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

COMMISSION COMMUNICATION ON THE FRAMEWORK FOR ACTION IN THE FIELD OF PUBLIC HEALTH

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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.

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 :

- the ageing population of the Community,
- increasing population mobility into the Community and between Member States,
- changes in the environment and in the work setting,
- rising expectations about what health services can and should deliver, and
- 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 of the communication summarises 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, emphasising that questions of the finance and delivery of care and treatment services are for each Member States 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.

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, cardio-vascular 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 :

- Consultation and participation. Appropriate mechanisms will be set up to give advice to the Commission on formulating and implementing activities.

- 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.

- Cooperation with international organisations 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.

- 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.

- 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.

- 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 disease - specific ones. They are :

- Health promotion, education, information and training,
- Health data and indicators, and monitoring and surveillance of diseases,
- Cancer,
- Drugs,
- AIDS and other communicable diseases,
- Accidents and injuries,
- Pollution - related diseases,
- Rare diseases,
- 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 on 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(0) 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:

- ageing population. The proportion of people of 60 and 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.

- 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;

- diseases asising 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 musculo-skeletal problems are also increasing significantly.

- 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 disavantaged 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.

- 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 1970's and 1980's, health expenditure increased significantly in relation to Gross Domestic Product (GDP), partly reflecting the slowdown in the rate of the economic growth. In the latter part of the 1980's, however, the figures for certain Member States stabilised and even declined as growth picked up. Nevertheless, costs containment remains a topic of major concern in the 1990's 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 (eg, 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 N° C304 of 23.11.1991). This Resolution, and indeed the Treaty on European Union, makes 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 maximised 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 as well as 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 that 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 life style 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/her own health and the modifications he can make to his/her 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 International Children's Fund (UNICEF), the Food and Agricultural 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 characterised by two major trends in the health status of the population of 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 1000 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 1000) was better than the best in 1970 (12.75 per 1000).

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 cardio-vascular 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 cardio-vascular 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 - 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 cardio-vascular 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 in the Community. Overall these figures show a decline in the death rate in the Community from traffic accidents in the period 1970 - 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 cardio-vascular 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.

Table 1

RELATIVE IMPORTANCE OF DIFFERENT DISEASES MEASURED BY HOSPITAL ADMISSIONS AND BED-DAYS +

	FRANCE 1985-1987		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	
Cardio-vascular	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	
Musculo-Skeletal conditions	6.3	7.0	14.8	15.5	
Other diseases	39.1	35.5	23.4	24.3	

+ 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.

20. The data that exist confirm that cardio-vascular diseases are the most important contributors 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 musculo-skeletal 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 :

Table 2
DISEASES PRODUCING HIGH MORTALITY AND/OR MORBIDITY
Accidents
Cardio-vascular diseases
Cancer
Mental illness, including suicide
Musculo-skeletal conditions
Respiratory diseases, including asthma

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 emphasised 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.

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 has 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). On its national rate (51.1) Italy 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:

a. 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.

b. 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 maximise 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.

c. 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.

d. 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

[1]see paragraph 7 on page 4

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 30-39) 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 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(0) 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 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 at 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 minimise 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 status. Treatment, as opposed to prevention, is therefore a matter for 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 of necessity 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 recognises 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 Government 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) [2] 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

[2] OJ C184 of 23.7.1986

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 Community action against the scourges of cancer, drugs, and AIDS.

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, for long 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 important 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 re-affirmed 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 multi-annual 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 organisations. 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. C128, 16.5.1983, p.86)
- European charter of rights of hospital patients (OJ. C46, 20.02.1984)
- Community programme of research into AIDS (OJ. C46, 20.02.1984)
- children in hospital (OJ. C148, 16.06.1986, p.37)
- women in childbirth (OJ. C235, 12.09.1988, 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 3rd 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, health care costs, and research and health policy. The Committee made several proposals for Community action, including calls to the Commission to provide for widescale consultation procedures; establish an epidemiological investigation service; collect, analyze 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 on-going 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 "Inter-group on Health", and to its STOA group (Scientific and Technological Options Assessment).

iv) Economic and Social Committee

46. During the past ten 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 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 communication 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
- cardio-vascular 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 personnal
- 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 minimising 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 organisations 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;

* standardisation 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, which diseases, from among those identified following the two-step procedure, should be tackled as a matter of priority can be determined by seeking to maximise 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 early diagnosis and, thereby, early intervention. Improved capacity for making 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.

Cardio-vascular diseases.

60. There is a general trend towards a decrease in mortality from cardio-vascular 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 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 from 1970-1990, 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 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 injecting 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 the communicable diseases.

Other important diseases.

65. As pointed out in Table 1 above, several other diseases, notably mental illness, musculo-skeletal 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 multi-faceted 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 respectively in December 1990 and which was 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 3-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-Jacob 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 maximise 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 that it is aimed 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 recognised 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.

Table 3

FACTORS IMPLICATED IN DISEASE CAUSATION

DISEASE	FACTORS
Accidents	Drunken 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
Cardio-vascular 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
Musculo-skeletal conditions	Poor working environment, physical stress, nutrition, lack of exercise
Respiratory diseases, including asthma	Environment problems, including pollutants, smoking, genetic factors

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 risks 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 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 micro-biology 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, 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 1976-1990 the total consumption decreased in six northern States by between 13.4% in Denmark (from 1801 to 1560 units per year) and 25.5% in the Netherlands (from 2086 to 1555 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 1122 to 2109 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 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 emphasised 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 organisation 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 organisations and non-governmental organisations 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 organisations 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 organisations and third countries, information, education, health promotion, training and research, which are further discussed below

TABLE 4

POSSIBILITIES FOR COMMUNITY ACTION

TYPE OF ACTION HEALTH THREATS AND DISEASES	Health data indicators	Surveillance Monitoring	Health Information Public	 S pecific groups	Health education / promotion	Training of health professionals	Cooperation between Member States	Policy co-ordination	Strategy formulation & implementation	Use of instruments in other policies	Financial support	Surveys, studies	Cooperation with internationasl organisations 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	****	***	****	***	****	***	***	***	***	****	**	****	**	*
Muscolo-Sceletal problems	**	*	***	***	**	**	**	*	*	**	**	**	**	*
Visual problems	**	*	**	**	**	**	**	*	*	**	**	**	**	*
Auditory problems	**	*	**	**	**	**	**	*	*	**	**	**	**	*
Mental disorders suicides	****	*	*	**	**	**	**	*	*	**	**	***	**	**
Nutrition related disorders	**	*	*	**	**	**	**	*	*	**	**	***	**	*

**** = HIGH *** = MEDIUM ** = LOW * = NONE

TYPE OF ACTION HEALTH THREATS AND DISEASES	Health data indicators	Surveillance Monitoring	Health Information Public	 Specific groups	Health education / promotion	Training of health professionals	Cooperation between Member States	Policy co-ordination	Strategy formulation & implementation	Use of instruments in other policies	Financial support	Surveys studies	Cooperation with internationasl organisations and third countries	Other specific preventive actions
AIDS	****	****	**	****	****	****	****	****	****	***	****	****	****	****
Other communicable diseases	****	****	**	****	**	****	****	****	****	**	****	****	****	***
Rare diseases	***	***	*	***	*	***	****	***	**	*	**	***	***	**
Food borne diseases	***	***	**	**	**	***	***	***	**	***	**	***	**	**

**** = HIGH *** = MEDIUM ** = LOW * = NONE

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-governemental organisations will be recognised.

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' policies 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 underway concerning communicable diseases, and appropriate iniatives will be taken concerning other diseases, building on systems and arrangements already existing, e.g. on cancer.

(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 categorised 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 (TV 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 or accidents (cancer, AIDS, drugs, cardiovascular diseases, accidents, etc), 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 organisation 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:

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

- lend support by providing appropriate incentives;

- initiate, generate, and coordinate, as necessary, activities at Community level.

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

c) 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 130 millions ecus.

98. Current research covers four main areas:

- coordination of research on prevention, care and health systems,
- major health problems and diseases with an important socio-economic impact,
- human genome analysis,
- 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 underway 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 4th 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 1994-1998:

- AIDS, tuberculosis and other infectious diseases;
- cancer;
- pharmaceutical research;
- neurosciences and brain research;
- prevention, occupational health, risk factors, and public health research;
- epidemiology of illnesses with a major socio-economic impact;
- cardiovascular diseases;
- human genome analysis;
- health services research;
- biomedical technology and engineering;
- 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 100 million ecus for the period 1991-1994, are intended to improve the quality and cost-effectiveness of health services by the use of "telematics", i.e. 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:

- the identification based on clear priorities agreed at Community level of those aspects of public health that need stimulus and promotion through research,

- coherence between public health actions and research activity,

- a clear strategy covering those matters relevant to public health topics,

- the step by step establishment of appropriate structures e.g. networks.

- the proper dissemination of research results and their impact on decision 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 multi-cultural dimension, e.g. the role of nutrition, migration (e.g. related to thalassaemia and HIV), and

their knowledge of conditions that are gaining in importance (e.g. 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 organisations and third countries

105. Whilst cooperation with third countries and international organisations 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 organisation. 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 organisations (Art. 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 organisations 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 organisations in the field of public health it is necessary to have good knowledge of on-going and planned cooperation between Member States and third countries and international organisations. 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 organisations, both governmental and non-governmental have health on their agenda. The main organisations concerned are: WHO, Council of Europe, International Organization for Migration (IMO), UNESCO, International Atomic Energy Agency (IAEA), OECD, ILO, FAO, United Nations international Drug Control Programme (UNDCP), International Federation of Red Cross and Red Crescent Societies, and the International Council on Alcohol and Addictions.

108. Agreements in various forms have been established with most international organisations, and in one instance the Community has become a full member of an international organisation (FAO, 1991). With the exception of WHO, whose activities encompass all health matters, other international organisations 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 organisation.

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

- to strengthen the public health actions within the Community, as well as those undertaken outside the Community but which have an impact on it;
- 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 organisation 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, as for example 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-CEC collaboration has been transmitted to 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 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:

- 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).
- in areas reserved for cooperation between the Member States, the Commission can enlist the help of such organisations, in conducting joint programmes and actions which benefit some or all of the Member States.
- in areas where the international organisations 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) Cooperation with 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 on-going 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 in 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 benefitting 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 focussed, 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 organise 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 on nutrition and on smoking in relation to cancer and to cardio-vascular 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 furthered by measures based on Article 129, or indeed other appropriate Articles of theTreaties.

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 cardio- and cerebro-vascular

disease, mental disease, congenital defects, perinatal conditions , and musculo-skeletal 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 occurrence 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 multi-annual 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 PREVENTIVE 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:

- mid-term priority setting;

- coordination of local and regional initiatives which fit well with the overall, national and community context;

- integration of sectorial approaches into a general health promotion frame; for example school health, mental health, drug prevention, and child and family issues;

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

- provision of adequate resources for specific preventive action, notably in the field of AIDS, cancer, cardiovasuclar diseases, perinatal mortality , accidents, tranmissible diseases and mental health;

- action by the authorities assisted by other partners such as the "Flemish Health Promotion Institute" which, since 1991, constitutes an important forum for all organisations concerned with health promotion and education;

- other coordination mechanisms have also been set up in specific fields , such as AIDS, tobacco prevention, alcohol and drugs, cancer, etc.

- 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 programme, published in 1989, gave priority to programmes on cancer, cardiovascular disease, accidents, psychological problems and musculo-skeletal 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 decentralised 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 health 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 utilisation 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, e.g. 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 by the Central Health Council which comprises experts from across the health professions. Specialised quasi-governmental 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 nation-wide donation campaigns.

5. SPAIN.

The general health policy 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 with 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) iii) and 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 Minster for Health in order to give advice on public health questions and policy . This Committee is at present re-shaping 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, STD's, 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 immunisation 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 will propose a national health strategy which will, in particular, include a strategic plan for health promotion, map 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 (N° 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 Art. 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 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 Organisations.

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 1970's preventive action has been an integral part of the overall Health Policy in Luxembourg. This was reflected in the re-organisation 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 cardio-vascular diseases, and on cancer. In addition to this, a special programme has been launched to promote healthy nutrition and healthy lifestyle.

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 being 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, etc.

Preventive activities are carried out by national specialised 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 cardio-vascular 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 rationalise existing human resources and promote a better distribution of medical health care personnel. The Ministry of Health is carrying out specific programmes on: 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 UK is made up of four parts:

- screening and immunisation programmes including breast and cervical cancer screening, and immunisation of all children for diphtheria, tetanus, whooping cough, polio, measles, mumps, rubella, BCG and HIB.

- specific health iniatives, 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 stroke, 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.

- health promotion and education activities. 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.

- 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, Vol. 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 link closely with the Community's Public Health measures in the field of toxicology and poison centres [1].

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 on the components of food products. To this end, the Commission has instituted a major nutritional study under the "Europe against cancer"[2] programme.

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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

2 European Prospective Investigation of Cancer, Nutrition and Health (EPIC) 1998/9 - 1998

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 accident [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 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 1408/71/EEC, 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 organisations 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.

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[3] Council Directives 65/65, 75/318 and subsequent legislation

[4] Council Directive 90/385/EEC of 20.6.1990 (OJ L 189 of 20.7.1990) and Council Directive 93/42/EEC of 14.6.1993 (OJ L 169 of 12.7.1993)

[5] Council Directive 88/378 of 3.5.88 (OJ L187 of 16.7.88)

[6] Council Directive 92/59

Disease prevention and health promotion

The Community's public health activities since the mid-1980s have gone beyond control and protection from environmental and workplace health hazards to the encouragement and coordination of measures to combat major diseases and positively to promote health.

The Community's programme to combat cancer (1987-1989) 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 ten-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, mid-way through its implementation, has 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 (1991-1993) has ten 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-infected 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. 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:**

(1951-1957): 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 :

- 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 (Ch. III)
- safeguard inspections and training of inspectors (Ch. VII)
- conclusion of agreements or conventions with international organisations, third countries (Ch. 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 & 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 aspects of health and safety at work (Article 118a), and twelve 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 L196, 16.8.1967 p.1)

1976: Council Directive relating to restrictions on the marketing and the use of certain dangerous substances and preparations (OJ L262 27.9.1976, p.201)

1982: Council Directive on the major accident hazards of certain industrial activities (OJ L230, 5.8.1982, p.1)

1993: Council Directive on principles for assessment of risks to man and the environment of substances

2) **Air**. Example include :

1970: Council Directive concerning air pollution by emissions from motor vehicles (OJ L76, 6.4.1970, p.1)

1982: Council Directive on a limit value for lead in the air (OJ L378, 31.12.1982, p.15)

1985: Council Directive on air quality standards for nitrogen dioxide (OJ L87, 27.3.1985, p.1)

3) Directives on **waste** (OJ L194, 25.7.1975, P.39) waste water treatment (OJ L135, 30.5.1991, p.40) waste prevention of air pollution from waste incineration plants. (OJ L163, 14.6.1989, p.32; OJ L203, 15.7.1989, p.50)

4) **Noise** (motor vehicles, aircraft, construction plants, household appliances, etc.) (OJ L42, 23.2.1970, p.16)

5) **Water** (drinking water quality, bathing water) (OJ L347, 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 list 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 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 Directive 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 good 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 n° 2309/93 (Article 235 if the EEC Treaty) and Council Directives 93/39/EEC and 93/40/EEC (Article 100a) creating an European Medicines Evaluation Agency 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, para. 2, of the EEC Treaty).

▷ **Medical and para-medical 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 EEC Treaty)

Followed by the:

- Council Directive concerning the mutual recognition of diplomas of nurses (1977); of dentists (1978); of midwives (1980); 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 Drugs 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 organisations: 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; standardisation, 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 specialised 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 commercialisation 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, sub-programme on medicine, health and nutrition in tropical and sub-tropical areas.

* **Culture, Communication and Information**:

People's Europe: activities aimed at young people, e.g. drugs, AIDS; sport.

* **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 1: human genome analysis; biomedical ethics; research on health services and technologies and diseases associated with lifestyle: AIDS, cancer, drugs, ageing, quality control. 4th RTD programme: preventive and epidemiological research on diseases with major socio-economic 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 countriess.

* **Social and health statistics**

Annex IV

IDENTIFICATION OF "MAJOR SCOURGES" IN THE EUROPEAN COMMUNITY

Disease / Health Problem	Standardised death rates per 100,000 or incidences per 100,000 (estimates)	Costs for Health Services (and other costs e.g. absenteeism)	Practical possibilities for prevention	Community Added Value (opportunities for intervention)	"Major Scourges" (major health problems)	Previous Community public health action
CANCER	337	***	***	****	****	****
Cancer of colon	29					
Lung cancer	42					
Digestive organs	62					
Breast cancer	33					
Prostate cancer	19					
DISEASES OF THE CIRCULATORY SYSTEM	338	****	***	****	****	**
Hypertensive disease	16					
Acute myocardial infarction	90					
cerebrovascular	90					
ischaemic heart disease	137					
RESPIRATORY DISEASES		***	***	***	***	**
Bronchitis, emphysema , asthma	17					
Congenital abnormalities	5	***	****	***	*	**
Perinatal conditions	5	***	****	***	*	**
ACCIDENTS (including poisoning)	51	****	****	****	****	**
Motor vehicle accidents	15					
Drug and alcohol abuse		***	****	****	****	***
Musculo-skeletal problems		****	***	***	***	**

**** = HIGH *** = MEDIUM ** = LOW * = NONE

Disease /	is death rates per , or ncidence per	Costs for Health Services (and th sts e.g. absenteeism	Practical possibilities for prevention	mmunity Added Value o rtu iti for	"Major Scourges" (major health problems)	Previous Community public health action
Visual problems		**	**	*	*	*
Auditory problems		*	**	*	*	*
Mental disorders suicides	13	****	**	*	***	*
Nutrition related disorders, including diabetes, dental caries		***	***	***	**	***
AIDS	2.41 (incidence)					
OTHER COMMUNICABLES DISEASES, E.G. sexually transmitted diseases and tuberculosis		*** ***	**** ****	**** ****	*** ***	*** ***
CHILDHOOD INFECTIONS, e.g. Measles	51 (incidence)	**	****	****	*	*
rubella	26 (incidence)					
other childhood infections						
RARE DISEASES, e.g. Thalassaemia , sickle-cell anemia, rickets		*	***	***	**	*
FOOD BORNE DISEASES , e.g. salmonella poisoning		**	****	****	***	*

**** = HIGH *** = MEDIUM ** = LOW * = NONE

ANNEX V

STATISTICAL DATA

Total and public expenditure on health care in relation to national expenditure in the Community, 1970, 1980 and 1991

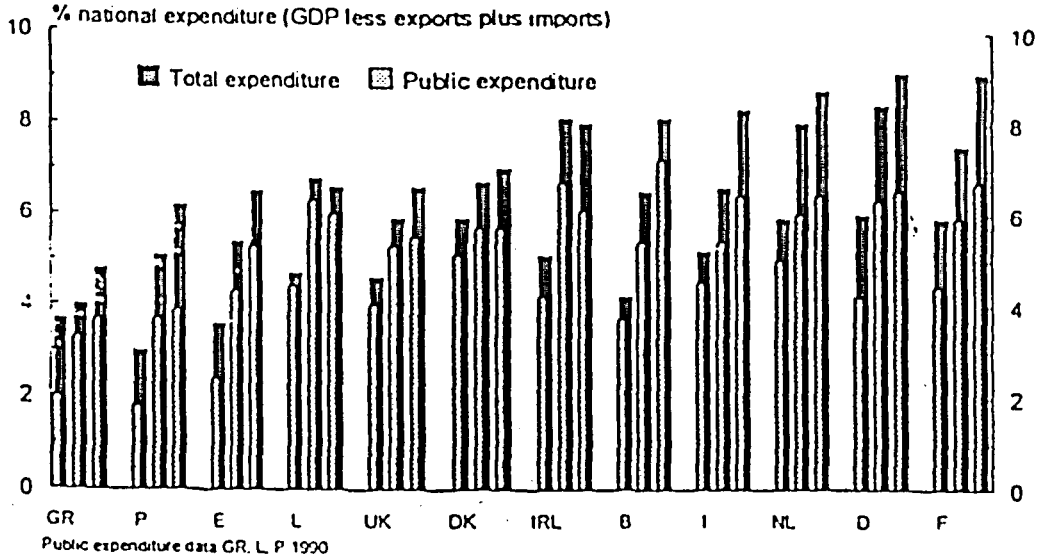


FIGURE 1

Temporal distribution of causes of death EUR 12

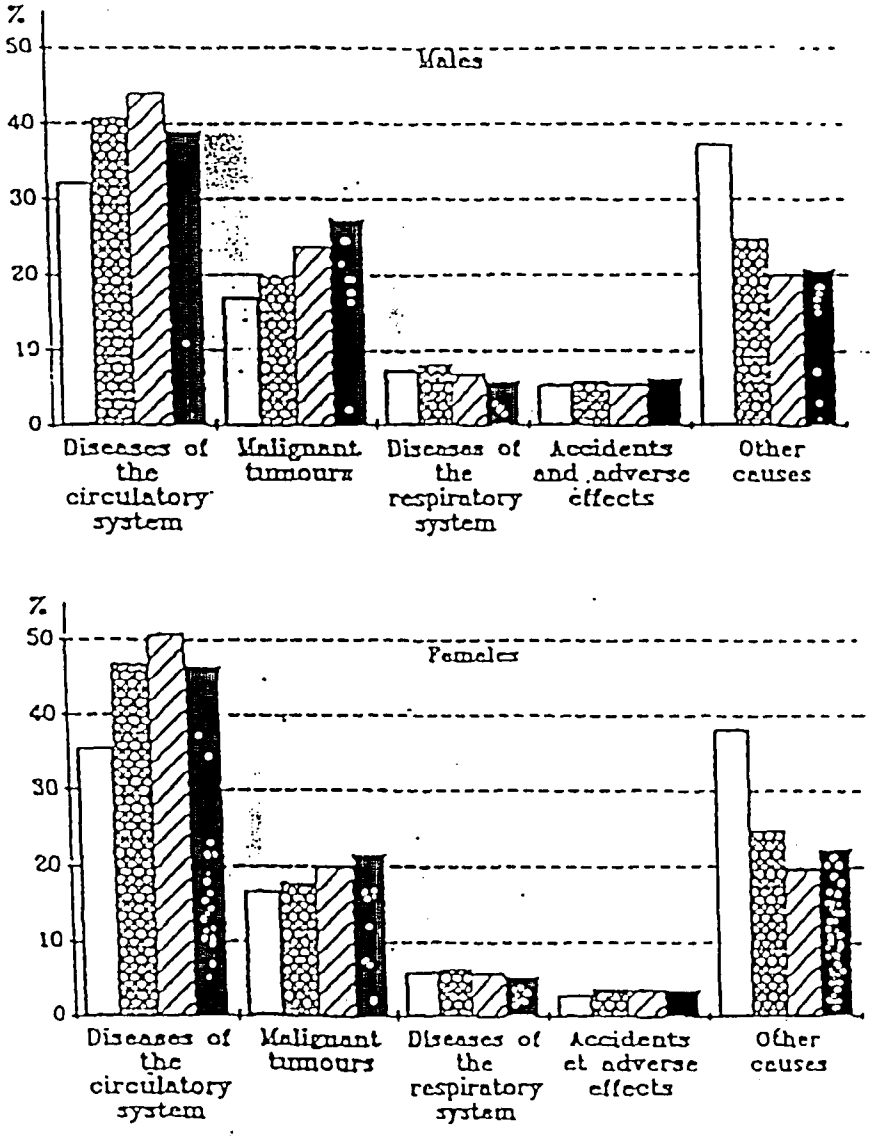
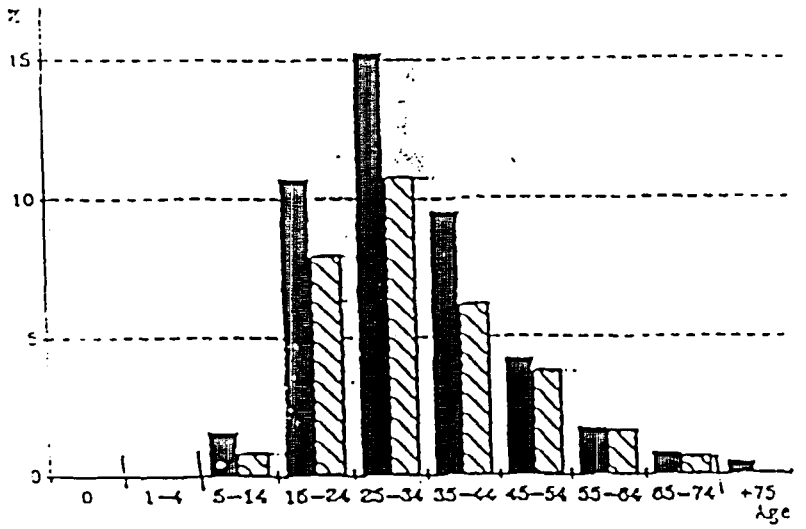


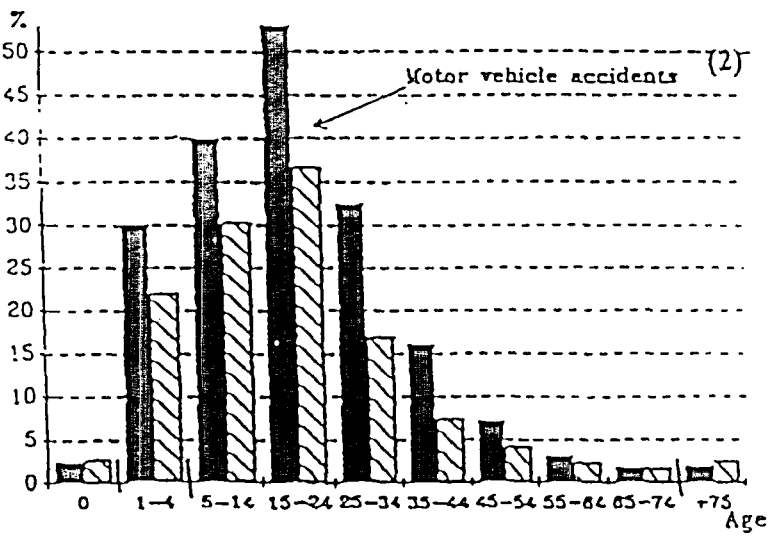
FIGURE 2

Causes of deaths by age group - EUR 12 - 1989 (1)

Suicides



Accidents



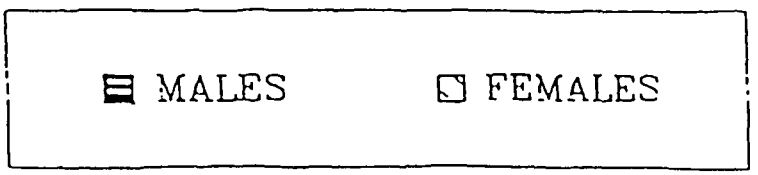
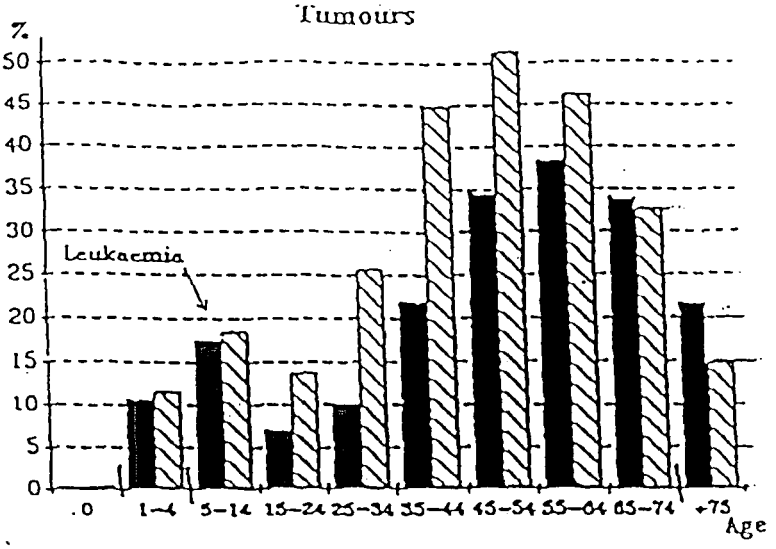
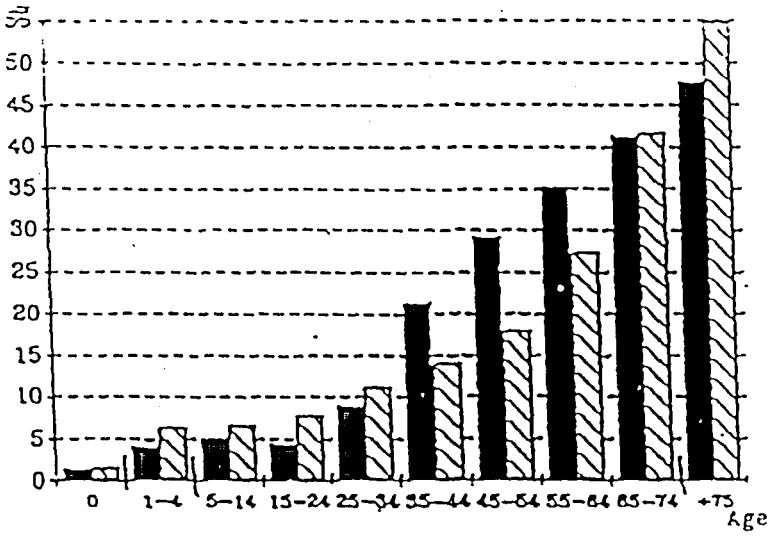


FIGURE 3

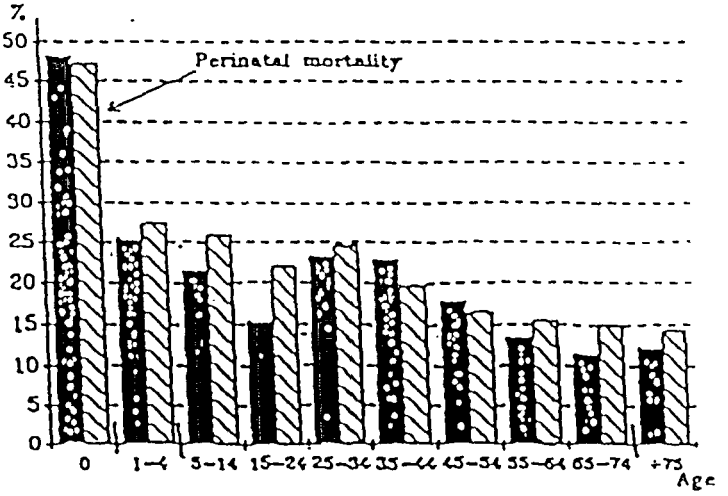
Tumours



Diseases of the circulatory system



Other causes (3)



(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-uninary system, of the nervous system, of the blood, skin etc.

FIGURE 4

TABLE 5
LEADING CAUSES OF DEATH BY AGE AND SEX

IN THE EUROPEAN COMMUNITY

Age	Male	Female
under 1 years	Hypoxia, birth asphyxia & other respiratory conditions	Hypoxia, birth asphyxia & other respiratory conditions
1 - 4 years	Motor vehicle accident	Congenital anomalies of heart & circulatory system
5 - 9 years	Motor vehicle accidents	Motor vehicle accidents
10 - 14 years	Motor vehicle accidents	Motor vehicle accidents
20 - 24 years	Motor vehicle accidents	Motor vehicle accidents
28 - 29 years	Motor vehicle accidents	Motor vehicle accidents
30 - 34 years	Motor vehicle accidents	Suicide
35 - 39 years	Suicide	Breast cancer
40 - 44 years	Acute myocardial infarction	Breast cancer
45 - 49 years	Acute myocardial infarction	Breast cancer
50 - 54 years	Acute myocardial infarction	Breast cancer
55 - 59 years	Acute myocardial infarction	Breast cancer
60 - 64 years	Acute myocardial infarction	Breast cancer
65 - 69 years	Acute myocardial infarction	Acute myocardial infarction
70 - 74 years	Acute myocardial infarction	Acute myocardial infarction
74 - 79 years	Acute myocardial infarction	Acute myocardial infarction
80 - 84 years	Acute myocardial infarction	Acute cerebrovasc. disease
over 85 years	Diseases of pulmonary circ. & other cardiopathies	Diseases of pulmonary circ. & other cardiopathies

Source : World Health Organisation