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A round table on health from a European perspective

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People and goods move around Europe more freely than any other comparable regional block. That makes us vulnerable to the spread of infections. Despite many inequalities in infection risk and access to healthcare across the EU, there is no requirement for countries joining the EU to have good public health capacity. This is in striking contrast to the requirements for animal health. Round table participants looked at the arguments for making minimum standards for public health a requirement of EU membership

Round table participants



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High standards for animals in EU – not people

Delyth Morgan Hello and welcome. Let's make maximum use of our time with Rosie and ask her to give a few thoughts to kick us off.

Rosie Winterton Thanks. Goodness, we have a room full of experts.

What are the challenges that Europe faces, particularly as we go through the enlargement process and the demographic changes?

We have an ageing population and there are increasing expectations from the public, not only about healthcare systems, but also about what they want to know about their own conditions.

The economic challenges are quite enormous. They come from changes in medical technology and drugs that come on the market, pushing up the costs of healthcare throughout Europe. Patient mobility and staff mobility within the EU present particular challenges and there are also globalisation issues around the effect that common European action, for example, could have on developing countries.

When we come to things like pandemic or avian flu, we face the challenges of the globalisation of disease and what has been done or is being proposed at European level, and how far we should be joining in and encouraging that.

You are aware that the challenges of chronic diseases, such as diabetes and mental health conditions, can be strongly linked with health inequalities. We can look at things like poor diet and its effect on diabetes, unemployment and its effect on mental health; things that apply across all sectors.

The challenge for us is to determine what we can tackle at member state level and what we can do at the European level. During the UK presidency we placed particular emphasis on things like health inequality, patient safety and mental health. Very often that was about what is considered best practice in different countries and where you could take action

at European level, for example, around things like food labelling.

The member states are very anxious to be able to retain control over healthcare systems and healthcare is not included in the services directive and the implications of some of the European Court of Justice (ECJ) decisions. Questions are being asked about whether legislation in health matters should be considered and to what extent that needs to preserve the obvious desire of member states to be able to control their own health systems.

Recently, as health ministers, we put together a set of common values and principles about what it is that European citizens should expect. Generally, that is equality of access, universality of provision, high emphasis on patient safety and emphasis on eliminating health inequalities. Collectively, we are saying that these are the issues we agree should form the basis of our healthcare systems. At the moment there is an argument that, in a sense, because there is no legislation that can influence that, judgements come out of the ECJ that are open to different interpretations. John Bowis MEP has done a lot of work on this. So those are the fundamental issues before us at the moment.

Delyth Morgan Regarding the value statement that you are talking about, was it a challenge to produce a common set of values? Was that very difficult? Did you see that as a starting point for future common initiatives?

Rosie Winterton In fact there was consensus around it quite quickly. People were very keen that health ministers were able to express a view as to the type of issue that ought to be taken into account if there were proposals or legislation.

At the moment, the idea is that the European Commission is going to come forward with what will

probably be quite an open document as to whether these are the questions that are before us, whether there should be legislation and, if so, what form that should take. There was a consensus that people did want the ability to be able to pursue their own policy objectives within healthcare systems. They did not want interference and being thrown off course.

Clive Needle This government, among its mistakes, has had to be dragged, kicking and screaming, to the European table to make the progress that is now happening. If I think back to 1999, the concept of health inequalities at a European level was completely misunderstood. I can remember various members of the European Parliament saying, “This just means that you want a socialist-type Europe, with all the hospitals and all the health services being run by the European Commission.”

The amount of information that has been made available has increased. While this is partly due to the work of the European Commission, it is also a result of the rulings of the ECJ, which have increasingly prompted member states to come together when they realise they have to take action.

It is a time of fundamental change. There are massive democratic changes. The technological revolution that is happening on a global scale is having a massive impact on the ability of people to exchange information between and within countries. There is a potential threat of increasing inequalities between those with access to information and the power to act on it and those who are without that. What is not happening is implementation. I am not convinced that member states have the power to act alone because regionalisation is increasingly an important factor in healthcare delivery.

Charles Tannock My party would far rather have co-operation, co-ordination and intergovernmental

agreements that are agreed by democratically elected politicians than EU legislation that is binding. John Bowis has been very proactive in parliament on the issue of patient mobility and there is a much greater public awareness, of human rights and the right to health, which is one of the clauses in the, as yet unpassed, European Charter for Fundamental Rights and Freedoms. I think the public has a perception that their country being a member of the EU has added value because they can go to another European country and be provided with some safety-net type of healthcare. The new health card, which came out of the European Commission, is one of the more positive initiatives.

The enlargement of the EU brings in a whole load of new questions. On one side, there is the issue that these countries are much poorer. However, their economies are growing very rapidly. They are catching up with the EU average and they are beginning to spend much more money on their health services, because that is something that they need to address. The other question, particularly with the accession of Romania and Bulgaria, is that they have a very large rover population, three to four million strong, which does have huge health problems. One of the more alarmist predictions of the tabloid newspapers back in 2003, was that we would see a huge influx of these people coming to this country seeking healthcare or whatever, but it did not come to pass. Clearly, it remains an issue and these issues will need to be addressed.

To what extent the EU gets involved remains to be seen. My party would prefer to see this done by intergovernmentalism.

The internet means it is now much easier for members of the public in different jurisdictions and countries to be aware of the different treatments that their peers receive and compare that with what they are receiving in their home countries. We see this within our own country now with postcode rationing of expensive drugs. This will now occur at a supranational level. Will there be a flurry of litigation going to the ECJ demanding remedy? These are the questions we will have to address.

Angus Nicoll At the European Centre for Disease Prevention and Control, we have had the privilege of going into a number of European countries, to look at how prepared they are for pandemic and bird flu. It is interesting that this has been done as a joint assessment, without any legislation. It has revealed all sorts of very interesting things.

First, there is the diversity. Not all differences are inequalities. There are certain things that represent democratic differences or historical differences and they do not have to be evened out.

On infection, one of the interesting issues that arises is what you do inside Europe when you find a

The danger is that there could be increasing inequality between those in Europe with access to information and the power to act on it and those who are without that
Clive Needle



Romania's mental health budget – for 23 million people – is the same as that for Wiltshire's mental health trust, which provides for 747,000 people
Rodney Elgie



country that represents a bit of a threat. The UK suffered a bit like that with BSE and Creutzfeld-Jacob disease but it is now happening the other way round with, say, food poisoning. Because of the freedom of movement of goods around Europe, certain countries are exporting infections because they have not got their act together in their own countries. I am thinking particularly of salmonella in eggs. You could say that the citizens in those countries are at a big disadvantage with their health, compared with people in the countries where agricultural systems have managed to stop that problem.

It is interesting to see the impact that becoming a member of the European club has. There is a lot of money that goes into strengthening animal health services and the state veterinary service, which is almost a condition of membership. However, you do not find a complementary investment in the state public health services. There is no European jurisdiction over that.

In the future it might be possible for us to have European legislative jurisdiction for certain areas of public health – infection being one of them – because that is one way a country can threaten another. That doesn't mean you are going to tell a country how to run its health service, but you can point them towards another country where they are getting it right so that they can learn from them.

Rodney Elgie One of the key influences for me is the information and education of patients. We have been battling long and hard with the European Commission to get information to patients. The Directorate General for Enterprise and Industry started an initiative back in 2001 and it created two committees, one looking at information and one looking at advertising. I was delegated to write to the commission and say, "Would it not be a good idea to have at least one patient representative on each of

these committees, looking at advertising and information?" The response came back, "No, we do not need you. We have the composition of the committees established, no problem whatsoever." John Bowis and I both appealed to the Directorate General for Enterprise and Industry and the Directorate General for Health and Consumer Affairs (DG SANCO), but they kept playing us off against each other, telling each of us that it was the other's responsibility and denying the existence of the committees. That was the barrier that we came across.

The issues were raised with the G10, which looked at information and also the value for money and innovation of drugs but, again, there was no patient representative. We criticised that and now we have a pharmaceutical forum where we do have a seat, and seats on the three subcommittees looking at information to patients, pricing, reimbursement and health technology assessments. However, this has been going on for five or six years and I am concerned that nothing will really come of it.

The original idea of information for patients was limited to Aids, asthma and diabetes, because there are very strong patient organisations in these three areas and commonality of treatment. Really, it was nothing to do with the European Commission, but the "big five" (the UK, Germany, France, Spain and Italy) did not really want well-informed, well-educated patients and preferred to have it contained in three disease areas. Meanwhile, the world was passing them by. Now, at the pharmaceutical forum, we see that they are again looking at diabetes and cardiovascular diseases. Again, we cannot see why. If we are going to overcome an ageing population and a decrease in the number of carers, we want ordinary citizens moving from ignorance to information, to education, to empowerment and then to real involvement in their own healthcare.

Within my own area of mental health, it is a different world. Romania's mental health budget is the same as that of the mental health trust in Wiltshire. There are 23 million people in Romania and only 747,000 people in Wiltshire, so Wiltshire spends 30 times more per person. When they were looking at accession, some of us went to do a study in Romania and I saw that they have a 200-bed psychiatric hospital with 420 patients — that's two or three to a bed — in the middle of nowhere. The mental health patients are treated by ordinary domestic people because there are no nurses there.

When you look at the cost-effectiveness of treating mental illness in Moldova, you find that 80 per cent of mental health patients die within ten months of being admitted to a psychiatric ward because they are not fit. The most cost-effective way is to kill them off.

Ilona Kickbusch We have to be very careful when we talk about health or health policy that we do not only

look at the care issues. One of the really challenging areas for health in Europe is public health. Steps to improve public health provision have been taken — via tobacco policy, for example. I think, particularly with the new countries and the inequality issues, we can no longer avoid having European public health standards and we need countries that come into the EU to reach those standards. This brings in a whole lot of dimensions, ranging from infectious disease and surveillance to research.

I was working at the World Health Organisation (WHO) when the Soviet Union disbanded and the new countries came into the WHO in their own right. The WHO set up a list of matters of urgency. I was head of the Department of Lifestyles and Health and we saw, as a matter of urgency, good Aids legislation and good tobacco legislation. However, it was other things such as care issues that were always brought to the table.

European countries need to be aware of public health issues and to push them with a political awareness. The responsibility of some of the older and more developed European countries is important. That is not to say that all of them have such strong public health systems. When I think of my own country – Germany – I blush. This has to be a European move and, once that is clear within the EU, it then has to go that step further in terms of neighbourhood policy. There are larger international responsibilities and there are values that Europe needs to stand for in its international health work. That is a big issue here.

Health is one of the largest and most rapidly growing businesses within Europe. Within Germany, for example, there are a couple of regional states that have developed health-market strategies in an attempt to position themselves in competition with other areas within Germany: for the best treatment in hospitals, for research, for wellness

centres and for health tourism. If I think of all the German doctors who earn their money at weekends in England, that gives me an indication. It's nothing new, but something is going on that national healthcare policies need to respond to. The EU, in its totality, needs to consider how that market should grow and what opportunities it gives to new member states.

If it is cheaper to have your teeth done in Hungary, let us encourage that, but let us ensure that the quality of care is what it should be, with good agreements or legislation. If you look at the Lisbon Agenda, the health market is part of the growth opportunities of the member states. If Hungary has highly trained people, why should patients prefer treatment in the UK rather than alongside a nice Hungarian lake?

There is an experiment going on between Switzerland and Germany in the Basle area to see how each can use the other's health services without a problem and what each can gain. Germany is cheaper than Switzerland, for example, and the Swiss insurance companies are now asking their patients if they are willing to be treated in Germany.

Delyth Morgan How does patient safety come into all this in terms of regulation when sharing information and standards?

Ilona Kickbusch This cross-border collaboration is an experiment right now. There need to be agreements and legislation. The standard of professionals is very high, but the technology is not available in every country. Enormous dynamic changes are going on. People are moving, professionals are moving, the market is moving and we have the internet.

Our healthcare debates and our health policy debates are incredibly staid, when, instead, we should be trying to encourage patients and consumers and industry to develop good care for everyone by making those resources we have available to everyone. Doing that would address a lot of inequalities.

Kate Lloyd It is interesting to think about the contextual and cultural differences in healthcare and the situations in which those matter less. When the pharmaceutical industry does research, it does it globally. We would recruit patients for a given study across the whole of Europe, including Lithuania, Latvia and Estonia, where the quality of the work is extremely high. In general though, in the UK it is difficult and slow to start studies because of the procedures that are required and the fact that we have to negotiate hurdles that operate in series rather than in parallel.

Delyth Morgan Regarding the European directive on clinical trials, I have heard all sorts of stories about inequality there.

If it is cheaper to have your teeth done in Hungary, Let us encourage that, while ensuring that the quality of care is what it should be

Ilona Kickbusch



When a patient phones a pharmaceutical company with an adverse-event report we take it very seriously. We would like to give them appropriate information, but we cannot
Kate Lloyd



Kate Lloyd That was not really my point, although that is an issue. The UK has adopted the European Clinical Trial Directives a lot more rigorously than other parts of Europe, but it is clear that you can have trans-European clinical research done in countries where the quality of normal healthcare is very variable and where the cultural expectations of people are very variable.

To have clinical studies that produce evidence-based medicine guidelines seems to me something that could be adopted without thinking about national borders and it is very important.

On Rodney's point about information, what is available to patients is of very variable quality. Interestingly, the pharmaceutical industry, which can only deal with evidence-based medicine, is prohibited from talking to patients about prescription medicines. It is not that we want an American-style direct-to-patient advertising of a product. What we would like is to be able to give good quality-assured information to patients in an appropriate way, perhaps to counter some of the slightly whackier bits of information that they can get on the internet.

When patients phone up a pharmaceutical company with an adverse-event report, we take it extremely seriously. We want to gather all the information we can, but they want some information in return and we cannot give it.

Understandably, patients sometimes get infuriated and perplexed by that. It seems fundamentally wrong that the people who know most about a medicine cannot convey that information to the people who want to know.

Delyth Morgan I will play devil's advocate here; there are some sound reasons for that, are there not?

Rosie Winterton Can you not say to that person, "You need to go to your doctor and your doctor can

get the information that is relevant to you as an individual, because we don't know your condition"?

Kate Lloyd Of course we say that. However, patients think it is wrong that they should be treated like that. Rodney was talking about more educated patients who expect to be treated as intelligent people. We think it is an unfortunate barrier.

Charles Tannock As a retired clinician I think that this is a ludicrous protectionist attitude, rather paternalistic of the medical profession, even though I am a member of it. I think that whatever is in the data sheets should be freely available to all patients. Sometimes, when you buy the product, you get a data sheet included in the package.

Rosie Winterton It can be given out with the medicine?

Kate Lloyd Yes.

Rosie Winterton But cannot be spoken about over the phone?

Charles Tannock That sounds like a bit of nonsense, really.

Suzanne Wait The big problem is that, even if the patient information sheet is available for patients, it is completely unintelligible for most people. That is not necessarily the pharmaceutical industry's fault, because the patient information sheet is a regulated document. People have been saying this for years and years and yet there is this blockade in terms of that information. Why can we not move to a stage where we figure out what patients need to hear? We can probably do a survey of pharmacists, doctors, pharmaceutical companies, and get the information translated so that those questions can be addressed.

Sally Greengross What about the Freedom of Information Act? Why can I not get information if it is available on the internet?

Kate Lloyd If you are right about the freedom of information request, (I would need to check that out) we would probably be obliged to give it to you, but that could put us at risk under the Medicines Act.

Charles Tannock A sledgehammer to crack a nut, by the sounds of it.

Rodney Elgie I think it is more a matter of human rights than freedom of information. I think that you have the human right to know what it is you are taking into your body.

I find it quite absurd that, as an ordinary human

being, you can decide whether something is promotional in terms of a washing machine, a mobile phone, a car or a telephone, but, once you become a patient, apparently you become totally naïve and cannot sort out the wheat from the chaff.

If I decide to buy a car, I can go to the garage and test-drive the car; I can get information about the performance of the engine. I can also choose whether to have metallic paint, leather upholstery or PVC. I can get the detailed technical specifications from the manual that is produced by the manufacturer. Why then can I not go direct to the pharmaceutical company and get some information?

Most people that I know as patients want that information and want to be able to approach the pharmaceutical company that made the drug.

Delyth Morgan What about when you have a class of drug; when you have a group of companies or a lot of companies who are all interested in promoting awareness and commitment to a particular class of drug? An example would be the aromatase inhibitors, where there have been concerns about the extent to which some pharmaceutical companies are involved with particular patient organisations. We need to take these circumstances seriously, if a practical way forward is to be achieved. From my point of view, looking at the work of patient organisations in the UK, such as Macmillan and Cancer BACUP, we produce a lot of very useful information with industry support.

I have worked with and led patient organisations in the past and have found that, if you are very clear about the basis on which your relationship is founded, then you have a very strong and fruitful relationship that can bring vital resources to patient organisations.

That then brings me on to the whole question of cross-fertilisation of ideas and experience across

Europe, and I know that the experience of the voluntary sector outside Europe is very different.

Rodney Elgie There is a code of conduct and there is a transparency directive in terms of where you get your information and whether it is biased. But, so far as I am concerned, there is only one pharmaceutical company based in New Jersey that actually wants anything approaching what we have in Europe.

Hanna Edenhalm I want to go back to the issue we initially started discussing, that of the basic healthcare standards that would be pan-European and that all member states would be required to abide by. I absolutely agree that there is a dire need for something like that. Whether or not the states would be reluctant to support such standards is another matter but this is not a measure of whether such an approach is needed or not.

We are witnessing unparalleled economic growth in many of the new member states in Europe, yet, in the vast majority of cases, this economic progress is not translated into the social context.

Progress in this area is not happening. Even the successes that many of those countries had managed to achieve in the past are now being reversed. The old Soviet model of healthcare was, for example, immensely successful in the eradication of contagious diseases and in reducing child and mother mortality rates with simple obstetric care and simple interventions. Where it was found significantly wanting was in the treatment of non-communicable diseases, for a variety of reasons, including lack of foreign currency to purchase modern technology and lack of easily attainable scientific information. Suffice it to say that treatment regimes were unorganised, laboratory-based and unsuccessful.

Where many of those countries have been successful in the past in the treatment of contagious diseases, we are now seeing higher rates of mortality and morbidity. This is largely because of the inability of these countries to respond to changed patterns of certain diseases; the development of new pathogens and resistance to antibiotics. These issues require constantly adapted approaches and medical treatment. Obviously, you will reduce health inequality to a large extent through an excellent publicly-funded health service and an excellent publicly-funded education service. These are the two *sine qua nons* but they are not sufficient.

Health inequalities will never be reduced unless social and economic inequalities are reduced. The fact that a service exists does not mean that everybody has access to it, because there may be real or perceived obstacles. Sadly, many new member states lack screening programmes, but, even where they do exist, there are a lot of social and economic groups where people – for example those in Roma

Patient organisations, such as Cancer BACUP and MacMillan, produce a lot of useful information with support from industry
Delyth Morgan



Several NGOs are proposing that access to healthy and safe food should be incorporated into CAP as its key objective, as a basic human right in Europe

Hanna Edholm



communities – do not have access to the programmes. Sometimes, even if they do have access they are not aware that they need medical help.

What happened after the collapse of the Soviet Union was that the old, inadequate, healthcare system was dismantled but nothing tangible has been built in its place. In most countries, a network of insurance schemes has been set up and it is now very much about supply and demand, we are told. However, groups, such as the Roma, are very often consigned to the margin of society. They have the need, but they also have the inability to voice that need and to effectively translate it into demand.

Delyth Morgan You said we cannot reduce health inequalities without tackling social programmes as well as health. It sounds as though you are saying that we have to do everything. We know we cannot do everything: we have to start somewhere. If you were to start somewhere, where would you start?

Hanna Edholm I would not wait while addressing the issue of economic inequalities because there is a direct relationship between those and poor health.

Even if you put all your money and effort into creating an effective health service, this health service will not be able to cope with the increased workload caused by economic and social problems. A good example is access to a healthy diet. The recent WHO report says 14 per cent of premature deaths in Europe are due to bad diet. A number of non-governmental organisations (NGOs) are now proposing that the Common Agricultural Policy should be adapted and changed and that access to safe, healthy food should be incorporated as its main objective, as a basic human right in Europe.

By reducing the economic and social inequalities we shall also reduce the undue pressures that are weighing down the health services, which are already

under strain, but will strive to improve the health services at the same time.

Maggie Rae One of my great difficulties is why people feel the need to spend lots of time asking what the problem is. We have had a fantastic opportunity over the past five years to spend lots of time sharing information across Europe and, maybe that is part of the journey; I understand that. Some of the discussion today has been very much around whether it is about drugs, or whether it is about giving people more money, or about achieving world peace.

All of those elements are hugely important, but what interests me is that we seem to be quite relaxed now and in a position to move into action. I know that action is sometimes a bit scary, but we will not achieve anything if we do not move towards action.

One of the fantastic things for me, about working in the Department of Health in the past year was that it gave me the opportunity to review our health inequalities target. We have been telling the world about how proud we are of establishing the health inequalities target.

On life expectancy, the real issue is in the regional variations. When we looked at it across the country, what astounded us was that 20 per cent of our most deprived areas, which we call spearhead areas, are on target to deliver; it is just that we didn't know. This is why I feel we must move beyond describing the problem and take some action.

I will give you a really good example of that just so you can focus on it. In addition to the spearhead areas delivering on the health-inequalities, life-expectancy target, we also have a further 40 per cent that are delivering it, either for the male part of their population or for the local female population. So, for example, Manchester males are on target and Manchester females are not. We do a great disservice to people if we spend a lot of time in our intellectual fashion not focusing on practical actions.

The most important thing of all is that we recognise the sophistication of communication across Europe. There are very few people that do not have a mobile phone in 2006, however deprived their circumstances may be. Deprived people quite often do not have access to the internet, but they will almost certainly have a TV in their house. That provides us with a wonderful opportunity for communication.

Of all the recent work that we have been doing in terms of policy, we have been overwhelmed by public interest in health and, as we learned from our own lessons on the smoking ban, the public is often ahead of us in terms of its desire for health. Some of our enlargement countries want to short-circuit the years that it took us to get to that point in the UK. I would like us to be a bit more optimistic about the contribution we could make.



Angus Nicoll On moving access and services across countries I would like to see now whether I can get one of my Swedish colleagues to access NHS Direct when they next have a problem and to track what happens at that point. One of the bits of mythology about Europe is that, because the health services are strong, it follows that the public health infrastructure is strong. We found that is not the case.

When you do an assessment in Germany, you suddenly discover that, in the former East Germany, the legacy of a very robust public health infrastructure is still there but, in the west, public health is not valued.

Probably, one of the ways of counteracting health inequalities is to make sure that you have good people and good systems in the countries to pick that up, not always expecting to pick it up at the EU level.

When you go to some of the countries that are newer to the EU, you find that, again, there may be an element of “four legs good, two legs bad”. The public health people responsible for agriculture are being encouraged to have strong systems — they have to — but there is no incentive at the European level for the improvement of the public health systems for the human population.

Odd things happen. With influenza, which we have been obsessed with over the past year, uptake rates for vaccine are different across European countries. In some countries, uptake has fallen away. Elderly people on fixed incomes cannot pay for the vaccine, so their uptake has gone down and down. However, in other European countries uptake is going the opposite way.

I am coming to the conclusion that the idea that Ilona and others have voiced, of having an EU minimum public health structure requirement, might be something you could sell as a worthwhile element of European added value. Hopefully, this could be done without it being generally perceived as

the EU interfering in the health services of its member states.

Delyth Morgan Do you think the experience with avian flu is helping us to promote that idea? You were saying earlier on that you were able to go in and do inspections without any legislation.

Angus Nicoll Yes, it has been welcomed. We can say, “You have a problem there but have you looked at what France or Lithuania has done to solve that one?” It is just not the case that you must always have a common set of guidelines issued from an EU structure. I would hate to have a situation where you always have to have EU guidelines. Why can you not say, for example, that the guidelines from Italy look pretty good, so they could be adopted as good-enough guidelines across the EU?

We also have to be careful that, because we tend to be looking inside Europe a lot, we do not overlook some of the excellent examples outside. In preparing for flu, the best example I have seen for some of the public health measures has been from Hong Kong. We need to look outside Europe as well.

Ilona Kickbusch I want to say that there is another European example, which is the regional office of the WHO. On the one hand, standards are being set, but the added value of the European aspect is to make those standards do-able.

With WHO standards, unless they then turn into international health regulations or treaty-like things such as the Tobacco Convention, they will tend to be goals, rather than standards.

Angus Nicoll With flu, it has been WHO standards that we have been getting EU countries to enact. The relationship between Copenhagen and Stockholm is a close and intimate one.

Charles Tannock There is a third example: the Council of Europe, which has 47 member states, has a number of conventions. They are supposed to be the guardians of human rights and it gives a wider European audience. If you argue that you perceive a good public health system as a human right, the Council of Europe might be the more logical place to base it, rather than using EU legislation all the time.

Carol Jagger I wanted to pick up some points on the uniformity of healthcare and clinical information. I have to take issue a little bit with Maggie when she says that we know everything and that now is the time for action. I think that the underlying data in measuring inequality is not uniform across the EU and, that inequalities are being measured in some very different ways.

However, now there is a real will to change that

One myth about Europe is that, because the health services are strong, it follows that the public health infrastructure is strong. We found it is not
Angus Nicoll



Forty per cent of employers in this country will not even consider employing someone with a mental health problem
Sally Greengross



because of legislation and because of the recognition of the healthier life view as a structural indicator.

There are still a few gripes, because it is perceived that there will be a ranking of countries and somebody has to be bottom in any ranking. We have to be very careful about how we try to introduce the uniformity of data. The big challenge is the EU versus the country. You have to show people what the benefit is of everyone having uniform information and uniform measures. You have to say, “Look, we can learn from each other if we can find these differences. It is not the fact that you are on the bottom; it is the fact that there is huge variation.”

Delyth Morgan On the basis of my experience of the NGO sector, having well-established data and comparison is very important when it comes to promoting or campaigning for policy changes.

Carol Jagger Even though we haven’t yet got the perfect data, we can still say that the trend in some countries is for life expectancy and disability throughout life to converge over time, but that in other countries life expectancy and disability trends are diverging.

Sally Greengross I was interested in what you were saying about the difference in the relationship between the WHO, the EU and the individual countries. It seems to me that the WHO works independently with each member state, whereas the EU can look EU-wide at developing policy and practice. There are some areas of health where I think it is absolutely vital.

The one that you have mentioned is mental health, where the discrepancies and discrimination are appalling. Forty per cent of employers in this country will not even consider employing someone with a mental health problem and yet 25 per cent of the

population suffer from mental health problems, many of which are treatable and need not stop them from working or having a career — as long as we can somehow change this attitude.

It seems to me that if we look a bit harder at the workplace, we could overcome some of the problems of looking at a European level, because there is competence that we can look at it from the point of view of social inclusion within a particular area.

I feel that we must get our act together, as there are so many people suffering from depression, which is often undetected and could become extremely serious later. This might be something that could really make the policy in Europe very relevant to every country.

The discrepancies in some countries regarding health in the workplace are alarming. Perhaps that is one area that could be brought into these discussions, especially as we have an increasingly older workforce that acquires disabilities. People are not always disabled from birth or from a very young age.

Delyth Morgan Am I right that the European sub-committee is doing a review on mental health?

Sally Greengross That is really why I brought this up. We are just about to embark on this piece of work and a report will not be too far away.

Rodney Elgie Following up on Sally’s point, the commission has the European debate on mental health. It talks about severe mental illness, but there is no mention of schizophrenia and bipolar disorder, the two most serious ones. It is stress in the workplace, depression, alcohol and substance abuse and suicide. We can see this downward progress because it does not have the competence to get involved.

I get terribly frustrated because the budget for DG SANCO is €52m. With 450 million-odd citizens, that is about €12.5 — that is less than 9p per person per year. However, you look at the Common Agricultural Policy and see that every cow in the EU gets a subsidy of €18. On average, they give €10,000 to each farmer for producing tobacco (most of it is in Greece). To me, that is why nobody can really engage with the European Commission, because it does not have our priorities and yet it should be able to. They are now talking about the budget for 2007-2013 being even less in terms of value for money for public health than it is now. How can we engage with the commission on these aspects? It does seem crazy to me.

Mental health is a huge problem. In a quick study done from the enlargement from September 2004 to August 2005, 86 million people had a mental illness in the EU, resulting in them being unable to function for a week, whether it was to go to work, take their children to school or go shopping. On the basis of those figures the number of people with a mental

illness in that year was equal to the combined populations of the UK, Austria, the Czech Republic and Sweden. Why are we not focusing on these key issues? I wish the commission would put money in where it is needed rather than it being a question of one country scratching another's back in terms of olive groves and so on.

Ilona Kickbusch A critical issue is that we lack a strong and loud public health voice in Europe. That voice can be some of the member states. Those who believe strongly in public health within their own borders and understand that it has to be cross-border need to push within the EU in two ways. First through the Council of Ministers and others and second, through the European Parliament, where it can come from certain parliamentary groups better than it can in a national sense when it is a certain political grouping or coalition which takes this up.

The commission has put forward a fantastic proposal in combining public health and consumer policy. That really is modern public health thinking at its best. A lot of the diseases in modern Europe relate to food and to a whole range of consumer products.

We need to ensure that, wherever a European citizen travels within Europe, they are secure and safe in relation to A, B or C, through an integrated approach. It could also be the basis for growing a health programme with exactly the same direction.

Public health associations at European and national level are incredibly weak. They have money and not much status. I really think that one of the things we need to think about is where that public health voice comes from. It can be from countries. It can be a non-governmental voice. I think the consumer associations and citizenships speak out much more. As Maggie said, people are much more interested in health than their governments. They are not only interested in illness and disease. Look at surveys and

what people research on the internet, what products they buy. Nestlé has redefined itself as a health and wellness company because health is one of the biggest markets out there.

Citizens, in so many cases, are so much further ahead than their governments and their health policies. I think they are sometimes also far more aware of how global an issue of health is.

If Europe wants to be closer to its citizens, let that be in health.

Europe is shifting. For a while, the WHO was 31 or 32 member states. Then eastern Europe and the Soviet Union collapsed, so Europe became 51 or 52 member states. Now, with the EU expansion, very soon there will be 27 EU countries that will be a part of the WHO. This means that they are the majority block within anything that people go to them for, within the European office of the WHO. If the EU got its act together, it could have a significant influence on neighbourhood policy with the rest of Europe.

This affects Russia and a whole range of problem areas: drugs, TB, HIV and Aids. How one can influence European and global health is a critical issue. We need to be clear about what our standards are and what our guidance is.

Delyth Morgan I think we should spend the final 20 minutes talking about what are the key steps to take us forward.

Kate Lloyd The private sector can do more. I would like to introduce this by talking about a pilot project that Pfizer Health Solutions has been conducting with the Department of Health in Haringey Primary Care Trust. This small pilot project was set up just over a year ago and has covered 600 patients with cardiovascular disease, heart failure and diabetes. It is a project to assess whether interactions by a nurse over the telephone with individual patients can help them to manage their own health better. It has been externally evaluated by the Royal College of Physicians and the results are due to be made public quite shortly.

What it has already shown is that a public/private partnership is feasible to do this type of thing. The Haringey pilot scheme has generated so much interest that an additional project has been developed in Birmingham that is called Birmingham Own Health. This is going to be substantially larger, with 2,000 patients.

In addition to that, we are working on a project in southern Italy in another very deprived area in a similar sort of way and also in Ireland on a project on obesity in children. In the Ireland project, a programme of education has been set up in a number of schools to try to tackle obesity where it starts.

So the private sector could do much more. We feel that it is an area where we would like to be

We were astounded that 20 per cent of our most deprived areas – the spearhead areas – are on target to deliver on life expectancy. It is just that we didn't know
Maggie Rae



**When German doctors come here to work at weekends what happens to clinical continuity and to any continuity of care when things go wrong?
Charles Tannock**



doing more, and where we are working closely with the government and the NHS to be part of the solution and not, as the industry is so often seen, as part of the problem.

Delyth Morgan What about roll-out across Europe?

Kate Lloyd We have begun sample projects, initially in Ireland. This is small and we are still trying to evaluate how it works. The original idea came from the US, where a programme was put in place in Florida. This has had to be massively adapted for use in the UK, with regard to the cultural and clinical context and the healthcare environment.

Maggie Rae Picking up on some of the themes around health at work, the workplace is a major economic driver. It is certainly giving people jobs and something productive to do, which improves health in itself. However, we have this great unspoken, unchallenged and really difficult situation with the recognition of depression. It is a huge burden in all countries in Europe.

I want to focus on happiness because, for me, happiness is very important. It has to be about quality of life. If we focus on happiness and try to think about the contribution we can make, we have to be champions ourselves. That is the first action necessary. We have to believe that we can all add value, whether it is from the private sector, from the public sector or whether it is as politicians.

I think we have to be much smarter in terms of recognising the strength and values of people who can market terribly well, whether it is using the techniques of global companies like Nestlé or devising strategies for the kind of success we have had in other countries on reducing smoking.

We have to focus those efforts on upcoming things, such as alcohol or global warming. There is a real

opportunity for us to learn from that. What we have to do is to move people along as we develop information. We need to recognise our own weaknesses in areas such as Bradford and Birmingham, where mortality rates are as bad as some of the worst areas of Europe. We feel that is shocking in today's society. We are facing our own challenges, but we should not forget that we really do have an enormous potential.

Delyth Morgan If there was one key message that you want to come out of the discussion today then let us get it on the record now. Who is going to start off that process? Charles?

Charles Tannock There is an enlightened self-interest that always appeals to me as a Conservative to improve standards of public health and best practice across the whole of the EU. Particularly, as was pointed out by my colleague here, because this would have a top-down effect on the European neighbourhood as well, including Russia, the Ukraine and Moldavia.

Back in 1992 the member states were very reluctant to allow public health to be part of the treaty, articles 129 and 152, and so on. Nevertheless, because we now have a huge migration of people as patients and as professionals; because there is so much legislative competence through the EU, whether it is in terms of harmonising professional qualifications for doctors and nurses or labelling cigarettes; all that dimension is now under EU competence and the ECJ.

One of the points I would like to make is that we need to have a few practical suggestions regarding cross-border issues. There are questions being asked about what are the consequences of the jurisprudence of the ECJ that may cause problems in the future.

You mentioned these German doctors coming over to Britain to work at the weekends. What concerns me with that kind of thing happening on an ad hoc basis is what happens to clinical responsibility and to continuity of care when things go wrong? Who would be suing who and in what jurisdiction?

Are they, for instance, breaching the Jaeger ruling on the Working Time Directive in the ECJ? Are they working overtime and not declaring it? All these issues need practical solutions and we need to think, in a fairly sort of generous term, about how we deal with them.

Delyth Morgan So, sort out the legals. Angus?

Angus Nicoll First, if I have not already convinced you that infectious diseases are part of the inequalities agenda, then I have failed. Second, I think we could aim towards saying we hope the EU structure will do as much for the public health of humans as it does for the public health of animals in Europe.

One other thought is that being very involved in the influenza preparations has brought a health issue up at prime ministerial level and this starts getting the Cabinet Office and such people involved. I was just wondering whether that happens at all at the EU level, or whether it is all still being contained in the DG SANCO.

I also think that Ilona's point about health and consumers is a very important point.

Suzanne Wait One thing that has emerged in the different areas is how governance is required to remove health inequalities. Also, as we move to the system which includes a number of new member states, there is the importance of health information. More and more, the onus for taking care of health is about ensuring that health is being put on the agenda of individuals.

We need to rethink who has the responsibility for helping individuals to take on those roles. It is not only governments, not only the private sector, not only citizens themselves, but partnerships between the different players.

Delyth Morgan Who wants to go next? Kate?

Kate Lloyd Picking up on Angus's point about flu, when we have our pandemic we will need treatments, we will need vaccines. So, in whatever we do, let us not put up additional barriers to innovation in producing new medicines. It is difficult enough now, let us not make it any worse.

Carol Jagger I think my message has to be education, education, education, really, at all levels, but particularly on information sharing.

I feel that lots of good things are going wrong in addressing health inequalities. It is as though each of us has one piece of the jigsaw and we are trying to do

this jigsaw in a very unstructured way. It would be good if all the edging pieces came together and we could try to build a picture of it more coherently.

Hanna Edenholm The health sector in itself can only achieve limited results in reducing health inequalities. However, by integrating health determinants into fiscal education, agriculture and housing policy, a great deal could be done to narrow the inequalities.

Relative poverty translates into absolute disease. One thing that could be thought about, is a redistributive tax policy, given that a minor shift in wealth could prevent numerous premature deaths. Another point is social transfer payments. Countries that are most successful at reducing inequality are those that spend the largest amount on social transfer payments, such as supplementary pay for childcare, support and so on.

I would like to see the reform of the Common Agriculture Policy, going back to the WHO's call on reducing food inequity or poor diet.

We need to tackle homelessness and make housing improvements, and, most importantly, the lack of insulation and heating that breeds ill health.

We need to support health-promotion initiatives that benefit the poor because we know they never listen to information campaigns. Let's develop national health inequality targets that work at the local level and integrate health determinants into other policy areas.

We also need to consider the impact of psychosocial factors. If you live in a society where you have no control over either your professional or personal life or over your future, you will suffer from poverty and long-term unemployment. In those circumstances single men tend to die faster than any other group. Social isolation and lack of social support networks can push such people into substance abuse and that puts further pressures on the health service.

Clive Needle One thing I will take away from today is that we all need to understand the possibilities and the limitations of what the EU can and cannot do. Our primary call is to sit down in a couple of years and review what kind of strategy has been developed. I want to see heads of state and governments looking at health as a key factor in the overarching economic priorities for the EU and to realise that we cannot be a successful and competitive Europe without also being a healthy Europe.

As part of that we will also be reviewing the Common Agricultural Policy shortly and, as people have said, that is another opportunity where we can change things that affect people's diet. Finland is proposing major changes in approaches to alcohol policy. The commission has just proposed a new strategy on children's rights.

We can affect children's early years, and that is an

The big problem is that, even if there is a patient information leaflet, it is unintelligible for most people. That's not the fault of the pharma industry
Suzanne Wait



Things are going wrong in addressing health inequalities. It is as though we each have a piece of the jigsaw and are trying to do it in a very unstructured way
Carol Jagger



absolutely crucial element within this whole debate.

The European Commission now has a website, www.healthinequalities.org, which provides examples of good practice in addressing inequalities from 25 countries across Europe, and that will grow. These are being evaluated and that information can be used. Sweden has 90 interventions in the public health field that can be brought to bear and transferred elsewhere. As people have been saying, if we already know enough to act, we can act now. We can act on things like the social marketing that the Department of Health is working on with the National Consumer Council.

I would love, but do not have the time, to tell you about the initiative of the platform on diet, nutrition, and physical activity, where the world's biggest food producers are sitting down with health and consumer organisations. The European Commission has regulatory powers tucked up its sleeve if these groups do not work together on voluntary agreements. That means it is going to come down to real commitments from those people to work together.

That takes me back to my first point; in reality it is all going to come down to commitment and political will. I am sad to have to repeat the point, but the government has still not shown it has that political will or realisation.

As Ilona and others have said, often the public and organisations and representative bodies are too far ahead of their governments and it is time that governments caught up.

Sally Greengross Let us look at public health policy where Europe has some actual competence. For example, 20 per cent of people employed by the St George's Mental Health Trust in London have mental health problems, which shows it can be done.

I think one way of getting attention to what we want is to look at the economy and to look at

investment in the economy, private or public, as being worth doing. The Royal Mail here has done some pilots on musculoskeletal rehabilitation; it invested £1m and saved £5m by doing so.

The EU set out the Lisbon agenda in 2000 to tackle economic issues. If we can provide examples of how to save huge amounts in healthcare and other benefits by employing disabled people, we can help to make the goals of this agenda a reality. This can be seen as a plus for the Lisbon Agenda.

Rodney Elgie On healthy ageing, I would like to point out that there is no point talking about healthy ageing when you reach retirement, that is a bit too late in the day. Information will change perceptions, but it is education, education and education that will actually change people's behaviour.

I suspect my plea to Kate is whether we can import Barbara De Bono's Pfizer health literacy project with the Hispanics in the USA over here. It is a brilliant campaign. It is easy to do. It is there and it is working, so why can we not use it? It is the best way of increasing health literacy in Europe.

Ilona Kickbusch First, within Europe, health needs to be understood as a driving force. When we speak about health, we should speak about medical care, about investments where they are needed and expenditures when they are required. Unless we get that clear, we will always have a big muddle. Understanding health is the driving force. Also, as an economic driving force, health is an economic chance and opportunity for Europe.

Second, Europe must put citizens at the centre of its health understanding and its health policy. I take up the point that Rodney made. It needs to put health literacy very high on the agenda.

Third, is that you need a health strategy with goals, targets and standards. When Bulgaria and Romania join the European Union, public health should be part of the development and infrastructure and money, whatever they are called in European lingo. That will put them on European levels much sooner.

Europe should promote public/private partnerships in health and public health, particularly at the European level, because many of the companies are European or global companies. Their transnational nature can help in working across borders.

Finally, while we are trying to improve the health of the Europeans, let us not forget the health of the rest of the world and show global responsibility. Europe will only be credible if it shows global responsibility, rather than abdicating that role to the US.

Delyth Morgan Thank you very much. I think that is a very fitting way to bring this discussion to a close. Thank you very much for taking time out to join the *New Statesman* and Pfizer.

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