How should European health policy develop? A discussion

Tessa Richards, Richard Smith

Until February 1992, when the Maastricht Treaty on European Union was signed, the European Community had no legal basis to act on public health. The inclusion of article 129 (box), the health chapter of the treaty, changed this, and the European Union is now legally obliged to work towards improving public health in its member states. It has also to consider the health implications of other European Union policies such as those related to the environment and agriculture. In April we held a conversation in Brussels with people at the heart of the debate: André Emmanuel Baert, head of division, medical and health research Directorate General XII, European Commission; Adriana Ceci, member of European parliament for Bari, Italy and chair of European parliament intergroup on health; Ken Collins, member of European parliament for Strathclyde and chair of European parliament's environment, public health, and consumer protection committee; Andrew Hayes, secretary of European Public Health Alliance; William Hunter, director of public health division, Directorate General V, European Commission; Michael Joffe, chair of European Public Health Alliance; and Hans Stein, director of European Union health affairs, Ministry of Health, Bonn, Germany, and member of European Union Health Council, commission high level committee on public health, and commission advisory committee on health research.

Article 129 of the Maastricht Treaty on European Union (1992)

"The Community shall contribute towards ensuring a high level of human health protection by encouraging cooperation between Member States and, if necessary, lending support to their action.

Community action shall be directed towards the prevention of diseases, in particular the major health scourges, including drug dependence, by promoting research into their causes and their transmission, as well as health information and education.

Health protection requirements shall form a constituent part of the Community's other policies"

selective. We have to try to get a short list of those we should be doing something about. The list should complement and reinforce what is being done nationally. The aim is to promote exchange and support national actions and so produce "European Union added value." A good example of where we could contribute specifically is rare disorders for which information may be sparse at national level.

RS: Does this mean that health policy is more about combating diseases than promoting health?

WH: It's about both. Promoting health is one element of combating diseases.

ADRIANA CECI: I don't think the emphasis on major health scourges is the right approach. We should look at the key problems that all member states face—for example, aging populations, high environmental risks, and social inequalities. We must work together to find the best way to protect vulnerable populations. The central objective of the European Union's health policy should be to specify a health standard for all of its people. We should not use the principle of subsidiarity as an excuse for failing to define and apply specific public health strategies on, for example, primary prevention and health education.

RS: What processes have and are being gone through to decide what the priorities will be?

HANS STEIN: It is still unclear how we should go about setting priorities. There is a danger that the European Commission is putting too much emphasis on its existing programmes such as those against AIDS, cancer, and drug dependency. Who says that these are the biggest problems? They have political appeal, I agree. The idea of supporting cancer research is more appealing to electorates than collecting good, comparable, epidemiological data, but that does not mean that collecting such data is not just as, if not more, important. We should use the existing proposals of the European parliament and the commission only as a framework on which we establish better priorities.

WH: With respect, it was not the commission's idea to put the focus on individual diseases. If we go back to 1985 it was the European Council that decided to do something on public health and it invited the commission to make a proposal for a cancer programme; topics like AIDS came along afterwards. You must also remember that the commission cannot do anything without funds, and these come from the European parliament and the council.

RICHARD SMITH: Before discussing the aims of the European Union public health policy we should define what public health means in this context.

KEN COLLINS: It's easier to define what it is not—it is not about the health care of individuals or health care delivery. It is about the health of the public in the collective sense and includes other areas that affect general health such as environmental policy. Broadly, we all accept the World Health Organisation's definition: "The expression of public health is now used in a broad sense to encompass the problems affecting the health of the population, the collective status of health of the people, environmental health and health services, and the administration of health care services."

RS: Why is the European Union not much interested in health services?

KC: Firstly, the delivery of health care to individual people is better organised nationally and locally than it ever could be from Brussels. Secondly, the British Department of Health and its equivalents in other member states would never tolerate interference in the way they run their affairs.

Combating disease or promoting health?

RS: The Maastricht Treaty gave the European Union a mandate to help prevent major health scourges and drug dependence. What is this going to mean in practice?

WILLIAM HUNTER: I'd like first to go back to exactly what the treaty said. The only major health threat it defined by name was drug dependency.

RS: Why?

WH: Because it's an increasingly important problem in all member states. It is not a disease, and therefore unless it was specifically mentioned it would not have been clear that it was covered by article 129. The mandate is to prevent disease, and we clearly have to be

Ken Collins: "There is also much to be gained from health professionals exchanging experiences and working in other member states"

BMJ, London WC1H 9JR
Tessa Richards, associate editor
Richard Smith, editor

Correspondence to:
Tessa Richards.

BMJ 1994;309:116-21

William Hunter: "Health has always been dealt with at union level, albeit under the umbrella of other policies"

Our approach has been to look at morbidity and mortality across the union and to identify the main diseases. We have then looked at how these might be prevented and how action by the union might have "added value." Our proposals, which were shaped by the parliament's public hearing on health policy in Europe, are being discussed by the council. When it has responded we can update our priorities.

Importance of consultation

TESSA RICHARDS: How will you do this? The commission's draft paper for action on public health stated that it would set up a committee to advise the commission on "all matters related to health protection" with a membership drawn from experts from each member state. But this proposal was dropped in the definitive document. How is the consultation process working? With whom are you consulting?

"The central objective of the European Union's health policy should be to specify a health standard for all its people."

WH: We are following the normal consultation procedures with the European Union institutions such as the economic and social committee, and a list of priorities is emerging. For each priority we will draw up a programme and appoint a committee to advise on each proposal.

MICHAEL JOFFE: What about consultation outside the European Union institutions—with, for example, non-governmental organisations, public health professionals, and organisations representing the various health professions in Europe? No proposals have been put forward for consultation with them.

KC: One of the main reasons for holding the parliamentary open hearing last year was to allow precisely that form of consultation, and we received views from many organisations, including the European Public Health Alliance. When the European parliament discusses these issues it has to consult at European level. If we were to open discussions with, for example, a British organisation such as the Royal College of Physicians, we would then have to have similar consultations with comparable organisations in each of the member states. Such an approach is not feasible. We short circuit the procedure by consulting only with European organisations, and that was what we did at the hearing.

MJ: I appreciate this, but so far it seems to have been a one off. What is going to happen in the future?

KC: The hearing was particularly important and not just to us but to the commission and council too. We were hoping that people would come forward with views spontaneously rather than waiting to be asked.

RS: And you don't have a tradition of people turning up and giving their views?

KC: Well they cannot just turn up but they can always write in with their views. We welcome that.

RS: What you are saying is that if you want your voice heard in Europe you must be organised at a European level.

KC: Well, it helps enormously.

Reactions to the priorities for health

RS: Is the parliament happy with the priorities that are beginning to emerge?

KC: Yes, and that owes a lot to good cooperation

and communication between the commission and the parliament before the commission published its proposals. In fact there has always been good cooperation on health policy and on environment and health and safety policy, although it is a different story on agricultural policy.

HS: I am not sure that I agree that the consultation process between the European institutions has worked that well, but that is not the key issue here. The crucial times for consultation and discussion are before proposals about priorities are drawn up and, once the proposals have been accepted, before their implementation. The consultation process needs to be improved at these stages and the contribution of member states strengthened. We need to get the views of a wide range of non-governmental organisations, health professionals, and research workers. The problem is that if you set up an advisory body with, for example, four representatives from each member state you end up with a committee of 48 (and by next year this could be 64 if the four countries who are set to join the union in 1995 do so). Such a committee is too large to be workable.

AC: I agree that the consultative and advisory committees that are set up by the commission are going to be crucial. They must include experienced people who are appointed openly. Those concerned should not only advise but also be concerned with decision making. I think the experience of the recently set up European Medicines Evaluation Agency will provide helpful information about how best to go about this.

KC: Another key point is that we have to guard against being too ambitious. The parliament could have proposed a radical proactive plan to eradicate disease across the community and tackle all the major health issues—but it would have been totally unrealistic. We pared the proposals down to ones that the commission might reasonably be expected to implement in the relatively short term. The argument for having a

"We have to guard against being too ambitious."

European health policy at all is that we have a population of about 345 million, and epidemiological work on a population of this size should produce valuable information on, for example, patterns of disease that might not be discernible in population studies on smaller national populations. There is also much to be gained from health professionals exchanging experiences and working in other member states.

The need for better data

AC: I would like to sound another cautionary note. The European parliament has called for the commission to establish a European epidemiological investigation unit to collect and examine data from member states. It will also establish target figures for the reduction of disease and coordinate union-wide information schemes. The problem is that you can amass a lot of data over the years without making any tangible progress. You also risk repeating work that national institutions and other international organisations have already done well. This wastes time and resources. We must have clear objectives. It is essential that data should be defined, collected, and evaluated homogeneously. We will also need to develop new health care indicators—including economic indicators—if we are going to build a worthwhile European health information centre.

rs: What is all this activity going to mean to the man or woman in Strathclyde or for that matter any other city in Europe? How is the public going to notice the difference?

kc: One example would be if a person were to develop a rare cancer. The local surgeon might not know how to manage the condition appropriately, but in future the surgeon may be able to get information from a European data source.

rs: But doesn't this conflict with the idea of tackling major scourges, which for cancer means lung and breast cancer.

kc: No. Let's take breast cancer, for the sake of argument. It's clearly more common in some countries than others. Studies across the union may give us valuable information about why this is so.

wh: I agree. Take the example of mammography. The Dutch did the first pilot study on mammography, and it was their data that showed that this was a worthwhile screening procedure to introduce across the community. Cervical cytology with quality assurance is another example of something that has been developed nationally and then extended across the union. That is what union added value means.

"Work that has been proved to be valuable ought to be applied everywhere."

rs: You mean it is picking up on ideas that could be developed more widely?

wh: Yes and no. It's using results that are very good, exchanging information, and showing that work that has been proved to be valuable ought to be applied everywhere. It is also a good way of promoting good practice that might otherwise lie dormant at national level for some years.

mj: Returning to the opportunities for epidemiological research, the excellent thing about Europe is that the population is not only large but heterogeneous. Comparisons among Germany, Spain, Italy, the United Kingdom, and the other states have great potential. We may be growing closer but there are still appreciable cultural and historical divides that are reflected in different patterns of disease, and this is a first rate opportunity for epidemiologists to put this together. My worry is that to do this properly we must, as Mrs Ceci has emphasised, have good quality, complete, and comparable data. The parliament, commission, and council have all called for this, but I am not sure how it is to work. It is a huge task. The WHO is already doing something along those lines, but it cannot take on the task of working with member states to plug the gaps in the data and improve data quality.

ANDRÉ BAERT: The commission's medical and health research programme is well aware of this complex task, and it has some experience in collecting health data. For example, it started the WHO/EX Paris Centre on epidemiological monitoring of AIDS in Europe. The *Atlas of Avoidable Deaths*, which examines avoidable mortality across the European Union in a standardised way for 21 common diseases, suggests that about 110 000 deaths in people aged under 65 would be avoided annually if each region could attain the optimal death rate reported nationally for these diseases. Further interesting information has come from the SANGUIS Concerted Action, which has examined the use of blood and blood products in 41 hospitals. For hip replacements, for example, there is a 10-fold variation in the consumption of blood and a threefold variation in time spent in hospital among member

Hans Stein: "The idea of supporting cancer research is doubtless more appealing to electorates than collecting good, comparable, epidemiological data, but that does not mean that collecting such data is not just as, if not more, important"

European Commission's priorities for future European Union action on public health

Five year programmes are to be introduced over next three years 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 injuries and emergencies
- Pollution related diseases
- Rare diseases

states. The reasons for such differences should be explored. It is not desirable to impose uniform standards, but it is valuable to compare patient care and management—in other words, to use the European scene with its wide variations as a vast human laboratory.

hs: You said there is much activity going on, and you named some projects. I could name hundreds more. The problem is, however, that until now neither the member states nor the commission or parliament have succeeded in coordinating the information collected. We have an AIDS centre in Paris, a drugs centre in Lisbon, and a cancer centre somewhere else—but these are not enough. The parliament has suggested creating an epidemiological centre within the commission to tie these things together and put the data into a form that we can use. We need to develop an

"It is impossible to make sound decisions on priorities when even [the statistical] data are so poor."

overall coordination strategy. We must also ensure that research findings are analysed and interpreted appropriately. So far, the information we have accrued on avoidable deaths, for example, has had no political impact because we do not have a mechanism for translating what is known into a strategy for action. We have to tackle this in order to exploit the differences that we find.

Coordinating information and policies

rs: Ken Collins, do you accept that coordination is lacking and lots of the information that is being collected is not being used?

kc: I think that is inevitable with so many countries involved, but I agree we must get better at coordinating information. One thing I can say is that so far at least the dialogue on health issues between parliament and commission has been conducted entirely openly. Relevant documents can be inspected, and this is important for the confidence of health professionals, consumers, and patients. I do, however, have doubts when priorities are being set by the health council of the European Union. Firstly, because the council meetings are closed, which is arguably undemocratic. Secondly, priorities set by the council are overlaid all the time by the vested interests of individual member states. What I want is a genuinely European public health policy that takes all its citizens into account.

rs: Bill Hunter, do you accept that a lot of the activity

Michael Joffe: "Comparative studies stand or fall on the comparability of data. We have a lot of interesting data at European level, but do we really believe them?"

is uncoordinated and that much of the data that are being collected are not being used?

WH: This may be true across the member states, but that is why the exchanges of information and experience have so much to offer. That is where the union added value comes in.

TR: Yes, but what about coordination of public health matters within the commission and the call for a commissioner for health?

WH: Public health interests are coordinated by the commission in three ways. Firstly, the commission's secretary general has to ensure that Directorate General V is consulted on all new proposals that affect health. Secondly, the commission has set up an interservice group on health that covers all the commission services. This meets two or three times a year and looks at health matters. Thirdly, we are doing a report each year which details the health protection requirements of other policies. We also intend to include what is going on in public health right across the commission. So we are trying to improve the way in which information is collected and provided.

"We do not have a mechanism for translating what is known into a strategy for action."

RS: Is there any evidence that this is having any effect?

WH: Well, it is beginning to, but the initiative has been running for only a few months.

RS: There is a perception that much of what the European Union promotes at the moment is positively unhealthy—for example, subsidies to tobacco growers and some of the agricultural policies that encourage consumption of dairy products. Do you think the perception is true and is there going to be a real change?

WH: It is changing already. Tobacco subsidies are going down. The recent communication on cancer showed this.

HS: Are they? Well, it doesn't really matter whether it is 100m ecu or 90m ecu, the fact is that the amount paid by the commission in tobacco subsidies is 1000 times more than the total spent on health by all the member states, never mind the commission.

WH: Yes, but there are new developments. Our colleagues in the commission who deal with agriculture have also put forward a programme on tobacco information.

RS: It looks to me as if there is a health voice but that (as in Britain) it comes low down in the pecking order. The European Union was started as a commercial exercise to make Europe strong. Health has come along later. Does this not mean that the health voice is likely to be rather weak and not listened to?

WH: Health has not come along later. Chapter three of the Euratom treaty deals with the effect of ionising radiation on the health of the general population and the health of workers, and the first directive was in 1959. It is true that public health, in a wider context, has come along later, but health has always been dealt with at union level albeit under the umbrella of other policies.

A health audit on all policies

MJ: Can I go back to the question of health being introduced into other policy areas? We talked about agriculture, but a less problematic one is the environment, where the officers are open to discussing public health aspects. Is a systematic health audit of other policies going to be introduced?

WH: This is the annual report to which I have referred. This will comprise not only data on health within the member states but also within the EU institutions. Each directorate general will be expected to contribute. We have already started to do this—for example, in the cancer programme. That is why we have the information about tobacco subsidies going down.

RS: Will this information about the health effects of other policies be made public?

WH: Yes.

HS: But it is not post hoc reporting of the health implications of other policies that is most important. The key thing is to influence decisions when policies are being made. For example, the draft directive on data protection has implications for health research. The health lobby has tried to oppose the directive, but the decision rests with the internal market council and there seems no chance of the health voice getting through. Secondly, the commission has issued a big report on the industrial implications of the European pharmaceutical industry. It has many pages on how this affects health, but the conclusion seems to be that in order to improve the industry, public health interests have to step back. What should the health council do? Should it say that the interests of industry or the health aspects of this policy are more important. I do not want to be too negative, but I think it shows the difficulties of taking into account the health protection requirements in other policies. I do not know of any other constitution in the world where this so called health compliance clause applies. We have a tremendously difficult task in trying to make this work. It is not just a question for the commission but for the parliament too. It is not enough for parliament's health committee to make statements; it needs to influence the statements that are made by other more powerful committees, such as the agricultural committee.

AC: I agree that the objective to integrate health policy into other policies, especially agriculture, is a major challenge that the European parliament must tackle. And that will mean disturbing big commercial interests. This objective cannot be achieved if we do not create a high level public health administration within the EU institutions. A health commissioner is needed to combine the health functions that are today divided between 14 of the 23 directorates general. We will also need to increase the quality and quantity of commission staff concerned with health and ensure that they are consulting with bodies such as European Public Health Alliance.

"The objective to integrate health policy into other policies, especially agriculture, is a major challenge."

Relating research to health needs

HS: One idea we have for the German presidency is to develop the idea of running combined councils. Then the health ministers should form an alliance, which might enable them to overrule other councils. For example, the research council is due to make decisions on how the 336m ecu for the next biomedical research programme is to be spent—and incidentally this nowhere mentions article 129. These important decisions should not rest solely with the research council.

The commission should forget its "normal" priorities such as AIDS and cancer and concentrate on defining what the key health priorities are. In doing this on bovine spongiform encephalopathy, for example, we have to confront the difficult question of whether we care more

for British farmers than we do for the health of our people. To do this it is important that the EU institutions overcome their mutual hostilities and work together.

RS: Going back to the question of research not being related to article 129. If you look around the world, and certainly in Britain, it is often hard to see the link between the research and the health interests. Could you give us some idea of how this issue is being tackled in the union?

AB: In the biomedical research programme 10% of the budget has been earmarked for public health and health services research. So it is not true to say that article 129 has been ignored. Moreover, there is a representative from the public health division on the programme management committee. Of course in future there should be more input from health ministries.

HS: But we must move away from the system whereby the EU institutions make up a proposal to, for example, set up an epidemiological institute in the year 2000. It would be better for the commission and Directorate General XII to announce their broad strategy for improving epidemiological data gathering in Europe, and for this we need all kinds of different reports and surveys. It is not enough to say we can use more of the existing data. As the European Public Health Alliance and others have emphasised, the data that are currently being collected at national and European level are not being collected for health purposes. Even the statistical data we have are varied, and it is impossible to make sound decisions on priorities when even these data are so poor. One of the first tasks of any European health research unit should be to create new and better data.

"The key thing is to influence decisions when policies are being made."

AB: The next medical and health research programme (1994-8) intends to do that, but goes much further. The fourth research framework programme (box) gives the mandate to investigate health education, to evaluate health needs, to do research and development into measuring the performance of health policy initiatives and evaluating health technologies, to examine the impact of the internal market on provision, regulation, and deregulation of health care, and to examine the balance between private and public health care as well as research on biomedical ethics with respect to human dignity.

RS: What you are saying is that the next medical and health research programme will be responding to the priorities set in the public health programme?

AB: Yes, these are far reaching public health research goals which were unthinkable five years ago. For example, the development of performance indicators of health policy initiatives will give the scientific underpinning of article 129.

MS: The health research programmes funded by Directorate General XII have been pioneering, but I want to go back to the question of the quality of data. Epidemiologists are worried that we don't know whether variations in health data report real differences or arise simply because of different ways of collecting the data. Comparative studies stand or fall on the comparability of data. We have a lot of interesting data at European level, but do we believe them?

AB: I think there might be a danger of exaggerating this problem. We can never obtain absolutely perfect data. What is essential is to look at trends over time. These trends can be used to develop health policies.

André Baert: "It is not desirable to impose uniform standards, but it is valuable to compare patient care and management—in other words to use the European scene with its wide variations as a vast human laboratory"

WH: I do not believe that comparative epidemiological data between countries tell you much more than specific studies at national level. I agree that it is trends that are important.

A health commissioner?

RS: Mrs Ceci has told us that there should be a health commissioner, and the parliament agrees. Will there be such a commissioner?

WH: It is up to the new commission, which will be formed at the beginning of next year. It will be deciding on its new structure, and this is one of the things that might be discussed.

"The appointment of a health commissioner would be a big victory."

RS: What about a specific directorate general for health?

HS: I doubt if it's desirable. You said yourself that health policy is not regarded as a first division activity for the union. If a new single directorate is formed it will be even more difficult to integrate health policy into other policy areas. Health interests might become even more marginalised, and the new directorate general might not be adequately funded. A better approach would be to strengthen health influence in each directorate and identify someone who will take responsibility for ensuring that the health interests and effects of other policies are identified and acted on. It is better to act from the inside.

ANDREW HAYES: I agree. Over half of the directorates general are concerned with health, and it would be difficult to try to take existing bits out of these and move them somewhere else. It would provoke a lot of internal controversy, and that is the last thing people want at a time of such political uncertainty in Europe. But if, as expected, Austria, Finland, Sweden, and Norway join the union, four new commissioners will have to be found jobs. One of them could be given health—the commissioner in charge of Directorate General V, under whose umbrella public health currently falls, has a wide portfolio.

AB: Public health at European level is too important to be left to the medical profession. The appointment of a health commissioner would be a big victory. It would mean that at last public health has been recognised and

Fourth framework programme on research and development 1994-98

Decision of the European parliament and of the council (on 26 April 1994)

"Research on health systems and technologies, and on information and education on health matters. This will concentrate on primary care, the evaluation of health needs, performance measurements of health policy initiatives and the evaluation of health technologies. The impact of the Internal Market on the supply of health care across internal frontiers will be examined, as well as the following: regulation and deregulation, the balance between health systems financed by the private and public sectors; the need to define a European approach for the introduction of new technologies in health systems; research in bio-medical ethics, to address general standards for the respect of human dignity and the protection of the individual in the context of bio-medical research and its clinical application"

Andrew Hayes: "Over half of the directorates general are concerned with health, and it would be difficult to try to take existing bits out of these and move them somewhere else"

defined as a European issue in which the union has a small but crucial part to play.

Effects on ordinary people

rs: Can I go back to the question of how any of these discussions and machinations in the commission are going to affect the people in Strathclyde?

wh: People in Strathclyde are not going to notice a big change in their lives as a result of the commission's involvement in public health. It is member states that implement union decisions, so it is the member states that benefit from positive actions. This has been one of the union's problems.

rs: You mean national governments take the credit for things that go well and blame the union for things that go less well?

wh: Well I do think that we need to make people more aware of the good aspects of what happens at union level, and we are only going to do this by better information campaigns.

hs: The trouble with always trying to relate everything to the man or woman in Strathclyde is that it is difficult to bring down European health strategy that is necessarily at a high level to the level of individuals. If strategy is planned primarily to please them we end up with politically appealing projects on cancer rather than improving our data base. I also think that the principle of subsidiarity is important. Thus, most decisions that affect individuals are best taken locally. I agree, however, on the need for transparency and openness about what is happening at European level.

rs: But if you do not take the views of ordinary people into account they will continue to be sceptical about whether we need these ivory tower European institutions, and they will not turn up to vote in European elections.

The future

rs: Looking at the future now, what are going to be the most important developments in the next four years?

"[There is a] need for transparency and openness about what is happening at European level."

wh: From Directorate General V's point of view it is going to be continuing to develop its five year programmes on problems such as cancer, drug dependency, and AIDS and certain other communicable diseases plus the more horizontal programmes on health promotion and education, training, development of health indicators, and so on.

rs: If Europe expands, what is going to happen?

wh: I think that since the four countries concerned have an interest in public health the effects are going to be beneficial. I think that we are going to learn a lot, and the exchange of information will be very helpful.

hs: My answer is very different. I hope that in five years' time we will have established a European health information centre. This would increase awareness of public health issues, which is the first step towards improving public health. The status of public health in member states varies, and the links between this and how countries run their health care systems and the amount they spend on health need to be explored. We will also have developed a way of assessing the public health aspects of other EU policy areas.

ab: At the moment there are 400 research networks in

European parliament's priorities for action

1 Consult widely with medical professionals and health authorities of the member states and non-governmental organisations to develop common health policy definitions

2 Establish a European epidemiological investigation unit to collect and examine data from member states, to establish target figures for the reduction of disease and to coordinate EU-wide information campaigns

3 Set up a cross frontier network of notifiable diseases: to devise working definitions of such diseases; to collect, update, analyse, and disseminate data from member states on notifiable diseases; and to work with national and international agencies

4 Encourage exchange schemes for health care professionals among member states

5 Appoint one of its members to be responsible for all aspects of public health care policy, including research

6 To begin work on a report on the state of health in the community along the lines of the existing *State of the Environment in the Community*

7 To investigate the feasibility of encouraging greater use of generic pharmaceuticals and to bring forward proposals to coordinate the conditions of use of all pharmaceuticals

8 To develop and execute health promotion and education campaigns focused on immunisation, prevention of disease, drug misuse, and accidents

9 To develop a firm timetable for the implementation of the community's public health objectives

Europe with 4600 teams. These cooperate with each other on a self selected basis. This networking is preferable as no country wants a central institute like the American National Institutes of Health. We intend to strengthen this networking mechanism with shared costs, Eurofacilities, and intranetwork training schemes. New priorities are public health, brain research, pharmaceuticals (to underpin the activities of the European Medicines Evaluation Agency), AIDS research with other infectious diseases, and cardiovascular research. The emphasis will be on integrating basic and clinical research.

ac: A lot of research and other networks have been created in Europe together with new scientific organisations. In particular I would like to mention the International Public Health Society in Berlin and the Health Group and European Policy Research Network at the London School of Economics. I think that all this effort on research and collaboration over the next five years should take into account the needs of the eastern European countries. We must, however, guard against imposing our standards on them. I have the impression that their first contact with eastern European health care systems has been negative.

mj: I like the idea of a European health information system, but my priority is to translate the sentence in article 129 about health in other policy areas—including existing policies not only new ones. I would like to see real progress made in putting that into practice. In the short term that will probably mean with Directorate General XI and the environment. There are other community policy areas I have my eye on, and agriculture is one of them. But I think it's going to take more than five years to make any real headway. Meanwhile, we should achieve more than a fall in tobacco subsidies in the next five years. Turning to research, I am keen to see a lot of high quality research at European level that is relevant to policy making and will make a difference both to public health policy and ultimately to the people in Strathclyde.