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How should public health policy be developed? A case study in European public health

Christopher A. Birt, Louise Gunning-Schepers, Andrew Hayes and
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Abstract

Background Article 129 of the Treaty of Rome (as amended at Maastricht) gave new powers to the European Union (EU) institutions to develop and implement public health programmes at EU level. The authors were invited by the cabinet of Commissioner Flynn to assist the Commission by developing new policy proposals in certain specific areas.

Methods The approach was agreed with officials of the Public Health Unit (now the Public Health and Safety Directorate) in DG V. Working groups of experts were appointed to review policy options in five discrete areas. The experts were resident in 13 of the 15 current EU member states, and were employed in academic departments, in health ministries, in local government, and in non-governmental organizations. Draft reports were presented to an evaluation panel of additional experts, whose comments contributed to the final report to the Commission.

Results The final report consisted of five main chapters, corresponding to the work of the five working groups. The recommendations were grouped into those for which implementation would be short term, medium term or longer term, and these were summarized as a Plan of Action.

Conclusion Five criteria for good public health policy development were satisfied, but the approach used was excessively expensive and time-consuming. Some further lessons for future policy development work have also been recorded. This work provided a fascinating insight into the workings of the EU institutions.

Keywords: European, Commission, public health, policy

Introduction

Public health policy is becoming more important again in many Western countries, including those of the European Union (EU). Reasons for this include concerns about increasing health care costs, but also a clear perception that further health gains can be achieved through preventive interventions. In recent years, many European countries have been influenced, in the development of health policies, by the 'Health for all' campaign of the World Health Organization (WHO). As a result, we are now convinced that, if health policies are to be successful, they should be based upon health needs assessment, and that they should be 'evidence based' (in the sense that there should be

clear evidence that interventions are likely to bring health benefits for the population), so that targets can be set and programmes evaluated. However, it is also increasingly clear that sound intervention programmes have to be **socially acceptable, politically credible**, and that, especially if they are to gain wide support, there should be **democratic participation** of all interested parties, including members of the public. These elements have emerged clearly from recent discussions on member state co-operation in the European Union. In this paper we describe the development of some new EU public health policy proposals, and we seek to establish the extent to which it has met the above criteria.

Background

During the 1980s, member states of the European Community agreed on a voluntary basis to establish some pilot community public health programmes. The European Commission provided the necessary administrative support, and oversaw their implementation. The best known of the programmes emerging at that time include 'Europe against cancer', 'Europe against AIDS', and actions designed to limit drug dependence.¹

Article 129 of the Treaty of Rome, as amended at Maastricht, for the first time required the EU institutions to develop and implement public health programmes.² Shortly after the Treaty of Maastricht was implemented on 1 November 1993, the Commission published a 'framework' document, in which it

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indicated how it intended to address its new powers and responsibilities.³ Paragraph 54 indicated the criteria according to which the Commission intended to determine which health hazards would receive priority for public health intervention at an EU level, and paragraph 122 indicated the areas where the Commission intended to develop policy proposals during the first few years. The document also expressed the Commission's intention to formulate proposals for wide consultation throughout the Union on public health issues.

The brief

In December 1993, the Commission asked the authors to submit a proposal describing how they would seek to formulate draft policy proposals in some of the areas outlined in paragraph 122 of the 'framework' document. Their proposal was accepted by the Commission, and final arrangements for this project were agreed in February 1994 following two further meetings in Luxembourg.

In this paper we describe how appropriate consultation with experts was organized, we outline the nature of the final recommendations to the European Commission and finally we review to what extent this method of public health policy-making fitted the criteria mentioned above.

In consultation with the Commission, the following were identified as priority areas for this policy development:

1. Health data and information (i.e. the development and management of an EU public health common data set).
2. Prevention of intentional and unintentional accidents and injuries.
3. Prevention of pollution-related diseases.
4. An EU programme for management of rare diseases.
5. An appropriate mechanism for consultation on public health issues, throughout the EU, involving both professional representatives and members of the public.

Methods

Working groups were to be set up composed of members of relevant academic departments, representatives of national Ministries of Health, and representatives of non-governmental organizations with interest in public health, recruited from all member states, and (as they then were) candidate member states. Draft policy proposals were to be submitted to a process of peer review. The Commission agreed to finance the exercise.

Five working groups were set up, to match the five subject areas identified for the work. Three experts in each of these fields were first identified: one to write an appropriate position paper, a second to chair the working group, and a third to act as group rapporteur. Other members of the working groups were not necessarily experts in these particular fields, although they were experts in other aspects of public health.

In the case of rare diseases, a different method had to be applied, as general experts in all types of rare diseases do not exist. Accordingly, a group of experts, each with expertise in one category of rare diseases, was recruited to that working party, and together they constructed their own position paper as a first stage of the work of the group.

After preliminary work in summer 1994, all working groups were brought together for a short period of intensive work at Château de Limelette, near Brussels, in September 1994. An evaluation panel was recruited, for the purposes of peer review, from people with expertise in public health, or in health policy analysis, and from the European Parliament. Presentations of draft policy proposals were made to this panel on the final day of the meeting at Château de Limelette, and these proposals in written form were sent to panel members subsequently, so that they could prepare written comments on them.

The panel's comments were considered at a meeting held in Copenhagen in December 1994, attended by the group rapporteurs and the organizers of the work. At this meeting, decisions were made concerning the final content of the group reports, which were to be completed by the end of January 1995.

A preliminary report, incorporating the recommendations emerging from all of the five groups, was presented to the European Commission in February 1995. Following further comment and discussion, including with Commission representatives, a final report (216 pages long) was submitted to the Commission during May 1995.

Results

The final report submitted to the European Commission consisted of five chapters, incorporating the recommendations made in each of the five policy areas listed above, accompanied by an introductory section, and by a Plan of Action (see Appendix), which summarized the recommendations being made.

As far as possible, the recommendations were grouped according to whether implementation would be short term, medium term or longer term. In the section on health data and information, the outlines of a suitable data set were indicated, together with recommendations concerning the management of such an information system. The section on accidents and injuries outlined areas where legislation, regulations and the setting of standards might promote safety, and other areas where more dissemination of information and advocacy measures might be appropriate. This section also outlined desirable developments of health data systems in the field of accidents and injuries, identified areas where training should be developed, and also indicated particular research priorities in this field. In addition, it demonstrated how the European Commission might support the establishment of a European Injury Prevention Centre.

The section on pollution-related diseases concentrated on

promotion of more collaborative action between member states with a view to prevention of pollution-related health hazards, together with improved health data systems and systems for consultation. It also outlined areas where research should be sponsored, and it recommended the establishment of a public health information clearing house on environmental health risks.

The section on rare diseases recommended an interesting system whereby the Commission might seek to encourage identification of centres of expertise on rare diseases and support the establishment of networks for the development of research in appropriate fields. The section on consultation mechanisms suggested that a European public health forum should be set up, representing member state governments, public health professionals, the academic research community and voluntary organizations. However, it was recommended that most consultations should take place at member state level, with links to the recommended European public health forum.

The policy proposals in the final report submitted to the Commission were designed as little more than a skeleton of basic suggestions which would need to be worked on further by DG V before they could emerge as firm proposals from the Commission.

Discussion

The criteria set out at the beginning of this paper for good public health policy development were, broadly speaking, satisfied. The academic public health experts recruited to lead each group provided appropriate scientific appreciation of **health needs** in each case, knowledge concerning the practicability and possibility of influencing health outcome, and knowledge of likely **effectiveness and efficiency**. Involvement of lay members of non-governmental organizations throughout the Union provided the working groups with at least some appreciation of what proposals were likely to be **socially acceptable**, and involvement of civil servants from Ministries of Health provided working groups with an appreciation of what proposals were likely to be **politically credible** and acceptable. Involvement of lay members of non-governmental organizations also provided, at least to a small degree, some **democratic participation** by the public in policy development. The policy proposals which emerged also identified a certain number of implementation targets, although it was not felt that the working groups could be very specific in this area at this stage. Furthermore, adherence to the five principles outlined above was strengthened by the comments of the evaluation panel.

However, public health policy development carried out in this manner is both time consuming and exceedingly expensive. The sums spent on travel and subsistence for a large group of people (nearly 70, including members of the evaluation panel), resident in 13 of the 15 current member states (the exceptions were Austria and Luxembourg), were considerable,

necessitating the substantial budget required to carry out this work. Draft policy proposals could well have been formulated by a group of at most 20 academic experts meeting together for 2–3 days, and the cost would have been very much lower. However, proposals emerging in this way could not have been tested for social or political acceptability and credibility, and would have lacked any form of democratic participation in their formulation. Also, if only a limited number of member states had been involved this could have weakened support essential for implementation of the recommendations. The opportunity cost incurred when building in these additional benefits to policy development is clearly considerable; on what basis should we make decisions on whether or not such expenditure is appropriate and justified?

Some additional practical lessons were learnt by the organizers of this work. For example, fees were paid to the leading members of each working group (the position paper writer, the chair, and the rapporteur), and it was therefore relatively easy to ensure that their work was carried out satisfactorily. Members of the evaluation panel, on the other hand, although they received all their expenses, and were entertained relatively handsomely, were not paid. Accordingly, it was in some cases difficult to ensure that members fulfilled the obligations expected of them, as described to them when they were invited to join the panel. Thus, whereas some panel members were most assiduous in their efforts to comment constructively on all the reports submitted to them (and their comments and suggestions contributed significantly to the final outcome), certain others contributed little, if anything, to the exercise. It is therefore suggested that, when this approach is again utilized, members (of such an evaluation panel) should be contracted on the basis of the payment of a relatively modest fee for the work expected of them.

Similarly, it was evident that some members of working groups were less committed and less expert in their field than were others. It appears to be much more satisfactory to recruit known experts to assist with such work than to rely on nominations from other bodies (such as health departments of member states).

A final lesson learnt by the organizers is that, for such a project, it is important at all times to be clear as to the identity of the client and of the clients needs. Of necessity, this requires close contact with the client throughout the project.

This proved to be a fascinating and challenging project for those involved in its organization. It demonstrated on a miniature scale the multiplicity of interests that need to be engaged in any European public health policy development exercise. It showed that there is among many key actors a great deal of commitment and enthusiasm for the full implementation of Article 129. At times, the tensions between the various levels of decision-making – the Commission, the Council of Ministers, cabinet, etc. – became evident. At other times, the differences in the national policy stances of the different member states were to the fore. Add to that the

differences in language, culture, professional background and interests, and it was quite an achievement that consensual recommendations were made to the Commission on public health policy. The ultimate success of this exercise, however, can only be judged by assessing the public health policy proposals that emerge in the future.

References

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- 3 Commission of the European Communities, *Commission communication on the framework for action in the field of public health*. COM(93) 559. Brussels: CEC, 1993.

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Appendix: Plan of action (as submitted as a part of the final report to the European Commission)

Health data and information

In the following plan of action we give a summary of the proposals outlined in this report, grouping them into recommendations that could be implemented rapidly and those recommended for the long term, as well as grouping the recommendations that concern: preventive action, health data, consultation mechanisms (only in respect of those chapters not directly addressing these issues) and research and training.

Short term

1. From the recommendations of the Working Party on Community Health Data and Indicators, identify a sub-set of CORE health indicators to be used from 1996:
 - health status: life expectancy, infant mortality rate, major causes of death, other indicators specially relevant to the EU's current and planned public health programmes
 - lifestyles: tobacco use, alcohol consumption, diet and nutrition, drug misuse and sexual behaviour
 - health promotion: immunization rates, cervical cytology and breast screening uptake
 - living conditions and environment: employment and unemployment, housing, income and poverty, years in formal education, lack of clean water
 - health care: staff/population ratios, overall public and private funding of services, extent of public funding for social care
 - demography: proportion of children and dependent elderly, fertility rate, proportion of population living alone, urban–rural distribution.

It is recommended that these indicators should be able to show trends over time and differences between groups (age groups, gender, urban–rural, regional and by socio-economic groups).

2. Development of accounting systems to compare health indicators of health promotion, environment and health care is not recommended as an early priority, owing to the extent of practical difficulties in this area.
3. A European health survey should be commissioned at an early stage.
4. A member of staff within DG V should be identified to lead and co-ordinate all necessary action, supported by a team to ensure effective co-ordination and collaboration with member states and other bodies.
5. A project committee should be established with formal responsibility for the development of the health data system. The committee would be made up of representatives of member states, the Parliament, the Commission, and other international organizations. Representatives of non-governmental organizations would be invited as observers.
6. A strategy for dissemination of health information should be developed, such that relevant information is readily available to member states, to all parts of Commission and to international organizations, but also to health care workers and to citizens in all member states.
7. Arrangements for a major conference on health in Europe should be an early task to be addressed by the project committee and co-ordinating team.

Medium and longer term

8. As the database develops, information on health technology assessments and clinical effectiveness studies should be incorporated into it.
9. Research should be commissioned to study how best to carry out health audits of policies and programmes.

Accidents and injuries

Short term

Preventive action

10. A draft European Safety Charter should be prepared and disseminated for comment, starting with risks in locations such as schools and workplaces.
11. National legislation, regulations and standards pertaining to safety in all member states should be reviewed. An initial agenda for action in this area includes:
 - toxic product packaging, labelling and dosage
 - safety of domestic razors and other appliances
 - toy safety standards and regulations
 - motor vehicle speed limits and driving standards, including use of car phones
 - safety belt and child restraint regulations

- wearing of safety belts in public vehicles
 - wearing of safety helmets on bicycles and motorcycles
 - fire safety regulations and practices, including those relating to fireworks
 - firearms control
 - alcohol and drug laws
 - laws relating to incitement to suicide and violence
 - playground and equipment safety regulations.
12. Information dissemination and advocacy measures may be appropriate in the following areas:
- focused prevention campaigns
 - transport safety measures
 - 'designed driver' schemes (to control drunk driving)
 - injury prevention within schools
 - advice to foreign travellers
 - sport safety programmes
 - prison safety programmes
 - advice to parents and families.

Health data

13. An inventory should be established of procedures involved in injury mortality certification in all member states.
14. The possibility of making additional use of death certification systems in member states should be reviewed, with a view to obtaining data on cause and circumstance of injuries.
15. The ICD E (external cause) coding system for injuries should be implemented uniformly throughout the EU.

Training

16. A review should be carried out of the training offered to all those involved in generating injury mortality data.
17. The training of all professional staff concerned with safety and injury prevention in all member states should be reviewed.

Research

18. Research should be commissioned to develop injury severity scales for routine use.
19. Research should be commissioned to assess the costs of injuries throughout the EU.
20. Collaborative research, demonstration projects and networks concerned with study of injury causes, risk groups, surveillance, control methods, and sequelae of accidents should all be encouraged.
21. Research to identify good practice in product design and safety, and in environmental and urban planning, should be encouraged.

Medium and longer term

22. An agreed code of practice, for use throughout the EU, for generation of population-based injury mortality data should be published.

23. An agreed minimum data set for injury surveillance should be implemented throughout the EU.
24. Routine risk factor and exposure data collection should be extended to cover circumstances and causes of injuries.
25. A European Injury Prevention Resource Centre, with specific defined responsibilities, should be established.
26. Further research should be commissioned to identify a full minimum database for injuries.

Pollution-related diseases

Short term

Preventive action

27. The Commission should initiate improved arrangements for the public health monitoring of new and existing EU policies, together with identification of areas for public health intervention. This may be achieved by implementing explicit health audits.
28. The EU should promote an internationally accepted framework for the analysis, assessment and characterization of the public health impact of environmental exposures connected with socio-economic activities.

Health data

29. A comprehensive evaluation and integration of all available data, and its accessibility, should be promoted, including by full exploitation of all existing databases.
30. It is recommended that the Commission should initiate standardization of environmental health data collection systems within and among member states, including a review of data definition, recording format and coding practices.

Consultation mechanisms

31. Accurate information on environmental health issues should be made widely available in a clear and intelligible way. The Commission should therefore support information programmes on the concept of risk, and on the evaluation of environmental health issues.
32. The Commission should ensure that the public health sector is involved in the preparation of emergency response plans.

Research

33. The Commission should sponsor multi-centre epidemiological studies in the following areas:
- long-term health effects of particulate air pollution
 - risk assessment of pesticides in drinking water
 - exposure of populations in proximity to hazardous waste sites
 - health status of vulnerable populations, including those in poor housing, with unfavourable lifestyles, with poor immunization status, with poor access to health services, and with relatively high environmental exposures.

Medium and longer term

34. All information concerning environmental health risks should be made available to the Commission by member states. This information must be readily available and accessible by all citizens.
35. A public health information clearing house should be established to review information on environmental health risks and to disseminate this in a practical manner.
36. Further research should be commissioned in the following areas:
 - development, validation, and application of biological markers
 - risk perception and risk communication
 - utilization of morbidity indicators in epidemiological studies
 - improved techniques for health risk assessment
 - public health aspects of EU law.

Rare diseases**Short term**

37. Rare disease focal points (centres of expertise on rare diseases and networks with a central secretariat), should be identified. Existing structures concerned with rare diseases within the member states should form the backbone of the focal points.
38. The formulation of an ethical manifesto to safeguard the rights of individual patients with rare diseases and their families is recommended.

Medium and longer term

39. The creation of a data bank on rare diseases in a Rare Disease Information Unit is recommended, to provide

updated information to health professionals, patients, patient groups and the general public.

40. The creation of a Rare Disease Epidemiological Support Unit is also necessary. This would provide organizational and methodological support for supranational studies.

Consultation mechanisms for public health

41. A European Public Health Forum should be set up, possibly with four members from each member state, representing government, public health professionals, the academic research community, and voluntary organizations.
42. Within member states, governments should set up consultation mechanisms, involving all appropriate organizations, within which EU public health matters can be discussed. A member of the European Public Health Forum should be included in each member state mechanism.
43. The Commission should establish an 'ombudsman', to whom both organizations and individuals in member states could make representations, should they feel themselves to be excluded improperly from the consultative mechanisms.
44. The Commission should publish annually a major report on the state of health in the EU.

The above action points could constitute an adequate starting point for the implementation of the Commission's responsibilities in the field of public health for the areas addressed in this report. For the full details of how experts recommend that implementation should proceed, and of the background information on which they have based these action points, the reader should refer to the relevant sections of this report, which contain both the reports of the working groups and the relevant initial position papers.