot projects on the socioeconomic, sociocultural and psychosociological factors associated with drug dependence, including those in target groups.

5. Support studies and actions and promote the exchange of experience on ways and means of preventing the risks associated with drug dependence, in particular with a view to:

   — preventing, in drug-dependent pregnant women, the effects of drugs on the foetus and the risks of transmitting infections to the child,

   — reducing the risks associated with the injection of drugs,

   — making an assessment of accompanying health measures, in particular substitution programmes,

   — evaluating methods and programmes for prevention and risk reduction in the management of drug-dependent prisoners.

6. Encourage the exchange of information and experience on preventing drug addiction relapses, including the rehabilitation of drug users.

B. INFORMATION, HEALTH EDUCATION AND TRAINING

Objective

Contribute to improving information, education and training aimed at preventing drug dependence and the associated risks, in particular for young people and particularly vulnerable groups.

(a) *Information and health education*

Actions:

7. Support schemes to evaluate the effectiveness of information and health education campaigns and carry out regular public opinion surveys via Eurobarometer to monitor changes in Europeans' attitudes towards drugs.

8. Organize further European Drug Preventive Weeks on the basis of previous experience.

9. Help identify, test and develop the best information and educational tools and methods for target groups, and in particular:

   — encourage the use of information tailored to particular environments or circles, taking account of changes in patterns of use, and products used, and of the phenomenon of polysubstance dependence;

— support schemes to adapt messages to the needs and specific features of particularly vulnerable groups;

— support the development of telephone helpline services and consider the feasibility of introducing a single telephone number for such services in all Member States.

10. Help to define drug prevention guidelines and support the selection and use of teaching methods and materials, in particular within the context of the European network of health-promoting schools, in order to develop attitudes in young people which will enable them to avoid drugs and drug addiction; support integrated projects, programmes and other drug prevention initiatives in places frequented by children and young people, with the participation wherever possible of parents and those concerned.

11. Encourage exchanges of experience on initiatives aimed at improving cooperation between all those involved in the provision of education.

12. Support schemes for advising teachers, families and those responsible for young people on the early detection of the use of drugs and the action to take.

13. In cooperation with the EDMC and the Council of Europe, if need be, encourage the extension of the European network of 'test towns', so as to promote technical cooperation on the ways and means used by these towns to reduce drug demand.

14. Support for exchanges of experience, particularly on a regional cross-border basis, concerning local prevention initiatives. Exchanges of experience on prevention models and practices involving towns in different Member States which are particularly affected by the problem of drugs.

(b) **Training**

15. Promote initiatives to improve the drug prevention aspect of vocational training programmes for teachers and those responsible for young people and encourage exchanges of students training for the social and health professions, including exchanges under other Community programmes.

16. Support the development of further training programmes, teaching materials and modules for those likely to come into contact with drug users and groups at risk, including in particular social work, health, police and other law-enforcement professionals.

STATEMENT OF THE COUNCIL'S REASONS

I. INTRODUCTION

1. On 22 August 1994 the Commission submitted a proposal, based on Article 129 of the Treaty, for a Decision adopting a programme of Community action on the prevention of drug dependence within the framework for action in the field of public health.

2. The European Parliament, the Economic and Social Committee and the Committee of the Regions delivered their opinions, respectively, on 20 September 1995 [1], 22 February 1995 [2] and 16 November 1994 [3].

3. In the light of those opinions, the Commission submitted an amended proposal [4].

4. On 20 December 1995, the Council adopted its common position in accordance with Article 189b of the Treaty.

II. OBJECTIVE OF THE PROPOSAL

The programme proposed, which is regarded by both the Commission and the Council as one of the priorities for action in the field of public health for the next five years, is at the same time one of the essential components of the European Union action plan to combat drugs, for which the guidelines were approved by the Cannes European Council.

The general provisions of the programme are similar to those proposed in respect of other programmes presented in the same context (combating cancer, preventing AIDS and other communicable diseases, improving health).

The activities originally presented in the framework of this programme (Annex), worded in fairly general terms, were grouped under three main headings:

— improving public awareness in particular by means of coordinated transnational actions,

— using opportunities provided in other Community policies, programmes and instruments, when appropriate to prevent and combat drug dependence,

— initiatives and actions relating to young people of school age in relevant environments — home, leisure and school — and the promotion of best practices in this regard.

In its amended proposal, the Commission sets them out in more detail and extends them to:

— groups at risk,

— improving knowledge,

— improving training and cooperation for the purposes of prevention.

III. ANALYSIS OF THE COMMON POSITION

1. General comments

As regards the general features of the programme (Articles), the Council has introduced, in accordance with an approach similar to that followed in other cases in this field, amendments which it felt were necessary to clarify and strengthen the

[1] Not yet published in the Official Journal.
[2] OJ No C 110, 2. 5. 1995, p. 8.
[3] OJ No C 210, 14. 8. 1995, p. 88.
[4] COM(95) 579 final, COD 94/0135.

structures and conditions for implementing the programme, and in particular for cooperation between the Commission and the Member States.

As regards the content of the programme (Annex), the Council has adopted a range of actions which is significantly more developed and specific than that originally proposed by the Commission, in agreement with the elements contained in the communication accompanying the Commission proposal, and which are in line with its amended proposal.

2. **Specific comments**

2.1. Amendments made by the Council to the Commission's amended proposal

The main amendments to the proposal are, as regards the programme's general features, similar to those adopted in the Council's common position for the other programmes proposed in the health field [1] and reflect the considerations set out below. They concern the following aspects.

(a) *Establishment of the programme (Article 1)*

The aim of the amendments made is to clarify the programme's general objective (paragraph 2) and its structure (paragraph 3).

(b) *Implementation (Article 2) and Committee procedure (Article 5 — former Article 4)*

The adjustments made to the provisions and procedures for implementing the programme are aimed mainly at:

— identifying more accurately the respective roles and contributions of the various players participating in the implementation of the programme (Article 2),

— reconciling the requirement for flexibility in the management of the programme with the need to involve the Member States more actively in certain important decisions, by a mixed procedure, namely: the management committee procedure for the latter and, for the others, the advisory committee procedure (Article 5 (2) and (3) — in accordance with the interinstitutional *modus vivendi* referred to in recital 17).

In addition, the systematic provision of information about financial assistance granted and activities in other areas which are directly relevant to the achievement of the objectives of the plan, which is provided for in paragraph 4, meets the need for transparency and effectiveness (in relation particularly with the provision in Article 4).

(c) *Total appropriation (Article 3 (1))*

The amount adopted — ECU 27 million — which is only very slightly lower than the amount provided for by the Commission, constitutes a balance between the requirement for implementing and monitoring the programme's actions and the need to take account of budgetary discipline.

NB: *The relevant provisions (Article 3 and recital 22) comply with the text of the Declaration by the three institutions of 6 March 1995.*

(d) *Consistency and complementarity* (Article 4 — new)

This Article brings together the requirements imposed on the Commission and, where appropriate, the Member States, in the implementation of the programme in connection with:

— the other related programmes and initiatives,

— the European Monitoring Centre for Drugs and Drug Addiction,

— the European Union's action plan to combat drugs.

[1] The amendments were, moreover, agreed to in most cases by the European Parliament at second reading.

(e) *International cooperation (Article 6)*

The Council restricted itself to adjustments (see Article 5 of the proposal) intended to ensure consistency between these provisions and the provision of Article 5 (2) (f) (1) and existing agreements or agreements to be negotiated with the countries concerned (2).

(f) *Monitoring and evaluation* (Article 7)

The aim of the amendments made to the text (Article 6) is to clarify the conditions for monitoring in general and evaluation in particular.

(g) *Annex*

While keeping as close as possible to the field of action specified by the Commission in its amended proposal, the Council has adopted a more closely knit structure, more similar to the one adopted for the other programmes mentioned above, concentrating on two major areas of action — and listing their specific objectives — as indicated in Article 1 (3), and, where appropriate, in subheadings, under which the actions are grouped together.

2.2. European Parliament amendments

(a) *Amendments agreed to by the Commission*

The Commission agreed in full or in part to 20 of the 56 [1] amendments.

In accordance with the structure adopted or with an approach which is less detailed in places, the Council has embodied, in some cases in part, most of the amendments which the Commission agreed to in full or to some extent.

It follows that while the field of action of the programme resulting from the Council's common position is very close to that adopted most recently by the Commission, the presentation and wording differ from those of the European Parliament and the Commission in various respects, in particular:

— as regards amendments 11 to 40 (recitals and Article 2), where the main elements contained in the Commission proposal are included in the Annex to the Decision (specific objectives and actions), in particular:

  — amendment 28: see objective B

  — amendments 32, 33: see action 5

  — amendments 35, 36: see actions 3, 4

  — amendment 38: see action 14

  while the programme's general objective and the description of the programme's general areas are set out in Article 1 (paragraphs 2 and 3).

  The multidimensional nature of the drug problem (see amendment 21 in particular) is affirmed in particular emphasis in recital 9 of the common position.

  Some other elements are covered, in substance, as more general implementation aspects:

  — amendment 30 (cooperation with the plan) by Article 4 (3);

  — amendment 40: both by Article 4 (2) (EDMC) and by Article 2 (2) (NGOs).

  In doing this the Council has followed a layout which is closer to that adopted in the framework of other programmes in this area, while avoiding any duplication which might detract from the clarity and applicability of the text;

[1] Amendments 15, 22, 31 and 32, in full, and 11, 21, 23, 26, 28, 30, 33, 35, 36, 38, 40, 41, 49, 51, 52 and 61, in part.

— as regards the amendments to the Annex to the Decision proper, some aspects — which deal with ways of operating or implementing methods — are also covered in a general way by the provisions of Articles 2, 4 and 6.

The more specific elements of the content are included, as regards their substance, in less detailed form, or in part, as follows:

amendment 49: actions 7 to 9

amendment 61: actions 13 to 16 and 3 and 4

amendment 51: actions 4 to 6 and 9 to 11

amendment 52: actions 4 to 5

amendment 53: action 10.

(b) *Amendments not agreed to by the Commission*

In general the Council went along with the considerations which resulted in the Commission not agreeing to some of the European Parliament's amendments, either because they went beyond the framework of the programme (3, 4, 7, 17, 37, 39, 55 in part, 60) or the field of Community powers under which they come (1, 5, 8, 10, 13, 14, 24, 56 in part, 57), or introduced wording or elements which were too specific and could be included in another way, elsewhere or implicitly in the framework adopted.

However, among the amendments which the Commission said in its amended proposal that it could not agree to, the following are covered by the text of the Council's common position either in part or in another form:

— amendment 42 (the committee procedure) which, in general, is contained in Article 5 (2) and (3),

— amendment 48, by Article 5 (2) (b),

— amendments 55 and 56, partially covered by actions 3 and 5.

IV. CONCLUSIONS

Although the Council has not agreed to all the amendments submitted by the European Parliament in detailed and specific form, it has adopted a text which, as regards the content of the programme, covers a field of action very close to that adopted by the Commission on the basis of the European Parliament's opinion. As in the case of other similar programmes, it has also endeavoured to clarify presentation and to strengthen its conditions in order to ensure maximum transparency and effectiveness in implementing and monitoring the programme.

I

(Acts whose publication is obligatory)

DECISION No 645/96/EC OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL

of 29 March 1996

adopting a programme of Community action on health promotion, information, education and training within the framework for action in the field of public health (1996 to 2000)

THE EUROPEAN PARLIAMENT AND THE COUNCIL OF THE EUROPEAN UNION,

Having regard to the Treaty establishing the European Community, and in particular Article 129 thereof,

Having regard to the proposal from the Commission [1],

Having regard to the opinion of the Economic and Social Committee [2],

Having regard to the opinion of the Committee of the Regions [3],

Acting in accordance with the procedure laid down in Article 189b of the Treaty [4] in the light of the joint text approved on 31 January 1996 by the Conciliation Committee,

(1) Whereas, pursuant to Article 3 (o) of the Treaty, Community action must include a contribution towards the attainment of a high level of health protection; whereas Article 129 of the Treaty expressly provides for Community competence in this field insofar as the Community contributes to it by encouraging cooperation between Member States and, if necessary, by lending support to their action;

(2) Whereas the actions to be carried out must be undertaken within the framework for action in the field of public health set out by the Commission and take into account, as the Council requested in its Resolution of 27 May 1993 [5], other actions undertaken by the Community in the field of public health or having an impact on public health;

(3) Whereas the Council, in its Resolution of 2 June 1994 [6] in response to the Commission communication of 24 November 1993 on the framework for action in the field of public health, included health promotion, education and training among the priority areas for action for which the Commission was invited to bring forward proposals for action;

(4) Whereas, in their Resolution of 23 November 1988 concerning health education in schools [7], the Council and the Ministers for Education meeting within the Council emphasized that certain eating habits, the uncontrolled use of some chemical substances and medicines, drug abuse, smoking and environmental pollution have a harmful effect on health, also bearing in mind the problems of safety and accident prevention;

(5) Whereas, in their Resolution of 3 December 1990 concerning an action programme on nutrition and health [8], the Council and the Representatives of the Governments of the Member States meeting within the Council underlined that the promotion of a healthy lifestyle as regards nutrition is vitally important to enable people to make the necessary choices for ensuring appropriate nutrition in keeping with individual needs;

(1) OJ No C 252, 9. 9. 1994, p. 3, and OJ No C 135, 2. 6. 1995, p. 2.
(2) OJ No C 102, 24. 4. 1995, p. 15.
(3) OJ No C 210, 14. 8. 1995, p. 81.
(4) Opinion of the European Parliament of 15 March 1995, (OJ No C 89, 10. 4. 1995, p. 72), Council Common Position of 2 June 1995 (OJ No C 216, 21. 8. 1995, p. 21) and Decision of the European Parliament of 25 October 1995 (OJ No C 308, 20. 11. 1995). Decision of the European Parliament of 15 February 1996 (OJ No C 65, 4. 3. 1996) and Council Decision of 16 February 1996.
(5) OJ No C 174, 25. 6. 1993, p. 1.
(6) OJ No C 165, 17. 6. 1994, p. 1.
(7) OJ No C 3, 5. 1. 1989, p. 1.
(8) OJ No C 329, 31. 12. 1990, p. 1.

(6) Whereas, in their Conclusions of 13 November 1992 [1], in response to the Commission communication to the Council of 11 May 1992 on health education in schools, the Council and the Ministers for Health of the Member States meeting within the Council identified school as a vital setting for systematically developing a healthy lifestyle at an early age that would enable sickness and accidents to be reduced; whereas they considered that there were a variety of other settings such as local communities, homes, workplaces and hospitals, in which health education had a central role; whereas they invited the Commission to strengthen cooperation between Member States in implementing effective health education measures in the various settings;

(7) Whereas in its resolution of 19 November 1993 on public health policy after Maastricht [2] the European Parliament formulated a series of proposals for Community action in the field of accident prevention and prevention of cardiovascular diseases which are not currently the subject of Community programmes;

(8) Whereas, in its Resolution of 2 June 1994 concerning cardiovascular diseases [3], the Council invited the Commission to examine actions to encourage their prevention and further study of the risk factors for such diseases;

(9) Whereas the results of the integrated approach adopted in the joint World Health Organization — Council of Europe — European Community Project entitled 'The European Network of Health-Promoting Schools' are encouraging with respect to ways of implementing health promotion in particular settings;

(10) Whereas it is recognized that socio-economic conditions such as urbanization, housing, unemployment and social exclusion have to be taken into consideration in the promotion of health, particularly for those living in deprived areas;

(11) Whereas health education and information are expressly mentioned in the provisions of the Treaty dealing with public health, and constitute a priority for Community action in public health;

(12) Whereas, by reason of its scale and effects, Community action in support of health promotion enables the objectives envisaged to be more effectively achieved;

(13) Whereas cooperation with the competent international organizations and with non-member countries should be strengthened;

(14) Whereas a multiannual programme should be launched with clear objectives for Community action, and priority measures should be selected, as well as appropriate mechanisms for the evaluation of such action, with a view to promoting the health of all the citizens of the Community;

(15) Whereas this programme must contribute to raising awareness of health determinants and risk factors and encourage the development of an integrated approach to health promotion;

(16) Whereas, from an operational point of view, the activities undertaken in the past in terms of both the establishment of Community networks of non-governmental organizations and of the mobilization of all those involved in health promotion and education should be safeguarded and developed;

(17) Whereas the programme must take account of past and current measures implemented in the Member States either by the competent authorities or by other parties involved in health policy;

(18) Whereas, however, possible duplication of effort should be avoided by the promotion of the exchange of experience and by the joint development of basic information modules for the general public, for health education and for training members of the health-care professions;

(19) Whereas the objectives of this programme and the actions undertaken to implement it form part of the health protection requirements referred to in the third subparagraph of Article 129 (1) of the Treaty and as such form a constituent part of the Community's other policies;

(20) Whereas it is important that the Commission ensures implementation of this programme in close cooperation with the Member States; whereas, to that end, provision should be made for a procedure to ensure that Member States are fully involved in implementing the plan;

(21) Whereas a *modus vivendi* between the European Parliament, the Council and the Commission concerning the implementing measures for acts

[1] OJ No C 326, 11. 12. 1992, p. 2.
[2] OJ No C 329, 6. 12. 1993, p. 375.
[3] OJ No C 165, 17. 6. 1994, p. 3.

adopted in accordance with the procedure laid down in Article 189b of the Treaty was concluded on 20 December 1994;

(22) Whereas this Decision lays down, for the entire duration of this programme, a financial framework constituting the principal point of reference, within the meaning of point 1 of the Declaration by the European Parliament, the Council and Commission of 6 March 1995, for the budgetary authority during the annual budgetary procedure;

(23) Whereas this programme should run for five years in order to allow sufficient time for actions to be implemented to achieve the objectives set;

(24) Whereas, in order to increase the value and impact of the action programme, a continuous assessment of the measures undertaken should be carried out, with particular regard to their effectiveness and the achievement of objectives at both national and Community level and, where appropriate, the necessary adjustments should be made;

(25) Whereas responsibility for measures concerning sex education in general, especially measures designed to further integrate such education within schools, lies with the Member States, with due regard to their structures, especially schools,

HAVE DECIDED AS FOLLOWS:

Article 1

Establishment of the programme

1. A programme of Community action on health promotion, information, education and training, hereinafter referred to as 'the programme', shall be adopted for the period 1 January 1996 to 31 December 2000 within the framework for action in the field of public health.

2. The objective of the programme shall be to contribute towards ensuring a high level of health protection and shall comprise actions aimed at:

— encouraging the 'health promotion' approach in Member States' health policies by lending support to various cooperation measures (exchanges of experience, pilot projects, networks, etc.),

— encouraging the adoption of healthy lifestyles and behaviour,

— promoting awareness of risk factors and health-enhancing aspects,

— encouraging intersectoral and multidisciplinary approaches to health promotion, taking account of the socio-economic factors and the physical environment necessary for the health of the individual and the community, especially for disadvantaged groups.

3. The actions to be implemented under the programme and their specific objectives are set out in the Annex under the following headings:

A. Health promotion strategies and structures

B. Specific prevention and health promotion measures

C. Health information

D. Health education

E. Vocational training in public health and health promotion.

Article 2

Implementation

1. The Commission shall ensure the implementation, in close cooperation with the Member States, of the actions set out in the Annex, in accordance with Article 5.

2. The Commission shall cooperate with the institutions and organizations which are active in the field of health promotion, information, education and training.

Article 3

Budget

1. The financial framework for implementation of the programme for the period referred to in Article 1 shall be ECU 35 million.

2. The annual appropriations shall be authorized by the budgetary authority within the limits of the financial perspective.

Article 4

Consistency and complementarity

The Commission shall ensure that there is consistency and complementarity between actions to be implemented under the programme and the other relevant Community programmes and initiatives, as part of public health action or the fields of education and vocational training

(Socrates and Leonardo da Vinci programmes), research (Biomed II) and health and safety at work.

Article 5

Committee

1. The Commission shall be assisted by a Committee consisting of two members designated by each Member State and chaired by a representative of the Commission.

2. The representative of the Commission shall submit to the Committee a draft of the measures to be taken concerning:

(a) the Committee's rules of procedure;

(b) an annual work programme indicating the priorities for action;

(c) the arrangements, criteria and procedures for selecting and financing projects under the programme, including those involving cooperation with international organizations competent in the field of public health and participation of the countries referred to in Article 6 (2);

(d) the evaluation procedure;

(e) the arrangements for dissemination and transfer of results;

(f) the arrangements for cooperating with the institutions and organizations referred to in Article 2 (2).

The Committee shall deliver its opinion on the draft measures referred to above within a time limit which the Chairman may lay down according to the urgency of the matter. The opinion shall be delivered by the majority laid down in Article 148 (2) of the Treaty in the case of decisions which the Council is required to adopt on a proposal from the Commission. The votes of the representatives of the Member States within the Committee shall be weighted in the manner set out in that Article. The Chairman shall not vote.

The Commission shall adopt measures which shall apply immediately. However, if these measures are not in accordance with the opinion of the Committee, they shall forthwith be communicated by the Commission to the Council. In that event:

— the Commission shall defer application of the measures which it has decided upon for a period of two months from the date of such communication;

— the Council, acting by a qualified majority, may take a different decision within the time limit laid down in the first indent.

3. In addition, the Commission may consult the Committee on any other matter concerning the implementation of the programme.

The representative of the Commission shall submit to the Committee a draft of the measures to be taken. The Committee shall deliver its opinion on the draft within a time limit which the Chairman may lay down according to the urgency of the matter, if necessary by taking a vote.

The opinion shall be recorded in the minutes; in addition, each Member State shall have the right to ask to have its opinion recorded in the minutes.

The Commission shall take the utmost account of the opinion delivered by the Committee. It shall inform the Committee of the manner in which its opinion has been taken into account.

4. The representative of the Commission shall keep the Committee regularly informed of:

— financial assistance granted under the programme (amount, duration, breakdown and beneficiaries),

— Commission proposals or Community initiatives and the implementation of programmes in other areas which are of direct relevance to achievement of the objectives of the programme, with a view to ensuring the consistency and complementarity referred to in Article 4.

Article 6

International cooperation

1. In the course of implementing the programme, cooperation with non-member countries and with international organizations competent in the field of public health, in particular the World Health Organization and the Council of Europe as well as non-governmental organizations active in the areas covered by this programme, will be encouraged and implemented in accordance with the procedure laid down in Article 5.

2. The programme shall be open to participation by the associated countries of Central and Eastern Europe (Accee) in accordance with the conditions laid down in the Additional Protocols to the Association Agreements relating to participation in Community programmes, to be concluded with those countries. The programme shall be open to participation by Cyprus and Malta on the basis of additional appropriations in accordance with the same rules as those applied to the EFTA countries, in accordance with procedures to be agreed with those countries.

Article 7

Monitoring and evaluation

1. The Commission, taking into account the reports drawn up by the Member States and with the participation, where necessary, of independent experts, shall ensure that an evaluation is made of the actions undertaken.

2. The Commission shall submit to the European Parliament and the Council an interim report halfway through the programme and a final report on completion thereof. The Commission shall incorporate into these reports the results of the evaluations. It shall also send the reports to the Economic and Social Committee and the Committee of the Regions.

Done at Brussels, 29 March 1996.

For the European Parliament	*For the Council*
The President	*The President*
K. HÄNSCH	T. TREU

ANNEX

COMMUNITY ACTION PROGRAMME ON HEALTH PROMOTION (1996 to 2000)

A. HEALTH PROMOTION STRATEGIES AND STRUCTURES

Objective

To encourage the evaluation of the impact of health promotion policies and instruments and the development of a health promotion approach in the Member States by promoting the devising and assessment of health promotion strategies and dissemination of the best practices.

Actions

1. Surveys and comparative analyses of the impact of Community and national health promotion policies and instruments and of health promotion structures and strategies and the assessment of the latter; activities to encourage and support cooperation between Member States on various strategic aspects of public health and health promotion.

2. Support for transnational networks of national, regional or local health promotion bodies, adopting an integrated approach (i.e. an approach covering the various determinants, contexts and population groups) and promotion of joint activities and projects.

B. SPECIFIC PREVENTION AND HEALTH PROMOTION MEASURES

Objective

To improve knowledge, particularly in conjunction with measures under the Biomed programme, of the situation and the problem of health promotion in relation to certain risk factors and health determinants and to certain disadvantaged social groups. To promote intersectoral and multidisciplinary approaches to health promotion directed at vulnerable or disadvantaged groups.

Measures

3. Support for integrated health promotion measures and projects relating more specifically to groups which are disadvantaged as a result of their vulnerability or social exclusion, of social and cultural differences or of living in unfavourable areas or environments, together with measures to combat exclusion and precarious situations.

4. Examination of the role of nutrition and other life-style factors in the etiology of diseases and information to the public to improve understanding of basic nutritional principles and of new techniques and methods of presenting and preparing foodstuffs.

5. Promotion of analysis, evaluation and exchange of experience and information and support for actions in respect of innovative measures for the prevention of cardiovascular and cerebrovascular diseases, taking account of the risk factors for such diseases.

6. Support for exchanges of experience and information concerning the rational use of medicines, in particular generic medicines and self-medication, in cooperation with general practitioners and pharmacists. Exchange of experience on providing the public with information on the use of medicines, in particular medicines available without prescription.

7. Promotion of examination, assessment and exchanges of experience and support for actions concerning measures to prevent alcohol abuse and the health and social consequences thereof.

8. Support for measures to promote regular physical activity and to reach sound physical and mental hygiene practices.

9. Support for studies on ageing populations in the European Union and promotion of exchanges of experience and information on the prevention of age-related illnesses in conjunction with the other specific programmes.

C. HEALTH INFORMATION

Objective

To improve knowledge of mechanisms for devising health messages and assessing health information methods and encourage an exchange of information and documentation between professionals and those responsible for public health and health promotion policies.

Measures

10. Support for and coordination of work in the Member States to improve knowledge of the psychological, sociological and cultural mechanisms and the economic factors involved and of information methods to encourage the adoption of healthy lifestyles; support for the assessment of results and for dissemination of the best practices.

11. Surveys of public opinion on various aspects of health promotion (Eurobarometer survey) and support for the preparation and assessment of specific information campaigns including those coordinated at Community level or in several Member States.

12. Support for the development of a European infrastructure, for example in the form of transnational networks, reference centres containing information and documentation on public health and health promotion for use by professionals, administrators and decision-makers in the field of public health, and dissemination to interested parties of information on the Community's activities in this field.

D. HEALTH EDUCATION

Objective

To encourage greater integration of health education in schools, including sex education; to foster the development and dissemination of the best health education experiments and methods tailored to different contexts (e.g. school, work and leisure) and different target groups (e.g. children, adolescents and young adults, and workers).

Measures

13. Exchanges of experience between Member States concerning the development and distribution of appropriate health education programmes, teaching materials and modules. Support for information campaigns, demonstration projects and innovative experiments aimed at promoting healthy lifestyles and responsible behaviour including support for the European Network of Health-Promoting Schools in cooperation with the WHO and the Council of Europe.

14. Support for, coordination and evaluation of health education projects which are aimed at young persons and adolescents who have left the school system and are devised and implemented either by official bodies or by private associations and non-governmental organizations in settings such as sport and leisure activities and socio-cultural activity centres.

15. Support for innovative means of providing continuing structured health education, involving distance teaching and information technologies, for adults and the elderly.

16. Support for health education measures in the workplace, particularly in relation to nutrition and the risks involved in tobacco and alcohol consumption, as well as mental health factors, including prevention of stress-related risks.

E. VOCATIONAL TRAINING IN PUBLIC HEALTH AND HEALTH PROMOTION

Objective

To help to familiarize the various categories of health staff, those who decide on and administer health policy or action and those in the front line of health promotion (e.g. teachers, educators, social workers) with knowledge, ideas and methods relating to public health, prevention, health promotion, information and health education.

Measures

17. Review and assessment of existing structures and training schemes in public health and health promotion and compilation of a European directory. Support for cooperation between schools of public health, universities and bodies providing training in this area with a view to the development of common training courses and exchanges of students and teaching staff in conjunction with existing education and training schemes.

18. Promotion of cooperation beween Member States on the content of training courses and training activities in the fields of public health and health promotion for professionals, administrators and decision-makers, emphasizing interdisciplinary approaches (including social, economic, psychological and environmental aspects).

19. Support for training activities relating to health education in schools aimed at teachers, instructors and other staff concerned including development of modules, teaching aids and educational materials.

20. Encouragement and support for exchanges of experience relating to the training of health professionals in health promotion and the early detection and prevention of diseases, including cardiovascular diseases, and in identifying and controlling risk factors and situations, including those linked to alcohol abuse.

DECISION No 646/96/EC OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL

of 29 March 1996

adopting an action plan to combat cancer within the framework for action in the field of public health (1996 to 2000)

THE EUROPEAN PARLIAMENT AND THE COUNCIL OF THE EUROPEAN UNION,

Having regard to the Treaty establishing the European Community, and in particular Article 129 thereof,

Having regard to the proposal from the Commission [1],

Having regard to the opinion of the Economic and Social Committee [2],

Having regard to the opinion of the Committee of the Regions [3],

Acting in accordance with the procedure laid down in Article 189b of the Treaty [4] in the light of the joint text approved on 31 January 1996 by the Conciliation Committee,

(1) Whereas, at its meetings in Milan in June 1985 and in Luxembourg in December 1985, the European Council underlined the advantages of launching a European programme against cancer;

(2) Whereas the Council and the Representatives of the Governments of the Member States meeting within the Council adopted on 7 July 1986 a Resolution on a programme of action of the European Communities against cancer [5] and on 17 May 1990 Decision 90/238/Euratom, ECSC, EEC adopting a 1990 to 1994 action plan in the context of the 'Europe against Cancer' programme [6];

(3) Whereas in its resolution of 19 November 1993 on public health policy after Maastricht [7] the European Parliament asked that activities against cancer be intensified;

(4) Whereas in its Resolution of 13 December 1993 [8] the Council invited the Commission to submit in due course a draft third action plan, taking into account the Council Resolution of 27 May 1993 on future action in the field of public health as well as the objectives and improvements set out in the Annex to that Resolution [9];

(5) Whereas the Council, in its Resolution of 2 June 1994 [10], in response to the Commission communication of 24 November 1993 on the framework for action in the field of public health, included cancer among the priority areas for action for which the Commission was invited to bring forward proposals for action;

(6) Whereas, by reason of its scale and effects, Community action in support of cancer prevention enables the desired objectives to be attained more effectively;

(7) Whereas policies and programmes formulated and implemented at Community level should be compatible with the targets and objectives of Community action on cancer prevention; whereas, in particular, implementation of actions under the Community's biomedical and health research programme should be closely coordinated with the implementation of Community actions on cancer prevention;

(8) Whereas cooperation with the competent international organizations and with non-member countries should be strengthened;

(9) Whereas cancer is a major disease associated with lifestyles; whereas the risk factors inherent in them need to be reduced, especially tobacco consumption, which will also have an effect on combating other diseases, in particular cardiovascular diseases;

(10) Whereas, by ensuring wider dissemination of knowledge of the causes of cancer and of its prevention, by ensuring improved comparability and dissemination of information on these subjects, and by developing complementary actions especially in health education, this plan will contribute to the achievement of the Community objectives set out in Article 129 of the Treaty;

(11) Whereas measures must be adopted to combat promotion in the media of habits which may lead

[1] OJ No C 139, 21. 5. 1994, p. 12, and OJ No C 143, 9. 6. 1995, p. 16.
[2] OJ No C 393, 31. 12. 1994, p. 8.
[3] OJ No C 210, 14. 8. 1995, p. 55.
[4] Opinion of the European Parliament of 1 March 1995 (OJ No C 68, 20. 3. 1995, p. 17), Council common position of 2 June 1995 (OJ No C 216, 21. 8. 1995, p. 1) and Decision of the European Parliament of 25 October 1995 (OJ No C 308, 20. 11. 1995). Decision of the European Parliament of 15 February 1996 (OJ No C 65, 4. 3. 1996) and Council Decision of 16 February 1996.
[5] OJ No C 184, 23. 7. 1986, p. 19.
[6] OJ No L 137, 30. 5. 1990, p. 31.
[7] OJ No C 329, 6. 12. 1993, p. 375.
[8] OJ No C 15, 18. 1. 1994, p. 1.
[9] OJ No C 174, 25. 6. 1993, p. 1.
[10] OJ No C 165, 17. 6. 1994, p. 1.

to cancer, such as poor dietary habits and smoking;

(12) Whereas it is important that the Commission ensures implementation of this plan in close cooperation with the Member States; whereas, to that end, provision should be made for a procedure to ensure that Member States are fully involved in implementing the plan;

(13) Whereas a *modus vivendi* between the European Parliament, the Council and the Commission concerning the implementing measures for acts adopted in accordance with the procedure laid down in Article 189b of the Treaty was concluded on 20 December 1994;

(14) Whereas moreover, in order to have available to it all the necessary scientific information, the Commission cooperates with a high-level committee of scientific experts appointed by the Member States;

(15) Whereas, from an operational point of view, the investment made under the preceding action plans in terms of both the European pilot networks and the mobilization of all those involved in combating cancer should be safeguarded and developed;

(16) Whereas this plan must take account of past and current measures implemented in the Member States either by the competent authorities or by other parties involved in health policy;

(17) Whereas, however, possible duplication of effort should be avoided by the promotion of exchanges of experience and by the joint development of basic information modules for the general public, for health education and for training members of the health-care professions, which may be targeted on specific groups, including children;

(18) Whereas a Community strategy to contribute to combating cancer includes all aspects of primary, secondary and tertiary prevention, including exchange of experience on quality control in early detection of the disease and prevention of its development, and taking into account psycho-social aspects, with particular emphasis on the quality of life;

(19) Whereas, in order to increase the value and impact of this plan, a continuous assessment of the measures undertaken should be carried out, with particular regard to their effectiveness and the achievement of objectives at both national and Community level and, where appropriate, the necessary adjustments should be made;

(20) Whereas the objectives of this plan and the actions undertaken to implement it form part of the health protection requirements referred to in the third subparagraph of Article 129 (1) of the Treaty and as such form a constituent part of the Community's other policies, such as those on the environment, the protection of workers, consumer protection, nutrition, agriculture and the internal market;

(21) Whereas this Decision lays down, for the entire duration of the action plan, a financial framework constituting the principal point of reference, within the meaning of point 1 of the Declaration by the European Parliament, the Council and Commission of 6 March 1995, for the budgetary authority during the annual budgetary procedure;

(22) Whereas this plan should run for five years in order to allow sufficient time for actions to be implemented to achieve the objectives set,

HAVE DECIDED AS FOLLOWS:

Article 1

Establishment of the plan

1. A Community plan of action against cancer entitled 'Europe against Cancer', hereinafter referred to as 'this plan', shall be adopted for the period 1 January 1996 to 31 December 2000 within the framework for action in the field of public health.

2. The objective of this plan shall be to contribute towards ensuring a high level of health protection and shall comprise actions aimed at:

— preventing premature deaths due to cancer,

— reducing mortality and morbidity due to cancer,

— promoting the quality of life by improving the general health situation,

— promoting the general well-being of the population, particularly by minimizing the economic and social consequences of cancer.

3. The actions to be implemented under this plan and their specific objectives are set out in the Annex under the following headings:

A. Data collection and research

B. Information and health education

C. Early detection and screening

D. Training and quality control and guarantees.

4. The actions to be undertaken shall include in particular:

— the establishment of common objectives,

— the standardization and collection of comparable and compatible data on health, including the development and strengthening of the European network of cancer registers,

— programmes for exchange of experience and of health professionals and for the dissemination of the most effective practices,

— the creation of information networks,

— European-scale studies and dissemination of the results, including support for epidemiological studies focused on prevention,

— implementation of pilot programmes and pilot projects,

— compilation of reports, especially to monitor the measures taken,

— early detection and screening,

— exchanges of experience on quality control of the early detection of the disease and the prevention of its development, including palliative methods, and contributions for selecting priorities in cancer research and transfer of results of basic research into clinical trials.

Article 2

Implementation

1. The Commission shall ensure the implementation, in close cooperation with the Member States, of the actions set out in the Annex, in accordance with the procedure laid down in Article 5.

2. The Commission shall cooperate with the institutions and organizations which are active in combating cancer.

Article 3

Budget

1. The financial framework for implementation of this plan for the period referred to in Article 1 shall be set at ECU 64 million.

2. The annual appropriations shall be authorized by the budgetary authority within the limits of the financial perspective.

Article 4

Consistency and complementarity

The Commission shall ensure that there is consistency and complementarity between actions to be implemented under this plan and the other relevant Community programmes and initiatives, including the biomedical and health research programme under the Community's framework programme for research and the programmes introducing an integrated information network (information technology in areas of general interest).

Article 5

Committee

1. The Commission shall be assisted by a Committee consisting of two members designated by each Member State and chaired by a representative of the Commission.

2. The representative of the Commission shall submit to the Committee a draft of the measures to be taken concerning:

(a) the Committee's rules of procedure;

(b) an annual work programme indicating the priorities for action;

(c) the simplification and improvement of this plan's basic administrative procedures, which shall be duly published;

(d) the arrangements, criteria and procedures for selecting and financing projects under this plan, including those involving cooperation with international organizations competent in the field of public health and participation of the countries referred to in Article 6 (2);

(e) the evaluation procedure;

(f) the arrangements for dissemination and transfer of results;

(g) the arrangements for cooperating with the institutions and organizations referred to in Article 2 (2).

The Committee shall deliver its opinion on the draft measures referred to above within a time limit which the Chairman may lay down according to the urgency of the matter. The opinion shall be delivered by the majority laid down in Article 148 (2) of the Treaty in the case of decisions which the Council is required to adopt on a proposal from the Commission. The votes of the representatives of the Member States within the Committee shall be weighted in the manner set out in that Article. The Chairman shall not vote.

The Commission shall adopt measures which shall apply immediately. However, if these measures are not in accordance with the opinion of the Committee, they shall forthwith be communicated by the Commission to the Council. In that event:

— the Commission shall defer application of the measures which it has decided upon for a period of two months from the date of such communication,

— the Council, acting by a qualified majority, may take a different decision within the time limit laid down in the previous subparagraph.

3. In addition, the Commission may consult the Committee on any other matter concerning the implementation of this plan.

The representative of the Commission shall submit to the Committee a draft of the measures to be taken. The Committee shall deliver its opinion on the draft within a time limit which the Chairman may lay down according to the urgency of the matter, if necessary by taking a vote.

The opinion shall be recorded in the minutes; in addition, each Member State shall have the right to ask to have its opinion recorded in the minutes.

The Commission shall take the utmost account of the opinion delivered by the Committee. It shall inform the Committee of the manner in which its opinion has been taken into account.

4. The representative of the Commission shall keep the Committee regularly informed about:

— financial assistance granted under this plan (amounts, duration, breakdown, beneficiaries),

— Commission proposals or Community initiatives and the implementation of programmes in other areas which are of direct relevance to achievement of the objectives of this plan, with a view to ensuring the consistency and complementarity referred to in Article 4.

Article 6

International cooperation

1. In the course of implementing this plan, cooperation with non-member countries and with international organizations competent in the field of public health, in particular the World Health Organization and the International Agency for Research on Cancer, will be encouraged and implemented in accordance with the procedure laid down in Article 5.

2. This plan shall be open to participation by the associated countries of Central and Eastern Europe (Accee), in accordance with the conditions laid down in Additional Protocols to the Association Agreements relating to participation in Community programmes, to be concluded with those countries. This plan shall be open to participation by Cyprus and Malta on the basis of additional appropriations in accordance with the same rules as those applied to the EFTA countries, in accordance with procedures to be agreed with those countries.

Article 7

Monitoring and evaluation

1. The Commission, taking into account the reports drawn up by the Member States and with the participation, where necessary, of independent experts, shall ensure that an evaluation is made of the actions undertaken.

2. The Commission shall submit to the European Parliament and the Council an interim report halfway through the programme and a final report on completion thereof. The reports shall highlight, in particular, the complementarity between this plan and the other actions mentioned in Article 4. The Commission shall incorporate into these reports the results of the evaluations. It shall also send the reports to the Economic and Social Committee and the Committee of the Regions.

Done at Brussels, 29 March 1996.

For the European Parliament	*For the Council*
The President	*The President*
K. HÄNSCH	T. TREU

ANNEX

SPECIFIC OBJECTIVES AND ACTIONS

A. DATA COLLECTION AND RESEARCH

Objective

To extend and improve knowledge of the causes, prevention and treatment of cancer and to facilitate the collection of reliable and comparable data on the incidence of cancer, including data on paediatric oncology, in particular to identify trends and to devise European-scale epidemiological studies.

Actions

1. Support for exchanges of information and experience relating to the collection and dissemination of reliable and comparable data for cancer registers (prevalence, incidence, mortality, survival rates and age groups). Development and strengthening of a European network in cooperation with the International Agency for Research on Cancer (IARC).

2. Support for the carrying out of epidemiological studies at European level and for the dissemination of their conclusions with regard to the identification of carcinogens (physical, chemical and biological), with special attention to environmental factors and related conditions at work, the risks arising from exposure to them (types of exposure and population subgroups affected), methods of prevention and the introduction of programmes for objectively assessing survival rates on the basis of specific criteria (age, sex, position of the tumour, stage of development, histological type, etc.) and for assessing sources of disparities in those rates. On the basis of these conclusions, support for the drawing up and dissemination of recommendations. Cohort studies on cancer, diet and health (EPIC network), support for epidemiological studies based on research into nutrition as a potential preventive factor (identification of protective agents, modification of specific dietary factors) and, where appropriate, preventive chemical agents.

3. Contribution to the selection of priorities for cancer research to be carried out under the Community's framework programmes for research, and specifically the biomedical and health research programme, which includes basic and clinical cancer research, and promotion of research methods aimed at early, accurate and reliable diagnosis by means of laboratory diagnosis techniques, in particular based on immunology and genetics. Support for the establishment of an inventory of European basic and clinical cancer research measures; help with the transfer to clinical trials of the results of basic research; setting up and/or development of information exchange networks for clinical trials in progress, and help with the launching of multiple-centre and multinational clinical testing in order to speed up the assessment of new methods of care.

B. INFORMATION AND HEALTH EDUCATION

Objectives

— To help to improve knowledge of cancer risks and cancer prevention among European citizens and encourage them to adopt healthy lifestyles;

— to promote and assess policies and measures related to cancer causes and risks.

Actions

4. Establishment of an annual 'Europe against Cancer' week.

5. Improving the dissemination and effectiveness of cancer prevention messages, in particular the recommendations of the European Code against Cancer, by supporting targeted measures (for teachers, general practitioners, etc.) and pilot projects, studies and analyses of health promotion techniques and assessments of action in this field.

6. Supporting and extending pilot action networks for providing information and exchanges with regard to cancer prevention, taking into account the recommendations of the European Code against Cancer, in order to contribute to the highlighting and dissemination of best practice.

7. Promoting information and awareness-raising campaigns for specific population groups on health promotion and cancer prevention, particularly in public places and at work.

8. Encouraging projects with a European dimension relating to the prevention of tobacco consumption; assessment of the implementation of recommendations on tobacco consumption in public places, particularly on public transport and in education establishments. Promotion of strategies aimed at protecting the most vulnerable groups, in particular pregnant women and children, from the risk of passive smoking. Assessment of the effect of measures taken in the Member States to reduce tobacco consumption, for example the banning or control of direct or indirect advertising, taxation measures and the exclusion of tobacco from the price index, and dissemination of knowledge acquired from the assessment process. Support and assessment of pilot measures for preventing tobacco consumption as part of the exchange networks between Member States, for example networks of no-smoking towns, no-smoking hospitals and youth clubs in cooperation with healthcare workers and teachers.

9. Selection at European level and dissemination of the best methods of overcoming addiction to smoking, and evaluation of their impact as part of pilot measures to implement these methods in liaison with opinion formers and healthcare workers in the Member States. Launching, among the pilot projects in the media, of a project to combat passive smoking. Continuing classification of dangerous substances and preparations with the aim of improving packaging and labelling.

10. Contributing to the formulation and implementation of integrated health education programmes in different life contexts, with cancer prevention given a particularly important role. Definition and implementation of supplementary cancer prevention projects for specific groups in different contexts (town planners, environmental specialists, architects, radiologists).

    Evaluation, in the context of pilot Community networks, of health education initiatives, with priority being given to making individuals more aware of their responsibility for their own health, to discouraging smoking and excessive alcohol consumption, to promoting a healthy diet, especially increased consumption of fruit and vegetables, to appropriate media campaigns promoting a healthy diet and to making people aware of the risks associated with excessive exposure of the skin to ultraviolet radiation, targeted at young people.

11. Support for exchanges of experience under the integrated health education programmes with the aim of improving initial and continuing training for teachers and project supervisors in the field of cancer prevention, taking account of the experience gained in the framework of programmes such as Erasmus and the supporting actions of the Commission in the education field.

12. Support for the production and dissemination of Community teaching materials relating to cancer prevention, particularly those tested in the pilot networks, and for the evaluation of the impact of such materials.

13. Implementation of studies and dissemination of their conclusions, making it possible to improve the level of knowledge of the perceptions of young people with regard to cancer, tobacco, diet and the risks associated with excessive exposure of the skin to ultraviolet radiation. Carrying out analyses with the aim of increasing the effectiveness of preventive programmes among children and young people.

C. EARLY DETECTION AND SCREENING

Objective

To help improve and increase the possibilities of early detection, in particular through the development and dissemination of effective screening programmes and appropriate practices.

Actions

14. Support for the introduction and evaluation of European pilot project networks in the field of mass screening for breast and cervical cancer, on the basis of recommendations established at European level with regard to ensuring the quality of screening, and support for the organization of meetings to examine the feasibility of extending pilot projects to national and regional levels.

15. Support for the preparation and dissemination at European level of a common terminology and classification in order to improve the quality of anatomical and cytopathological interpretation, particularly of suspect growths in the breast and uterus, in particular for anatomists and cytopathologists in the Community.

16. Support for European feasibility studies on mass screening for other cancers (of the ovary, prostate, skin, colon/rectum and mouth), taking particular account of the medical, psychological, social and economic aspects.

D. TRAINING AND QUALITY CONTROL

Objective

To help improve cancer-related training for healthcare workers, including training in paediatric oncology, and quality control methods.

Actions

17. Further implementation of the Commission Recommendation of 8 November 1989 concerning the training of health personnel in the matter of cancer; assistance with the introduction of periodic assessment of the impact of the European pilot networks on initial and continuing training in the matter of cancer for the medical, nursing and dentistry professions, in particular for health personnel working in paediatric oncology.

18. Support for the mobility of the health professions (particularly trainers), in order to improve theoretical and practical knowledge of cancer (in particular primary prevention, early diagnosis, mass screening, particularly for cervical and breast cancer, and quality assurance), between those specialized centres in Member States offering training of a high quality, where such mobility is not ensured under existing Community programmes such as Comett II or Force.

19. Support for exchanges of experience and the drawing up and dissemination of conference recommendations for a consensus on good practice in the field of combating cancer and of recommendations by groups of experts, in order to speed up the dissemination and implementation of the results of controlled studies.

20. Preparation of teaching materials of European interest, aimed at improving training for healthcare workers in the matter of cancer, particularly through the use of interactive computer programmes; assessment of the impact of those materials in the pilot networks. In particular, support for the development, implementation and evaluation of prevention modules intended for the health professions, and of models to assist in diagnosis and in making decisions on measures to prevent the development of the disease and risks of relapse.

21. Promotion of initiatives and support for European studies and dissemination of their conclusions, particularly in the context of European-level meetings and exchanges of experience, in order to gain a better understanding of the quality control methods for measures aimed at correct early detection of the disease and prevention of its development, risks of relapse and associated syndromes and improving the effectiveness of those methods, taking into account the psychological and social aspects, in particular the quality of life of patients, including palliative methods.

22. Support for pilot projects in the area of quality assurance, including dissemination and evaluation of the results, with particular reference to practices connected with checks on radiotherapy installations and the training of health personnel.

DECISION No 647/96/EC OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL

of 29 March 1996

adopting a programme of Community action on the prevention of AIDS and certain other communicable diseases within the framework for action in the field of public health (1996 to 2000)

THE EUROPEAN PARLIAMENT AND THE COUNCIL OF THE EUROPEAN UNION,

Having regard to the Treaty establishing the European Community, and in particular Article 129 thereof,

Having regard to the proposal from the Commission [1],

Having regard to the opinion of the Economic and Social Committee [2],

Having regard to the opinion of the Committee of the Regions [3],

Acting in accordance with the procedure laid down in Article 189b of the Treaty [4] in the light of the joint text approved on 31 January 1996 by the Conciliation Committee,

(1) Whereas the Council, in its Resolution of 2 June 1994 [5], in response to the Commission communication of 24 November 1993 on a framework for action in the field of public health, included AIDS and other communicable diseases among the priority areas for Community action for which the Commission was invited to bring forward proposals for action;

(2) Whereas AIDS is at present an incurable disease regarded as a major scourge, to combat which coordinated action is required in the areas both of research and of prevention;

(3) Whereas it is important to promote the utilization and proper use of condoms as a means of preventing transmission of the HIV virus and other sexually-transmissible diseases;

(4) Whereas AIDS is a phenomenon that poses a dilemma not only for those parts of human relationships of most intimate concern to individuals, but also for modes of collective behaviour; whereas its implications extend to law and the economy, to politics, public health, education and culture, as well as to medicine, sociology and research;

(5) Whereas the plan of action adopted by Decision 91/317/EEC of the Council and the Ministers for Health of the Member States, meeting within the Council [6], in the framework of the 'Europe against AIDS' programme expired at the end of 1993;

(6) Whereas the 'Europe against AIDS' programme was extended until the end of 1995 by Decision No 1729/95/EC of the European Parliament and of the Council [7];

(7) Whereas the Council in its conclusions of 13 December 1993 on the setting up of an epidemiological network in the Community [8] and the European Parliament in its resolutions of 26 May 1989 [9], 15 May 1991 [10] and 19 November 1993 [11] took the view that it was essential to acquire a better knowledge of diseases on the basis of their causes and their epidemiological context; whereas, accordingly, the two institutions have called on the Commission to submit proposals for the setting up of an epidemiological network in the Community;

(8) Whereas the European Parliament and the Council emphasized that the smooth running of a network for gathering epidemiological data requires that the comparability and compatibility of data be ensured and that theoretical training in epidemiology and practical preparation in epidemiology in the field be developed for the teams participating in the network;

(9) Whereas the Community is in a position to make a major contribution towards the organization of exchanges of experience and the dissemination of information with regard to the specific training of health professionals and the information of all the social players involved, such as teachers, families, authorities and heads of undertakings;

(10) Whereas, in their Resolution of 13 November 1992 [12], the Council and the Ministers for

[1] OJ No C 333, 29. 11. 1994, p. 34, and OJ No C 228, 2. 9. 1995, p. 6.
[2] OJ No C 133, 31. 5. 1995, p. 23.
[3] OJ No C 100, 2. 4. 1996, p. 28.
[4] Opinion of the European Parliament of 27 April 1995 (OJ No C 126, 22. 5. 1995, p. 74), Council Common Position of 2 June 1995 (OJ No C 216, 21. 8. 1995, p. 11) and Decision of the European Parliament of 25 October 1995 (OJ No C 308, 20. 11. 1995). Decision of the European Parliament of 15 February 1996 (OJ No C 65, 4. 3. 1996) and Council Decision of 16 February 1996.
[5] OJ No C 165, 17. 6. 1994, p. 1.
[6] OJ No L 175, 4. 7. 1991, p. 26.
[7] OJ No L 168, 18. 7. 1995, p. 1.
[8] OJ No C 15, 18. 1. 1994, p. 6.
[9] OJ No C 158, 26. 6. 1989, p. 477.
[10] OJ No C 158, 17. 6. 1991, p. 45.
[11] OJ No C 329, 6. 12. 1993, p. 375.
[12] OJ No C 326, 11. 12. 1992, p. 1.

Health of the Member States meeting within the Council invited the Commission to consider the existing arrangements which provide for cooperation between Member States in the field of monitoring and control of communicable diseases;

(11) Whereas the actions undertaken at Community level in the field of AIDS need to be continued, extended to cover certain other communicable diseases, in particular sexually-transmissible diseases (STDs), and consolidated within the framework of the action in the field of public health set out by the Commission, in a manner consistent with measures against exclusion and situations of vulnerability;

(12) Whereas these actions must take into account, as the Council and the Ministers for Health of the Member States meeting within the Council requested in their Resolution of 27 May 1993 [1], other actions undertaken by the Community in the field of public health or having an impact on public health;

(13) Whereas, by reason of its scale and effects, Community action in support of the prevention of AIDS and other communicable diseases enables the desired objectives to be attained more effectively;

(14) Whereas policies and programmes formulated and implemented at Community level should be compatible with the aims and objectives of Community action on the prevention of AIDS and other communicable diseases; whereas, in particular, implementation of actions under the Community's biomedical and health research programme, in particular the development of vaccines and new forms of treatment, must be closely coordinated with the implementation of Community actions to prevent infection by the HIV virus and certain other communicable diseases;

(15) Whereas it is necessary to promote studies in the Member States to identify the most effective methods of prevention and to publish the most significant results of this work;

(16) Whereas cooperation with the competent international organizations and with non-member countries should be strengthened;

(17) Whereas a multiannual programme is required, defining the objectives of Community action, the priority actions for the prevention of AIDS and other communicable diseases, and the appropriate evaluation mechanisms;

(18) Whereas it is important that the Commission ensures implementation of the programme in close cooperation with the Member States; whereas, to that end, provision should be made for a procedure to ensure that Member States are fully involved in implementing the programme;

(19) Whereas a *modus vivendi* between the European Parliament, the Council and the Commission concerning the implementing measures for acts adopted in accordance with the procedure laid down in Article 189b of the Treaty was concluded on 20 December 1994;

(20) Whereas, from an operational point of view, the investment made under the preceding action plans in terms of both the European pilot networks and the mobilization of all those involved in combating AIDS and other communicable diseases should be safeguarded and developed;

(21) Whereas this programme must take account of past and current measures implemented in the Member States either by the competent authorities or by other parties involved in health policy;

(22) Whereas, however, possible duplication of effort should be avoided by the promotion of exchanges of experience and by the joint development of basic information modules for the general public, for health education and for training members of the health-care professions, which may be targeted on specific groups and on non-governmental organizations, including patients' associations;

(23) Whereas the provision of information to children and young people must begin at a very early age in the general context of information on hygiene and sexuality and health education;

(24) Whereas the objective of this programme must be to contribute towards stemming the spread of AIDS and other communicable diseases in the Community by improving knowledge concerning their prevalence and patterns, improving recognition of high-risk situations and practices and improving early detection and social, health and medical support, with a view to preventing the transmission of AIDS and other communicable diseases and thus reducing the associated mortality and morbidity as well as combating all forms of discrimination against people suffering from AIDS or infected with the HIV virus;

(25) Whereas, in order to increase the value and impact of this programme, a continuous assessment of the measures undertaken should be carried out, with particular regard to their effectiveness and the achievement of objectives at both national and Community level and, where appropriate, the necessary adjustments should be made;

(26) Whereas the objective of this programme and of the measures undertaken to implement it form part of

[1] OJ No C 174, 25. 6. 1993, p. 1.

the health protection requirements referred to in the third subparagraph of Article 129 (1) of the Treaty and as such form a constituent part of the Community's other policies;

(27) Whereas access to this programme should be facilitated, with particular stress on reaching organizations which lack means of easy access to information on Community programmes;

(28) Whereas the procedures for granting financial aid should be simple and accessible, and there should be guarantees of total transparency of these procedures and the relevant controls;

(29) Whereas this Decision lays down, for the entire duration of the programme, a financial framework constituting the principal point of reference, within the meaning of point 1 of the Declaration by the European Parliament, the Council and Commission of 6 March 1995, for the budgetary authority during the annual budgetary procedure;

(30) Whereas this programme should run for five years in order to allow sufficient time for actions to be implemented to achieve the objectives set,

HAVE DECIDED AS FOLLOWS:

Article 1

Establishment of the programme

1. A programme of Community action on the prevention of AIDS and certain other communicable diseases, hereinafter referred to as 'this programme', shall be adopted for the period 1 January 1996 to 31 December 2000 within the framework for action in the field of public health.

2. The objective of this programme shall be to help contain the spread of AIDS and reduce mortality and morbidity due to communicable diseases, by encouraging cooperation between Member States, promoting cooperation between prevention policies and programmes and supporting the activities of non-governmental organizations, including organizations for people affected by HIV.

3. The actions to be implemented under this programme and their specific objectives are set out in the Annex under the following headings:

A. Surveillance and monitoring of communicable diseases

B. Combating transmission

C. Information, education and training

D. Support for persons with HIV/AIDS and combating discrimination.

Article 2

Implementation

1. The Commission shall ensure the implementation, in close cooperation with Member States, of the actions set out in the Annex, in accordance with Article 5.

2. The Commission shall cooperate with the institutions and organizations which are active in preventing AIDS and other communicable diseases.

Article 3

Budget

1. The financial framework for implementation of this programme for the period referred to in Article 1 shall be ECU 49,6 million.

2. The annual appropriations shall be authorized by the budgetary authority within the limits of the financial perspective.

Article 4

Consistency and complementarity

The Commission shall ensure that there is consistency and complementarity between actions to be implemented under this programme and the other relevant Community programmes and initiatives, including the biomedical and health research programme under the Community's framework programme for research and Community action in developing countries.

Article 5

Committee

1. The Commission shall be assisted by a Committee consisting of two members designated by each Member State and chaired by a representative of the Commission.

2. The representative of the Commission shall submit to the Committee a draft of the measures to be taken concerning:

(a) the Committee's rules of procedure;

(b) an annual work programme indicating the priorities for action;

(c) the arrangements, criteria and procedures for selecting and financing projects under this programme, including those involving cooperation

with international organizations competent in the field of public health and participation of the countries referred to in Article 6 (2);

(d) the evaluation procedure;

(e) the arrangements for dissemination and transfer of results;

(f) the arrangements for cooperating with the institutions and organizations referred to in Article 2 (2).

The Committee shall deliver its opinion on the draft measures referred to above within a time limit which the Chairman may lay down according to the urgency of the matter. The opinion shall be delivered by the majority laid down in Article 148 (2) of the Treaty in the case of decisions which the Council is required to adopt on a proposal from the Commission. The votes of the representatives of the Member States within the Committee shall be weighted in the manner set out in that Article. The Chairman shall not vote.

The Commission shall adopt measures which shall apply immediately. However, if these measures are not in accordance with the opinion of the Committee, they shall forthwith be communicated by the Commission to the Council. In that event:

— the Commission shall defer application of the measures which it has decided upon for a period of two months from the date of such communication,

— the Council, acting by a qualified majority, may take a different decision within the time limit laid down in the first indent.

3. In addition, the Commission may consult the Committee on any other matter concerning the implementation of this programme.

The representative of the Commission shall submit to the Committee a draft of the measures to be taken. The Committee shall deliver its opinion on the draft within a time limit which the Chairman may lay down according to the urgency of the matter, if necessary by taking a vote.

The opinion shall be recorded in the minutes; in addition, each Member State shall have the right to ask to have its opinion recorded in the minutes.

The Commission shall take the utmost account of the opinion delivered by the Committee. It shall inform the Committee of the manner in which its opinion has been taken into account.

4. The representative of the Commission shall keep the Committee regularly informed about:

— financial assistance granted under this programme (amounts, duration, breakdown and beneficiaries),

— Commission proposals or Community initiatives and the implementation of programmes in other policy areas which are directly related to the attainment of the objectives of this programme, with a view to ensuring the consistency and complementarity referred to in Article 4.

Article 6

International cooperation

1. In the course of implementing this programme, cooperation with non-member countries and with international organizations competent in the field of public health, especially the United Nations and in particular the World Health Organization, the Council of Europe and non-governmental organizations competent in the field of public health or particularly involved in the fight against AIDS and other communicable diseases and the prevention thereof, will be encouraged and implemented in accordance with the procedure laid down in Article 5.

2. This programme shall be open to participation by the associated countries of Central and Eastern Europe (Accee), in accordance with the conditions laid down in the Additional Protocols to the Association Agreements relating to participation in Community programmes, to be concluded with those countries. This programme shall be open to participation by Cyprus and Malta on the basis of additional appropriations in accordance with the same rules as those applied to the EFTA countries, in accordance with procedures to be agreed with those countries.

Article 7

Monitoring and evaluation

1. The Commission, taking into account the reports drawn up by the Member States and with the participation, where necessary, of independent experts, shall ensure that an evaluation is made of the actions undertaken.

2. The Commission shall submit to the European Parliament and the Council an interim report halfway through this programme and a final report on completion thereof. It shall incorporate into these reports the results of the evaluations. It shall also send the reports to the Economic and Social Committee and the Committee of the Regions.

Done at Brussels, 29 March 1996.

For the European Parliament	*For the Council*
The President	*The President*
K. HÄNSCH	T. TREU

ANNEX

PROGRAMME OF COMMUNITY ACTION ON THE PREVENTION OF AIDS AND CERTAIN OTHER COMMUNICABLE DISEASES (1996 to 2000)

A. SURVEILLANCE AND MONITORING OF COMMUNICABLE DISEASES

Objective

To help to improve knowledge and dissemination of information and data concerning HIV/AIDS and other communicable diseases, taking into account international disease-classification provisions, and to improve the coordination of systems for monitoring these diseases and coordinating Community-level responses, particularly in the event of an epidemic outbreak.

Actions

1. Exploration with Member States of ways to increase the amount and improve the quality, comparability and availability of data and provide support for strengthening national or regional monitoring systems and implementing them as part of a network and, in the case of HIV/AIDS and connected diseases, support for the European Centre for the Epidemiological Monitoring of AIDS.

2. Contribution towards improving the quality and coordination of Member States' epidemiological monitoring systems and participation in the development of surveillance networks on the basis of the jointly-defined methodologies and conditions for data transmission, prior consultation and coordination of replies.

3. Setting up of a Community network of public health epidemiologists for the purpose of defining common surveillance methods and tools and enhancing the ability to respond in a coordinated way to the development of communicable diseases, especially in the case of epidemic outbreaks.

4. Contributing, in particular by the provision of the logistical support necessary, to the production and dissemination of a regular information notice and of a Community bulletin on communicable diseases surveillance, comprising both routine surveillance data and reports on specific epidemiological investigations.

5. Encouraging action aimed at increasing awareness of the problems and including comparable and reliable data on nosocomial infections particularly in routine surveys of hospital conditions; promoting knowledge and exchanges of experience on the ways in which surveillance results concerning infections caused by germs resistant to normal treatment (antibiotics) are analysed, processed and used by the actors in the field.

6. Promotion of investigations of the effectiveness and feasibility of screening for certain types of communicable diseases (tuberculosis, hepatitis, etc.), in particular among pregnant women. Coordination of research to minimalize transmission of diseases from mother to child.

B. COMBATING TRANSMISSION

Objective

To assist efforts to prevent the transmission of HIV and other sexually-transmitted diseases (STDs), particularly as regards high-risk environments and behaviour and ensure optimum vaccination cover in the Community for certain communicable diseases.

Actions

7. Coordination of studies and information on the problems and situations of persons whose behaviour places them at risk (parenteral drug use, prostitution and at-risk sexual relations, etc.), or placed in particular situations (travel, penal institutions, etc.) and modes of transmission; exchange of experience on preventive action including the promotion of risk-reduction measures; promotion of appropriate preventive measures and of pilot projects, including promotion of the use and availability of good-quality condoms, with instructions for use so as to avoid sexual transmission of disease, and promotion of facilitated access to such condoms.

8. Exchange of views and experience on information, advice and counselling for women who are pregnant or wanting to have children and who may be at risk of transmitting HIV to their babies.

9. Exchanges of information on messages and promotion of appropriate measures for the dissemination of effective messages aimed at the general public and at target groups, notably through campaigns to inform, educate and raise awareness concerning means of protection against the risk of sexual transmission of diseases, the problems they raise and their use.

10. Promotion of cooperation and of exchange of information between Member States on their vaccination policies and programmes as well as their arrangements for implementing them and their results among the general population and especially among children, groups exposed to risk and persons living in certain risk situations. Promotion of exchange of experience and information as regards determining vaccination cover, vigilance concerning vaccines and encouragement of measures and initiatives to ensure optimum vaccination cover.

C. INFORMATION, EDUCATION AND TRAINING

Objective

To help to increase awareness and improve public information and education and provide, including with regard to the early detection of communicable diseases, better training for health professionals and relevant personnel.

Actions

11. Evaluation of the impact of information campaigns on communicable diseases and their prevention; encouragement of exchanges between Member States on information campaigns at all levels; development of ways of linking and reinforcing campaigns in the Member States, such as provision of specific materials; utilization of telephone and other response mechanisms; definition and promotion of activities to complement national efforts, including the setting-up or strengthening of networks and the exchange of experience and expertise.

12. Gathering and analysis of information concerning preventive measures and promotion of the dissemination of the information; promotion of the development and use of assessment methods to determine the effectiveness of preventive measures and information campaigns aimed at the general public and target groups.

13. Encouragement of initiatives to ascertain and disseminate existing information about the knowledge, attitudes and behaviour of the general public and certain target groups, particularly children and young people, regarding HIV/AIDS and other STDs and about the preventive measures taken in the European Community; examination and evaluation of current practice in providing information both within and outside formal structures such as schools, training institutions and sports clubs; promotion of the exchange of educational and training material and methods, and support for pilot projects, especially those centred on groups of young people without any specific organizational framework or formal educational structure; development of training suited to every stage of the individual's development and exchange of educational material for this purpose.

    Promotion of information campaigns in the Member States on the utilization and proper use of condoms as a means of preventing transmission of the HIV virus.

    Carrying out new Eurobarometer surveys on trends in knowledge and behaviour with regard to HIV/AIDS, where existing information is inadequate.

14. Encouragement of initiatives relating to messages intended to inform and educate migrants in the Member States, taking particular account of cultural and linguistic differences.

15. Surveys and exchange of experience on training given to health professionals and those who, through their work, are brought into contact with certain communicable diseases or can act to prevent them, including personnel responsible for social support and counselling for HIV-infected persons and those living with them, in order to identify weaknesses and gaps in them and to help in devising and promoting new further training programmes; promotion of exchanges among the health professionals involved, where such action is not covered by existing Community programmes.

16. Support for the training of health personnel, in particular in the context of epidemiology and early detection of and screening for communicable diseases, including personal advice at the time of screening.

D. SUPPORT FOR PERSONS WITH HIV/AIDS AND COMBATING DISCRIMINATION

Objective

To assist efforts to ensure that persons suffering from HIV/AIDS receive assistance in line with their needs and are not discriminated against in any way.

Actions

17. Exchanges of experience and information concerning modes of assistance and support for those testing seropositive, those infected with AIDS and persons living with them. Promotion of studies, pilot projects and actions on the psycho-social aspects of HIV/AIDS, including the subject of HIV-positive children in the school environment.

18. Production and dissemination of information bulletins and directories giving the latest information on organizations providing information and support; encouragement of networks of associations providing information and psycho-social support.

19. Examination of actual or potential discriminatory situations in the Member States. Exchange of information on measures taken in the Member States to avoid or combat discrimination, particularly as regards employment, insurance, credit, housing, education and health care. Exchange of information and experience on HIV-testing policies and practices and drawing-up of a code of good practice on the matter.

II

(Preparatory Acts)

COMMISSION

Proposal for a European Parliament and Council Decision creating a network for the epidemiological surveillance and control of communicable diseases in the European Community

(96/C 123/08)

(Text with EEA relevance)

COM(96) 78 final — 96/0052(COD)

(Submitted by the Commission on 8 March 1996)

THE EUROPEAN PARLIAMENT AND THE COUNCIL OF THE EUROPEAN UNION,

Having regard to the Treaty establishing the European Community, and in particular Article 129 thereof,

Having regard to the proposal from the Commission,

Having regard to the opinion of the Economic and Social Committee,

Having regard to the opinion of the Committee of the Regions,

1. Whereas the prevention of diseases, and in particular of the major health scourges, is a priority for Community action, requiring a global and coordinated approach between Member States;

2. Whereas the European Parliament, in its resolution on public health policy after Maastricht [1], invited the Commission to set up a trans-frontier network to devise working definitions of notifiable diseases, to collect, update, analyze and disseminate Member State data on notifiable diseases and to work with national and international agencies on these matters;

3. Whereas in its resolution of 2 June 1994 on the framework for Community action in the field of public health [2] the Council agreed that priority should be given at present to communicable diseases in particular;

4. Whereas in its conclusions of 13 December 1993 [3], the Council considers that there is a need to develop at Community level a network for the surveillance and control of communicable diseases, the main purpose of which would be to collect and coordinate information from monitoring networks in the Member States;

5. Whereas in these same conclusions the Council requests the Commission to devote special attention, in its proposals relating to the framework for action in the field of public health [4], to setting up an epidemiological network in the Community, taking account of current proceedings and mechanisms existing at Community level and that of Member States, and ensuring the comparability and compatibility of data;

6. Whereas in their resolution of 13 November 1992 [5], the Council and the Ministers for Health meeting within the Council underline the desirability of improving, within the Community, the coverage and effectiveness of existing networks between Member States (including data-processing networks), and of maintaining, establishing or strengthening coordination between them for monitoring outbreaks of communicable diseases, where such action could add to the value of existing measures;

7. Whereas in this same resolution, the Council and the Ministers for Health meeting within the Council underline the value of collecting data from the Member States on a limited number of rare and serious diseases which require large samples for epidemiological study;

[1] OJ No C 329, 6. 12. 1993, p. 375.
[2] OJ No C 165, 17. 6. 1994, p. 1.
[3] OJ No C 15, 18. 1. 1994, p. 6.
[4] COM(93) 559 final, 24. 11. 1993.
[5] OJ No C 326, 11. 12. 1992, p. 1.

8. Whereas in this same resolution, the Council and the Ministers for Health meeting within the Council invite the Commission to examine the desirability of giving priority to certain suitable proposals relating to the control and surveillance of communicable diseases, in the light, *inter-alia*, of their estimated cost-effectiveness;

9. Whereas, in accordance with the principle of subsidiarity, any new measure taken in an area which does not fall within the exclusive competence of the Community, such as the epidemiological surveillance and control of communicable diseases, may be taken by the Community only if, by reason of the scale or effects of the proposed action, the objectives of the proposed action can be better achieved by the Community than by one or more Member States;

10. Whereas measures in the health field must take into account other actions undertaken by the Community in the field of public health or which have an impact on public health;

11. Whereas European Parliament and Council Decision .../.../EC adopting a programme of Community action on the prevention of AIDS and certain other communicable diseases within the framework for action in the field of public health envisages a number of Community actions for the creation and development of networks for the control and surveillance of certain communicable diseases, the early detection of such diseases, and promotion of the training of field epidemiologists;

12. Whereas cooperation with the competent international organizations, notably with regard to disease classification, must be fostered;

13. Whereas cooperation with third countries, notably in the case of the emergence or resurgence of serious communicable diseases, must be supported;

14. Whereas the emergence or recent resurgence of serious communicable diseases has demonstrated that when an emergency situation occurs all relevant information must be communicated swiftly to the Commission in an agreed form of presentation;

15. Whereas the introduction of specific Community arrangements will help to ensure that all Member States are swiftly informed in the event of such an emergency situation, so that the protection of the population can be ensured;

16. Whereas the provisions of Council Directive 92/117/EEC of 17 December 1992 concerning measures for protection against specified zoonoses and specified zoonotic agents in animals and products of animal origin in order to prevent outbreaks of food-borne infections and intoxications [1] apply equally to information concerning zoonoses which affect human beings, and whereas the same Directive provides for a system for collecting and transmitting information on specified zoonoses and zoonotic agents;

17. Whereas the setting up of a network for the epidemiological surveillance and control of communicable diseases at Community level necessarily presupposes observance of the legal provisions concerning the protection of individuals with regard to the processing of personal data and the introduction of arrangements to guarantee the confidentiality and security of such data and information; whereas in this connection the European Parliament and the Council adopted Directive 95/46/EC on 24 October 1995;

18. Whereas the Community projects in the field of the telematic interchange of data between administrations (IDA) [2] and the G7 projects should be closely coordinated with the implementation of the Community actions relating to the epidemiological surveillance and control of communicable diseases;

19. Whereas it is important, in an emergency situation, that the competent national structures should strengthen their cooperation, notably with regard to the identification of biological samples;

20. Whereas these Community arrangements for the rapid exchange of information do not affect the Member States' rights and obligations under Treaties or bilateral and multilateral conventions;

21. Whereas it is important that the Commission should implement the Community network in close cooperation with the Member States; whereas a procedure therefore needs to be established to ensure the Member States' full participation in this implementation;

22. Whereas an agreement on a *modus vivendi* between the European Parliament, the Council and the Commission concerning measures for the implementation of acts adopted under the procedure laid down in Article 189b of the Treaty was reached on 20 December 1994,

HAVE DECIDED AS FOLLOWS:

Article 1

A general network for the epidemiological surveillance and control of communicable diseases shall be set up in the European Community.

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[1] OJ No L 62, 15. 3. 1993, p. 38.
[2] OJ No L 269, 11. 11. 1995, p. 23.

This Community network shall be formed by putting into permanent communication with one another, through all appropriate technical means, structures which, at the level of each Member State and under the responsibility of the Member State, are charged with collecting information relating to epidemiological surveillance and coordinating control measures.

Article 2

For the purposes of this Decision the following terms shall have the following meanings:

— *epidemiological surveillance:* the ongoing systematic collection, analysis, interpretation and dissemination of health data concerning communicable diseases, for the purpose of enabling appropriate counter-measures to be taken,

— *control of communicable diseases:* the range of measures taken by the competent public health authorities to stop the spread of communicable diseases, as well as epidemiological studies, in particular of the pattern of spread of such diseases over time and space and analysis of the risk factors for contracting such diseases, the results of which enable appropriate preventive measures to be devised.

Article 3

For every Member State, the epidemiological surveillance and control of communicable diseases at Community level shall apply to:

(a) the appearance or resurgence on its territory of cases of serious and/or rare communicable diseases as listed in the Annex;

(b) the importation onto its territory, from another Member State or a non-Community country, of cases of serious and/or rare communicable diseases as listed in the Annex.

Article 4

For the purposes of implementing this Decision the Commission shall be assisted by a committee consisting of representatives from the Member States and chaired by a representative of the Commission.

The Commission representative shall submit to the committee a draft of the measures to be taken. The committee shall deliver its opinion on this draft within a time limit which the chairman shall lay down according to the urgency of the matter. The opinion shall be delivered by the majority laid down in Article 148 (2) of the EC Treaty in the case of decisions which the Council is required to adopt on a proposal from the Commission. The votes of the representatives of the Member States within the committee shall be weighted in the manner set out in that Article. The chairman shall not vote.

The Commission shall adopt the measures envisaged if they are in accordance with the opinion of the committee. If the measures envisaged are not in accordance with the opinion of the committee, or if no opinion has been delivered, the Commission shall forthwith submit to the Council a proposal concerning the measures to be taken. The Council shall act by a qualified majority.

If, within three months of the matter being referred to it, the Council has not adopted measures, the Commission shall adopt the measures proposed and implement them immediately.

Article 5

The measures referred to in Article 4 concern in particular:

1. case definitions, in particular the clinical definition and, where appropriate, the microbiological characterisation of the agent responsible;

2. the nature and type of data and information to be collected by the structures referred to in Article 1 in the field of epidemiological surveillance;

3. the epidemiological and microbiological surveillance methods;

4. the protective measures to be taken, in particular at ports and airports, notably in emergency situations;

5. information, recommendations and guides to good practice for the public.

Article 6

Each structure referred to in Article 1 shall communicate to the Community network and the Commission:

(a) information on the communicable diseases referred to in Article 2, together with information on control measures applied;

(b) any useful information concerning the progression of epidemic situations in the Member State to which the institution belongs;

(c) any evaluation element which will aid cooperation between Member States for the purpose of the control of communicable diseases, in particular the conservation of biological samples taken from patients for transmission to specialist laboratories linked to the Community network.

Article 7

Each Member State shall appoint, within six months following the entry into force of this Decision, the structure or structures referred to in Article 1, and shall notify the Commission thereof.

Article 8

The Commission may amend or supplement the Annex in accordance with the procedure provided for in Article 4.

Article 9

This Decision shall apply without prejudice to Council Directive 92/117/EEC concerning measures for protection against specified zoonoses and specified zoonotic agents in animals and products of animal origin in order to prevent outbreaks of food-borne infections and intoxications, and shall take account of the information collection and transmission procedure provided for in that Directive.

Article 10

This Decision shall apply without prejudice to European Parliament and Council Directive 95/46/EC on the protection of individuals with regard to the processing of personal data and on the free movement of such data, and to Council Decision 95/468/EC on a Community contribution for telematic interchange of data between administrations in the Community (IDA).

Article 11

This Decision shall not affect Member States' reciprocal rights and obligations deriving from existing or future bilateral or multilateral agreements or conventions in the domain covered by the Decision, and which are in line with the Decision's subject, methods of implementation and objectives.

Article 12

This Decision is addressed to the Member States and shall enter into force three months after the date of its publication in the *Official Journal of the European Communities.*

ANNEX

The communicable diseases referred to in Article 3 are divided into groups of serious and/or rare disorders, namely:

— **concerning paragraph (a):**

diseases requiring measures to be taken at local level and reported on periodically to the Member States' public health authorities in accordance with arrangements specific to each of these diseases and defined in accordance with Article 5, notably:

1. diseases preventable by vaccination (tuberculosis, tetanus, poliomyelitis, diphtheria, meningitis, measles, mumps, rubella, influenza and influenza syndromes, etc.);
2. sexually-transmitted diseases (hepatitis B, AIDS/HIV, chlamydiasis, etc.);
3. viral hepatitis (including hepatitis C and other as yet unclassified categories of hepatitis);
4. food-borne diseases (listeriosis, salmonellosis, etc.);
5. water-borne diseases and diseases of environmental origin (legionellosis, etc.);
6. nosocomial infections;
7. other diseases transmissible by non-conventional agents (including Creutzfeldt-Jakob disease, etc.);

— **concerning paragraph (b)**

the same diseases as under paragraph (a), plus diseases requiring exceptional measures to be taken at national and international levels, such as:

1. diseases covered by the International Health Regulations (yellow fever, cholera, plague);
2. other diseases (rabies, typhus fever, African haemorrhagic fevers, malaria and any other as yet unclassified serious epidemic disease, etc.).

COMMON POSITION (EC) No 35/96

adopted by the Council on 18 June 1996

with a view to adopting Decision No 220/96/EC of the European Parliament and of the Council adopting a programme of Community action on health monitoring within the framework for action in the field of public health

(96/C 220/04)

THE EUROPEAN PARLIAMENT AND THE COUNCIL OF THE EUROPEAN UNION,

Having regard to the Treaty establishing the European Community, and in particular Article 129 thereof,

Having regard to the proposal from the Commission [1],

Having regard to the opinion of the Economic and Social Committee [2],

Having regard to the opinion of the Committee of the Regions [3],

Acting in accordance with the procedure referred to in Article 189b of the Treaty [4],

1. Whereas, pursuant to Article 3 (o) of the Treaty, Community action must include a contribution towards the attainment of a high level of health protection; whereas Article 129 of the Treaty expressly provides for Community competence in this field insofar as the Community contributes to it by encouraging cooperation between the Member States and, if necessary, by lending support to their action;

2. Whereas the Council, in its resolution of 27 May 1993 on future action in the field of public health [5], considered that improved collection, analysis and distribution of health data, as well as an improvement in the quality and comparability of available data, are essential for the preparation of future programmes;

3. Whereas the European Parliament, in its resolution on public health policy after Maastricht [6], stressed the importance of having sufficient and relevant information as a basis for the development of Community actions in the field of public health; whereas the European Parliament called on the Commission to collect and examine health data from Member States with a view to analysing the effects of public health policies on health status in the Community;

4. Whereas the Commission, in its communication of 24 November 1993 on the framework for action in the field of public health, identified increased cooperation on standardization and collection of comparable/compatible data on health, and the promotion of systems of health monitoring and surveillance as a prerequisite for the establishment of a framework for supporting Member States' policies and programmes; whereas the area of health monitoring, including health data and indicators, has been identified as a priority area for proposals on multiannual Community programmes in the field of public health;

5. Whereas in its resolution of 2 June 1994 on the framework for action in the field of Community health [7], the Council indicated that the collection of health data should be accorded priority and invited the Commission to present relevant proposals; whereas the Council considered that data and indicators used should include measures relating to the quality of life of the population, accurate assessments of health needs, estimates of the avoidable deaths from the prevention of diseases, socio-economic factors in health among different population groups, and, where appropriate and if the Member States judge it necessary, health aid, medical practices, and the impact of reforms;

6. Whereas health monitoring at the Community level is essential for the planning, monitoring, and assessment of Community actions in the field of public health, and the monitoring and assessment of the health impact of other Community policies;

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(1) OJ No C 338, 16. 12. 1995, p. 4.
(2) OJ No C 174, 17. 6. 1996, p. 3.
(3) OJ No C 129, 2. 5. 1996, p. 50.
(4) Opinion of the European Parliament of 17 April 1996 (OJ No C 141, 13. 5. 1996, p. 94), Council common position of ... (not yet published in the Official Journal) and Decision of the European Parliament of ... (not yet published in the Official Journal).
(5) OJ No C 174, 25. 6. 1993, p. 1.
(6) OJ No C 329, 6. 12. 1993, p. 375.
(7) OJ No C 165, 17. 6. 1994, p. 1.

7. Whereas, on the basis in particular of knowledge of data relating to public health in Europe obtained by setting up a Community health monitoring system, it will be possible to monitor public health trends and define public health priorities and objectives;

8. Whereas health monitoring, for the purposes of this Directive, encompasses the establishment of Community health indicators and the collection, dissemination, and analysis of Community health data and indicators;

9. Whereas in Decision 93/464/EEC of 22 July 1993 on the framework programme for priority actions in the field of statistical information 1993 to 1997 [1], the Council identified under the heading 'Health and safety statistics' the analysis of mortality and morbidity by cause as one of the fields of priority actions under the sectoral programmes for social policy, economic and social cohesion and consumer protection;

10. Whereas in Decision 94/913/EC of 15 December 1994 adopting a specific programme of research and technological development, including demonstration, in the field of biomedicine and health (1994 to 1998) [2], the Council identified a specific research task of coordination and comparison of European health data, including nutritional data, from the various Member States; whereas this was taken up in the relevant research work programme;

11. Whereas health monitoring at Community level should enable measurements of health status, trends and determinants to be carried out, facilitate the planning, monitoring and evaluation of Community programmes and actions, and provide Member States with health information supporting the development and evaluation of their health policies;

12. Whereas, in order to give full effect to requirements and expectations in this area, a Community health monitoring system should be developed, comprising the establishment of health indicators and the collection of health data, a network for transmission and sharing of health data and indicators, and a capacity for analysis and dissemination of health information;

13. Whereas available options and possibilities for developing the various parts of a Community health monitoring system, including those making existing provisions more stringent, should be carefully examined with respect to the desired performance, flexibility and the costs and benefits involved; whereas a flexible system is required which can incorporate features which are deemed valuable at present while adapting to new requirements and other priorities; whereas such a system should include the definition of sets of Community health indicators and the collection of the data necessary for the establishment of such indicators;

14. Whereas Community health data and indicators should draw from existing European data and indicators, such as those held by Member States or transmitted by them to international organizations, so as to avoid unnecessary duplication of work;

15. Whereas the situation with regard to the collection of data varies from one Member State to another;

16. Whereas a Community health monitoring system would benefit from the establishment of a telematics network for the collection and distribution of Community health data and indicators;

17. Whereas the Community health monitoring system should be capable of producing data for the preparation of regular reports on health status in the European Community, analyses of trends and health problems, and should help produce and disseminate health information;

18. Whereas the setting up of a health-monitoring system at Community level necessarily presupposes compliance with provisions concerning the protection of data and the introduction of measures to guarantee their confidentiality and security, such as the provisions laid down in Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data [3] and in Council Regulation (Euratom, EEC) No 1588/90 of 11 June 1990 on the transmission of data subject to statistical confidentiality to the Statistical Office of the European Communities [4];

19. Whereas a multiannual programme should be launched within the framework for action in the field of public health, in order to permit the development of a Community health monitoring

[1] OJ No L 219, 28. 8. 1993, p. 1.
[2] OJ No L 361, 31. 12. 1994, p. 40.
[3] OJ No L 281, 23. 11. 1995, p. 31.
[4] OJ No L 151, 15. 6. 1990, p. 1. Regulation as amended by the 1994 Act of Accession.

system and of appropriate mechanisms for its evaluation;

20. Whereas, in accordance with the principle of subsidiarity, action on matters not falling within the exclusive competence of the Community, such as action on health monitoring, must be undertaken by the Community only if, by reason of their scale or effects, it can be better achieved by the Community;

21. Whereas policies and programmes formulated and implemented at Community level, in particular those undertaken within the framework for action in the field of public health, should be compatible with the targets and objectives of Community action on health monitoring; whereas the implementation of Community actions on health monitoring should be coordinated with and take account of relevant research activities under the Community's Framework Programme for Research and Technological Development; whereas projects on telematics applications in the health field under the Community's RTD Framework must be coordinated with Community actions on health monitoring; whereas actions under the Community's framework programme for statistical information, the Community projects in the field of telematic interchange of data between administrations (IDA) and G-7 health-related projects must be closely coordinated with the implementation of Community actions on health monitoring; whereas the work undertaken by the specialized European agencies, such as the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the European Environment Agency, should be taken into account;

22. Whereas cooperation with the competent international organizations and with non-member countries should be strengthened;

23. Whereas, from an operational point of view, the investments made in the past in terms both of the development of Community networks and of cooperation with international organizations competent in this field should be safeguarded and further developed;

24. Whereas it is important that the Commission should ensure implementation of this programme in close cooperation with the Member States;

25. Whereas a *modus vivendi* between the European Parliament, the Council and the Commission concerning the implementing measures for acts adopted in accordance with the procedure laid down in Article 189b of the Treaty was concluded on 20 December 1994 [1];

26. Whereas data are insufficiently comparable at present and unnecessary duplication of effort should be avoided by the joint development of comparison and conversion methods, criteria and techniques, suitable data collection tools such as surveys, questionnaires or parts thereof, and content specifications for health information to be shared using in particular a telematics network;

27. Whereas, in order to increase the value and impact of the action programme, a continuous assessment of the measures undertaken should be carried out, with particular regard to their effectiveness and the achievement of objectives at both national and Community level, and, where appropriate, the necessary adjustments should be made;

28. Whereas this Decision lays down, for the entire duration of this programme, a financial framework constituting the principal point of reference, within the meaning of point 1 of the Declaration of the European Parliament, the Council and the Commission of 6 March 1995 [2], for the budgetary authority during the annual budgetary procedure;

29. Whereas this programme should run for five years in order to allow sufficient time for actions to be implemented to achieve the objectives set,

HAVE DECIDED AS FOLLOWS:

Article 1

Establishment of the programme

1. A programme of Community action on health monitoring, hereinafter referred to as 'the programme', shall be adopted for the period 1 January 1997 to 31 December 2001 within the framework for action in the field of public health.

2. The objective of the programme shall be to contribute to the establishment of a Community health-monitoring system which helps to:

(a) measure health status, trends and determinants throughout the Community;

(b) facilitate the planning, monitoring and evaluation of Community programmes and actions; and

(c) provide Member States with appropriate high-quality health information to make comparisons and to support their national health policies,

[1] OJ No C 102, 4. 4. 1996, p. 1.

[2] OJ No C 102, 4. 4. 1996, p. 4.

by encouraging cooperation between Member States and, if necessary, by supporting their action through promoting coordination of their policies and programmes in this field and encouraging cooperation with non-member countries and the relevant international organizations.

3. The actions to be implemented under the programme and their specific objectives are set out in Annex I under the following headings:

A. Establishment of Community health indicators;

B. Development of a Community-wide network for sharing health data;

C. Analyses and reporting.

A non-exhaustive list of areas in which health indicators could be established is set out in Annex II.

Article 2

Implementation

1. The Commission shall ensure the implementation, in close cooperation with the Member States, of the actions set out in Annex I, in accordance with Article 5.

2. The Commission shall cooperate with the institutions and organizations which are active in the field of health monitoring.

Article 3

Budget

1. The financial framework for the implementation of the programme for the period referred to in Article 1 shall be ECU 13 million.

2. The annual appropriations shall be authorized by the budgetary authority within the limits of the financial perspective.

Article 4

Consistency and complementarity

The Commission, with the assistance of the Member States, shall ensure that there is consistency and complementarity between actions to be implemented under this programme and the other relevant Community programmes and initiatives, covering those that are situated in the context of public-health action as well as, in particular, the framework programme for statistical information, projects in the field of telematic interchange of data between administrations and the framework programme for research and technological development, in particular the telematics applications of the latter.

Article 5

Committee

1. The Commission shall be assisted by a committee, consisting of two members designated by each Member State and chaired by a representative of the Commission.

2. The representative of the Commission shall submit to the committee a draft of the measures to be taken concerning:

(a) the committee's rules of procedure;

(b) an annual work programme indicating the priorities for action;

(c) the arrangements, criteria and procedures for selecting and financing projects under the programme, including those involving cooperation with international organizations competent in the field of public health and participation of the countries referred to in Article 6 (2)

(d) the evaluation procedure;

(e) the arrangements for dissemination and transfer of results;

(f) the arrangements for cooperating with the institutions and organizations referred to in Article 2 (2);

(g) the provisions applicable to reporting the data, conversion thereof and other methods for making the data comparable in order to achieve the objective referred to in Article 1 (2);

(h) the provisions for the definition and selection of indicators;

(i) the provisions for the content specifications necessary for setting up and operation of the relevant networks;

The committee shall deliver its opinion on the draft measures referred to above within a time limit which the chairman may lay down according to the urgency of the matter. The opinion shall be delivered by the majority laid down in Article 148 (2) of the Treaty in the case of decisions which the Council is required to adopt on a proposal from the Commission. The votes of the representatives of the Member States within the committee shall be weighted in the manner set out in that Article. The chairman shall not vote.

The Commission shall adopt measures which shall apply immediately. However, if these measures are not in accordance with the opinion of the committee, they shall be communicated by the Commission to the Council forthwith. In that event:

— the Commission shall defer application of the measures which it has decided upon for a period of two months from the date of such communication,

— the Council, acting by a qualified majority, may take a different decision within the time limit laid down in the first indent.

3. In addition, the Commission may consult the committee on any other matter concerning the implementation of this programme, including the arrangements for coordination with the other programmes and initiatives referred to in Article 4.

The representative of the Commission shall submit to the committee a draft of the measures to be taken. The committee shall deliver its opinion on the draft within a time limit which the chairman may lay down according to the urgency of the matter, if necessary by taking a vote.

The opinion shall be recorded in the minutes; in addition, each Member State shall have the right to ask to have its opinion recorded in the minutes.

The Commission shall take the utmost account of the opinion delivered by the committee. It shall inform the committee of the manner in which its opinion has been taken into account.

4. The representative of the Commission shall keep the committee regularly informed of:

— financial assistance granted under the programme (amount, duration, breakdown and beneficiaries),

— Commission proposals or Community initiatives and the implementation of programmes in other areas which are of direct relevance to achievement of the objectives of the programme, with a view to ensuring the consistency and complementarity referred to in Article 4.

Article 6

International cooperation

1. In the course of implementing the programme, cooperation with non-member countries and with international organizations competent in the field of public health, in particular the World Health Organization, the Organization for Economic Cooperation and Development and the International Labour Organization, shall be encouraged and implemented in accordance with the procedure laid down in Article 5.

2. The programme shall be open to participation by the associated countries of Central and Eastern Europe (ACCEE) in accordance with the conditions laid down in the additional protocols to the association agreements relating to participation in Community programmes, to be concluded with those countries. The programme shall be open to participation by Cyprus and Malta on the basis of additional appropriations in accordance with the same rules as those applied to the European Free Trade Association (EFTA) countries, in accordance with procedures to be agreed with those countries.

Article 7

Monitoring and evaluation

1. The Commission, taking into account the reports drawn up by the Member States and with the participation, where necessary, of independent experts, shall ensure that an evaluation is made of the actions undertaken.

2. The Commission shall submit to the European Parliament and the Council an interim report halfway through the programme and a final report on completion thereof. The Commission shall incorporate into these reports information on Community financing in the various fields of action and on complementarity with the other programmes and initiatives referred to in Article 4, as well as the results of the evaluation referred to in paragraph 1. It shall also send the reports to the Economic and Social Committee and the Committee of the Regions.

3. On the basis of the evaluations referred to in paragraph 1, the Commission may, if appropriate, make relevant proposals with a view to the continuation of this programme.

Done at . . .

For the European Parliament
The President

For the Council
The President

ANNEX I

SPECIFIC OBJECTIVES AND ACTIONS

A. ESTABLISHMENT OF COMMUNITY HEALTH INDICATORS

Objective

To establish Community health indicators by a critical review of existing health data and indicators and develop appropriate methods for the collection of health data and for making such data comparable, in accordance with the objective referred to in Article 1 (2).

1. Carrying out an identification, review and critical analysis of existing health indicators and data at European level and at Member State level, taking as a basis data validated by the Member States in order to determine their relevance, quality and coverage with regard to the establishment of Community health indicators.

2. Identification of a set of Community health indicators, including a subset of core indicators for the monitoring of Community programmes and actions in public health and a subset of background indicators for the monitoring of other Community policies, programmes and actions, for providing Member States with common measurements for making comparisons. A non-exhaustive list of the areas in which health indicators could be established is set out in Annex II.

3. Development of the routine collection of data and of methods for making health data comparable, in order to achieve the objective referred to in Article 1 (2), including support for drawing up data dictionaries and the establishment of appropriate conversion methods and rules.

4. Contributing to the collection of comparable data by supporting the preparation of surveys, including Community-wide surveys in support of the framing of Community policies, or drawing up agreed specimen modules or questionnaires for use in existing surveys.

5. Fostering cooperation with international organizations competent in the field of Community health data and indicators and networks for the exchange of health data covering specific areas in public health, in order to enhance comparability of data.

6. Encouragement and support for the assessment of the feasibility and cost-effectiveness of developing standardized health-resource statistics with the aim of including them in a future Community health-monitoring system.

B. DEVELOPMENT OF A COMMUNTY-WIDE NETWORK FOR SHARING HEALTH DATA

Objective

To enable the establishment of an effective and reliable system for the transfer and sharing of health data and indicators using telematic interchange of data as the principal means.

7. Encouragement and support for the development of a network for transferring and sharing health data, mainly using telematic interchanges and a system of distributed databases, in particular by the establishment of data specifications and of procedures with regard to access, retrieval, confidentiality and security for the different types of information to be included in the system.

C. ANALYSES AND REPORTING

Objective

To develop methods and tools necessary for analysis and reporting and to support analyses and reporting on health status, trends and determinants and on the effect of policies on health.

8. Encouragement and support for the development of capacity for analyses by enhancing existing capabilities and for feasibility studies for possible new structures of comparative and predictive methodologies and tools, the testing of hypotheses and models and the evaluation of health scenarios and outcomes.

9. Support for the analysis of the impact of Community actions and programmes in the field of public health, and for drawing up and disseminating reports evaluating such impact.

10. Support for the preparation, production and dissemination of reports and other information material on health status and trends, health determinants and the impact on health of other policies.

ANNEX II

Non-exhaustive list of areas in which health indicators may be established

A. **Health status**

1. Life expectancy:
   — life expectancy at certain ages,
   — health expectancies.
2. Mortality:
   — overall,
   — causes of death,
   — disease-specific survival rates.
3. Morbidity:
   — disease-specific morbidity,
   — co-morbidity.
4. Functioning and quality of life:
   — self-perceived health,
   — physical disability,
   — activity limitations,
   — functional status/ability,
   — health-related work loss,
   — mental health.
5. Anthropometric characteristics

B. **Life style and health habits**

1. Tobacco consumption.
2. Alcohol consumption.
3. Illegal drug consumption.
4. Physical activities.
5. Diet.
6. Sex life,
7. Other.

C. **Living and working conditions**

1. Employment/unemployment:
   — occupation.
2. Work environment:
   — accidents,
   — exposure to carcinogenic and other dangerous substances,
   — occupational diseases.

3. Housing conditions.
4. Home and leisure activities:
   — accidents at home,
   — leisure.
5. Transport:
   — car accidents.
6. External environment:
   — air pollution,
   — water pollution
   — other types of pollution,
   — radiation,
   — exposure to carcinogenic and other dangerous substances outside the work environment.

D. **Health protection**

1. Sources of financing.
2. Facilities/manpower:
   — health-resource utilization,
   — health-care personnel.
3. Cost/expenditure:
   — in-patient care,
   — out-patient care,
   — pharmaceutical products.
4. Consumption/uses:
   — in-patient care,
   — out-patient care,
   — pharmaceutical products.
5. Health promotion and disease prevention.

E. **Demographic and social factors**

1. Gender.
2. Age.
3. Marital status.
4. Region of residence.
5. Education.
6. Income.
7. Population subgroups.
8. Health-insurance status.

F. **Miscellaneous**

1. Product safety.
2. Others.

STATEMENT OF THE COUNCIL'S REASONS

I. INTRODUCTION

1. On 17 October 1995, the Commission submitted a proposal for a Decision adopting a Community action programme on health monitoring within the framework for action in the field of public health, based on Article 129 of the EC Treaty [1].

2. The European Parliament delivered its opinion on 17 April 1996 [2].

   The Economic and Social Committee and the Committee of the Regions delivered their opinions on 27 March [3] and 18 January 1996 [4] respectively.

   In the light of these opinions, the Commission submitted an amended proposal [5] on 15 May 1996.

3. On 17 June 1996, the Council adopted its common position in accordance with Article 189b of the EC Treaty.

II. OBJECTIVE

The Decision concerns the fifth Community action programme, proposed in the framework for action in the field of public health and designated a priority by the Council in its resolution of 2 July 1994 [6].

The purpose of the programme is to establish a Community health monitoring system which will make it possible to measure the health situation, and health trends and determinants in the Community, and to make comparisons and support national health policies.

III. ANALYSIS OF THE COMMON POSITION

1. *Amendments made to the Commission proposal*

   General remark

   In the main, the Council accepted the approach proposed by the Commission and, regarding in particular the content of the programme, included all the actions in Annex I to the proposal.

   Financial framework (Article 3 (1))

   The Council adopted an amount — ECU 13 million — which, though not quite the same as that proposed, is extremely close to it and represents a balance between the need to implement and follow up the programme's actions, and the need to take account of budgetary discipline.

   Committee procedure (Article 5 (2) and (3))

   Here, however, the Council deviated from the proposed procedure and opted, as in the case of the programmes already adopted, for a mixed procedure which made it possible

[1] OJ No C 383, 16. 12. 1995, p. 4.
[2] OJ No C 141, 13. 5. 1996, p. 94.
[3] OJ No C 174, 17. 6. 1996, p. 3.
[4] OJ No C 129, 2. 5. 1996, p. 50.
[5] COM(96) 222 final — COD 95/0238 (not yet published in the Official Journal).
[6] OJ No C 165, 17. 6. 1994, p. 1.

to reconcile the requirement for flexibility in the management of the programme with the need to involve the Member States more actively in certain important decisions: management committee procedure for important decisions and, for the others, including detailed rules for coordination, the advisory committee procedure.

More specific points

In addition, it introduced certain specifications, clarifications or additions of limited scope, in particular regarding the reference to data protection provisions (recital 18), the objective of the programme (Article 1 (2)), consistency and complementarity (Article 4), international cooperation (Article 6 (1)) and follow-up and assessment (Article 7 (3) regarding possible action further to the programme). With regard to the collection of comparable data (Article 5 (2) (g) and Annex I, part A, specific objective and point 3), it opted for a broader, more flexible form of words.

2. *European Parliament amendments*

(a) **Amendments accepted by the Commission in its amended proposal**

Of the 44 amendments adopted by the European Parliament at first reading, the Commission accepted 28:

— seven in full (amendments 12, 16, 17, 18, 20, 23 and 29), and

— 21 in part (amendments 1 to 3, 4, 6, 7, 8, 9, 10, 11, 13, 19, 25, 33 to 40 and 42).

(i) ***Amendments accepted by the Council***

The Council included unaltered in its common position the following Parliament amendments: 17 and 20.

In addition, it included in part or in another form amendments 1, 4, 7, 8, 9, 11, 19, 23, 25, 29 (Article 1 (3) and Annex I, part A, point 2, 33, 35 to 40 and 42 (as a matter of form), in most cases adopting the version proposed by the Commission.

(ii) ***Amendments not accepted by the Council***

The Council felt unable to support the Commission in respect of the following amendments proposed by the European Parliament:

Amendments accepted in full by the Commission

— Amendment 12 (recital 15a)

The Council did not include this amendment concerning cooperation in the field of occupational health and safety, since it considered that such cooperation would exceed the scope of the programme and create budgetary difficulties within it.

It should, however, be pointed out that, in respect of international cooperation, Article 6 of the common position makes provision for the encouragement of cooperation with, *inter alia*, the International Labour Organization.

— Amendments 16 and 18 (new recital 16a replacing recital 23)

The Council did not feel it necessary to change the original position of this recital.

Amendments accepted in part by the Commission

— Amendment 3 (new recital 3b)

— Amendment 6 (new recital 11a)

— Amendment 34 (Annex I, part A, new point 6a).

The Council was unable to accept these amendments, which aim to establish a permanent structure (in particular in the form of a European health observatory), since it considered it inappropriate to prejudge the establishment of such structures in the context of this programme (which is of limited duration).

Accordingly, the Council confined itself to including, in a general form, the changes introduced in the Commission's amended proposal, which are on the same lines as these European Parliament amendments:

— a reference to 'making existing provisions more stringent' in recital 13 of the common position (former recital 12), and

— a reference to 'boosting existing capacity' in point 8 of part C of Annex I.

— Amendment 10 (recital 14)

The Council considered that the text of the initial proposal, which it retained, enabled the European Parliament's concerns to be covered, while offering greater flexibility in the technical procedures for organizing the monitoring system.

— Amendment 13 (recital 16)

The Council considered that the text of recital 18 of its common position took full account of existing obligations regarding the confidentiality and security of data.

(b) **Amendments not accepted by the Commission in its amended proposal**

(i) In general, the Council agreed with the reasons which prompted the Commission to reject certain European Parliament amendments, i.e. that the amendments:

— were not in line with the text or with the spirit of Article 129 of the EC Treaty, or were not compatible with the corresponding provisions in other public health programmes, or exceeded the framework of the proposed programme (amendments 2, 15, 21, 32, 43 and 47),

— proposed a less flexible text and/or one which restricts the scope of the programme (amendments 5, 14, 30 and 45),

NB: Regarding Amendment 30 (Annex I, part A, point 3), see comment in the fourth paragraph ('More specific points') of part III.1 of this document,

— were taken into account elsewhere (amendments 26, 27 and 28).

(ii) The Council accepted, in part or in another form:

— the substance of Amendment 31 (Annex I, part A), by means of an addition to the text of point 1,

— amendment 46, through the adoption of a wording for Article 3 identical to that approved for the corresponding provisions in the Decisions already adopted (recital 28 of the common position).

IV. CONCLUSIONS

The Council, while opting for a procedure for implementing the programme which was similar to that approved in the context of the programmes already adopted, retained the substance of the Commission proposal as amended in response to the European Parliament's opinion.

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