Community action in the field of public health

(2003-2008)

Work plan 2005

- PRELIMINARY ORIENTATIONS -

1. GENERAL CONTEXT

1.1. Policy and legal context

On 23 September 2002, the European Parliament and the Council adopted a Decision establishing a programme of Community action in the field of public health (2003-2008)[1].

The public health programme is a key instrument underpinning the development of the Community's health strategy. In Article 2.3, the programme Decision stipulates that it shall contribute to the promotion of an integrated and inter-sectoral strategy. One key element is to develop links with relevant Community programmes and actions and with national and regional initiatives, in order to promote synergy and avoid overlaps. These actions should take into account the reflection process for a new European health strategy, launched on 15 July 2004[2].

Synergy and complementarity will be pursued with the work undertaken by the relevant international organisations working in the health field, such as the World Health Organisation (WHO), the Council of Europe and the Organisation for Economic Co-operation and Development (OECD). Co-operation with them will be further strengthened in implementing the activities of the programme. Co-operation with third countries will also be developed, in order to share experiences and best practice.

The 6th Framework Programme of the European Community for research[3] provides for scientific support to Community policies. This specific research is intended to provide support to policies that are targeted precisely on needs "demand-driven", coherent across the various Community policy areas and sensitive to changing policies. The tasks with relevance to public health can be found in the Specific Programme for research, technological development and demonstration "Integrating and Strengthening the European Research Area (2002-2006)[4]",

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1 Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008). OJ No L 271, 09.10.2002

2 "Enabling good health for all – A reflection process for a new EU health strategy"

3 Decision No 1513/2002/EC of the European Parliament and of the Council of 27 June 2002. OJ No°L 232, 29.08.2002

4 OJ No C243/85, 10.10.2003. Link to 3rd Call FP6 policy-oriented research on CORDIS: http://fp6.cordis.lu/fp6/call_details.cfm?CALL_ID=83

under “Policy-oriented research”, strand 2 “Providing health, security and opportunity to the people of Europe”.

1.2. Allocation of resources

Actions under this programme must contribute to a high level of health protection and improve public health. Funding can be sought through project grants and public contracts (tenders).

This work plan gives an overview of the actions to be launched in 2005. Some will be implemented through a call for proposals “Public Health – 2005” to be published in the Official Journal in November 2004, as an indicative date. The general principles and criteria for the selection and funding of actions under the “Public Health” programme are set out in a separate document.

Applicants have three months to submit proposals from the date of publication of the call for proposals in the Official Journal. It is estimated that after this deadline a further five months will be necessary to undertake all the procedures leading to the Decision on financial assistance.

Specific calls for tenders will be published which refer to specific section(s) of the work plan.

The budget line for the operational credits is 17 03 01 01 - Public health (2003 to 2008).

The budget line for the administrative credits is 17 01 04 02 – Public health (2003 to 2008) – Expenditure on administrative management.

The financial envelope of the programme for the period 2003-2008 is € 353,77 million. The budget available for 2005 (commitments) is estimated at around €58.900.000[5]. To this budget, should be added:

- the contribution of EEA/EFTA countries: estimated at €1.242.790[5];
- the contribution of 3 Candidate Countries (Bulgaria, Romania, Turkey): estimated at €1.317.621[6];

The global budget for 2005 is therefore estimated at €61.460.411[5 6].

This includes both resources for the operational budget (grants and calls for tenders), resources for technical and administrative assistance, and support expenditure (including structural arrangements for the implementation of the programme).

The total for the operational budget is estimated at €53.685.051[5 6].

The total for the administrative budget is estimated at €7.775.360[5 6].

As far as the allocation of resources is concerned, a balance between the programme’s different priority areas will be maintained, so that the financial envelope will be split equally[7].

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5 Indicative amount, subject to approval of the Budget Authority

6 Indicative amount: this figure is a maximum amount and depends on the actual amount of the contribution paid by the Candidate Countries.

It is proposed to spend less than 10% of the operational budget on calls for tenders. The indicative global amount for the call for tenders would be up to €5.368.505[5] [6]. As a consequence, the indicative global amount for the call for proposals would be estimated at €48.316.546[5] [6].

Given the complementary and motivational nature of Community grants, at least 40% of the project costs must be funded by other sources. Consequently, the amount of the financial contribution under this programme can, in principle, be up to 60% of the eligible costs for the projects considered. The normal amount is likely to be less than 60%. The Commission will determine in each individual case the maximum percentage to be awarded.

Exceptionally, however, a maximum co-financing of 80% of eligible costs could be envisaged where a project has a significant European added value as well as involves the new Member States and Candidate Countries in a substantial manner. No more than 10% of the funded projects should receive a cofinancing over 60%.

The running period of any projects to be co-funded, should normally not exceed a maximum of three years.

2. PRIORITY AREAS FOR 2005

For the sake of clarity, the actions are grouped in sections corresponding to the priority areas referred to in section 1.2.: Health Information, Health Threats and Health Determinants. Each action refers to the corresponding Article/Annex of the Decision 1786/2002/EC.

The key priorities and areas for action have been identified taking into account the need for supporting Member States' actions and enhanced co-operation in the EU context, legal obligations and their implementation, major concerns that have been identified by the European Council, the Council and the Parliament.

[7] Each of these percentages could vary by up to 20%.

2.1. Health Information

The Public Health Programme aims to produce comparable information on health and health-related behaviour of the population (e.g. data on lifestyles and health determinants); on diseases (e.g. incidence and ways to monitor chronic, major and rare diseases); and on health systems (e.g. indicators on access to care for everyone, on quality in the care provided, on health human resources, and on financial viability of health care systems). This will be based on European-wide common agreed health indicators with regard to their definition, their methodology of collection and their use. Most of the actions supported by the former programme of Community action on Health Monitoring (ended 2003, but projects are still underway) were in relation to the development of indicators and the improvement of the methodology of collection of statistics and preparation of reports.

2.1.1. Developing and co-ordinating the health information and knowledge system (Article 3.2.d., Annex – points 1.1., 1.3.)

This action aims at developing the strategy for health information and knowledge, and creating the necessary co-ordinating and advisory structures, tackling the enlargement issues and contributing to the overall planning process for implementing the health information and knowledge system. Co-operation with international organisations, such as WHO, its observatories and OECD, will be maintained, strengthened and implemented at practical level, with a view to simplifying the data provision.

The elements that need to be implemented are:

(1) Putting into operation the already available and comparable indicators from the "first phase set of European Community Health Indicators (the “ECHI short list”)" with collection of related data http://europa.eu.int/comm/health/ph_information/indicators/indic_data_en.htm).

(2) Improving operational definitions of existing indicators in the “ECHI short list”, when necessary

(3) Developing the technical scientific work, in close collaboration with EUROSTAT, on EU health indicators in the areas not yet covered

(4) Selecting a few core indicators in these areas to be integrated into the “ECHI short list”. The indicators for the short list should be:

- easy to read and understand;
- policy relevant;
- mutually consistent;
- available in a timely fashion;
- available for most, if not all Member States and Candidate Countries;
- comparable between these countries and, as far as possible, with other countries;

- selected from reliable sources;
- not impose too large a burden to Statistical Institutes, Ministries of Health and other respondents.

(5) Continuing support to the network of competent authorities for health information and knowledge, and ensuring effective involvement of enlargement countries and international organisations.

(6) Continuing support for the network of Working Party leaders (see 2.1.2).

(7) Improve cooperation with the European Environment Agency and develop joint actions to improve collection and diffusion of environmental health information.

(8) Continue to develop environmental health indicators according to the ECHI strategy and improve availability of data in collaboration with EUROSTAT, according to action 1 of the "European Environment and Health Action Plan 2004-2010".

2.1.2. Operating the health information and knowledge system (Article 3.2.d., Annex – points 1.1., 1.4.)

On the basis of the ongoing activities the objective is to develop a Health Information and Knowledge System fully accessible to all the European experts and public. A main output will be a web EU Health Portal, supporting an easy access for citizens and professionals to thematic information resources on public health at EU level. In addition, diffusion through regular EU health reports will be developed with use of thematic conferences to improve exchange of information.

The main components of the European Union Information on Health and Knowledge System, as proposed by DG SANCO to the Network of Competent Authorities on Health Information, can be found in the document http://europa.eu.int/comm/health/ph_information/documents/ev20040705_rd10_en.pdf.

This document describes also the creation of the co-ordinating and advisory structures contributing to the overall planning process for implementing the system:

(Support shall be given to develop a scheme to use and apply IT tools in the collection of injury data in hospitals which allow a direct coding and processing of the data for the Injury Database (IDB), with a view to facilitating the interviews and input in the database and to reducing costs for collecting and processing of the data. Specific attention shall be paid to the inclusion of the ten new Member States in the IDB system.

2.1.3. Develop mechanisms for reporting and analysis of health issues and producing public health reports (Article 3.2.d., Annex – points 1.3., 1.4.)

Topics related to the components of the Health Information and Knowledge System as mentioned under point 1.1.2 are considered as a priority for reporting and analysis of health issues and production of public health report. There will be a continued collaboration with the Health Evidence Network (HEN) managed by WHO European region, and with the OECD.

To guarantee the necessary quality and comparability of the required and collected information, priority related to the improvement of health reporting mechanisms will be given to:

- Develop the European Health Survey System, in close cooperation with the Community Statistical Programme[8]. Implement and develop survey modules to collect the necessary data for the European Community Health Indicators (ECHI). The European Health Survey System is defined as a combination of existing national survey instruments with appropriately designed European common modules of questions. It is composed of a Core Health Interview Survey, managed by the Community Statistical Programme and European Special Health Interview modules, managed by the Public Health Programme. A pilot survey to test some of the priority special question modules should be implemented. A feasibility study for a European Health Examination Survey should be also a priority.

- Initiatives adapting data from existing ad-hoc data collections and registers into routine data collection with a view to producing regular time series for health indicators.

- Implement the European Community Health Indicators (ECHI) system at national level as a public database using a public web application.

- Complement national health indicators with a System of Regional Indicators on Health at sub-national level and developing a system of health indicators in the urban and rural areas.

- The system of inventories on sources on health information (which includes at present inventories on health surveys, communicable diseases sources, morbidity registers, organisation of health systems, etc.) needs to be maintained, updated and enlarged with a medium-term intention to do it on a routine basis.

- Collection and evaluation of Member State action in the field of bio-monitoring, according to action 3 of the "European Environment and Health Action Plan 2004-2010".

2.1.4. Developing strategies and mechanisms for preventing, exchanging information on and responding to non-communicable disease threats, including gender-specific health threats and rare diseases (Article 3.2.d., Annex – point 2.3)

The collection of indicators and data for non-communicable diseases should be:

- Valid (measuring exactly what the EU need to measure);

- Sensitive (correctly reflecting changes occurring in a given situation);

- Specific (to avoid the measurement of changes arising from external factors not related to the objectives and targets);

- Evidence based and timely;

[8] Decision No 2367/2002/EC of the European Parliament and of the Council of 16 December 2002 on the Community statistical programme 2003 to 2007. OJ No L 358 , 31.12.2002

- Permitting decisions about data collection. Defining inclusion criteria and exclusion criteria;

- Determination of interpretation (how to read data, limitation and acceptable tolerances);

- Data must be transformed into meaningful and useful information, reportable in a relevant manner to all stakeholders;

- The use of indicators should be followed by professional assessment, evaluation and interpretation.

Indicators and data on non-communicable diseases should be collected for a long-term and sustainable vision of the collections. This should not be a temporary or isolated exercise, but it should define suggestions and methods to sustain a routine register, a survey basis, or be based on future modules from the European Health Survey System or as a combination of sources.

On the basis of previous definitions of indicator initiatives, sustainable routine collection of information and data should be established for mental diseases, diabetes, asthma and chronic obstructive respiratory diseases, musculoskeletal diseases and cardiovascular diseases.

First steps of the disease information including inventory of sources and definition of indicators should be established for: haematological diseases, immunological disorders, allergies except asthma, genito-urinary diseases, nephrology disorders, ear-nose and throat disorders, ophthalmology disorders and dermatology diseases).

According to increasing impact in the sustainability of health care systems, special attention should be given to information on neurodegenerative (and, in general, brain diseases) relating to prevalence, treatments, risk factors, risk reduction strategies, cost of illness and social support as well as what constitutes a "healthy brain lifestyle". That includes Alzheimer and other dementias, Parkinson, Multiple Sclerosis, Epilepsy, and Amyotrophic lateral sclerosis as well as stroke, headache disorders and chronic pain.

Concerning rare diseases (Annex 2.3), including those of genetic origin, are life-threatening or chronically debilitating diseases which are of such low prevalence that special combined efforts are needed to address them. As a guide, low prevalence is taken as prevalence of less than 5 per 10 000 in the EU. Priority actions will be:

- Reinforcement of the exchange of information using already existing European information networks on rare diseases and promotion of better classification;

- Development of strategies and mechanisms for exchange of information among people affected by a rare disease, or volunteers and professionals involved;

- Co-ordination at Community level to encourage continuity of work and trans-national co-operation;

- Priority to generalist networks for improvement of information, monitoring and surveillance;

- Definition of relevant health indicators and development of comparable epidemiological data at EU level.

The future assessment actions on mortality information will focus on the analysis of potential effects and specific consequences of events leading to an unforeseen level of mortality (e.g. climate changes, an unanticipated epidemic, etc.).

2.1.5. eHealth (Article 3.2.d., Annex – points 1.7., 1.8)

Proposals will be encouraged, which organise a follow-up to the Ministerial Conference on eHealth of 2003 in Brussels and the eHealth conference of 2004 in Cork, building on their conclusions and including preparatory work at expert level, and taking account of the need to involve all stakeholders in the process.

Maintaining and developing further the European Health Information Network EUPHIN and integrating into the EU Public health portal.

2.1.6. Supporting the exchange of information and experiences on good practice (Article 3.2.d., Annex – point 1.7)

The use of common and harmonised international classifications on health is an essential tool to analyse information. In the field of diseases this is done with harmonised instruments such as the International Classification of Diseases (ICD) which is used in all the Member States.

To improve the quality of classifications and practices of codification using the ICD as well as other instruments in other fields priority should be given to support actions in the field of harmonisation of practices of information on hospital activity (especially information related to diagnosis discharges, codification of medical procedures and comparability of diagnosis related groups).

2.1.7. Health Impact Assessment (Article 3.2.c., Annex – point 1.5.)

Building on the methodology which has been developed for health impact assessment at Community level, case studies are encouraged which analyse the impact of activities on health in specific areas of legislation and sectors in which the Community has responsibilities (such as nutrition, alcohol, transport).

2.1.8. Co-operation between Member States (Article 3.2.d., Annex – point 1.5.)

The increased interconnection between health systems and health policies raises many health policy issues and offers scope for developing co-operation between Member States. In 2005, work will be supported taking account of the high-level process of reflection on patient mobility and health care developments in the European Union.

The following actions will be priorities:

- Quality assurance in Europe: This work will take stock of activities and initiatives related to quality assurance and improvement and accreditation systems across Europe, and develop perspectives for networking and collaboration, in particular at EU level covering also patient safety. Necessary studies on performance assessment of health care institutions to assess and compare quality strategies need to be developed in cooperation with the Health Care Quality Indicator Project from OECD.

- Pilot projects for cross-border co-operation in health services: The intention is to help develop co-operation, in particular in border regions, where this has not been developed before, and to identify potential benefits and problems associated with such co-operation.

- Issues related to the mobility of health professionals: There has been some concern that the mobility of health professionals could have unintended effects both for health systems and for the health status in sending and receiving countries. Projects should identify potential difficulties and develop an information system on mobility of health professionals based on existing known data (Labour Force Survey) and other data (professional organisations, other national sources). They should focus on general practitioners, specialists' and nurses' sustainable requirements; policy and planning tools available in the EU to influence the size, distribution and composition of the health workforce which preserve the sustainability of health systems; policy tools in the EU to improve health care system performance through a more efficient use of human resources; and the implications of health care system reforms in the EU for their human resources.

- Economics and health: Contribute to a better understanding of whether, why and how investing in health across all sectors has economic benefits to provide an important conceptual contribution to the Community's work on health. Actions should aim to strengthen understanding of these links, and should be developed in close co-operation with other relevant international organisations. See also § 2.3.3. (1).

- Develop a Hospital Activity and Resources Information System to strengthen the comparability of hospital information within the System of Health Accounts framework on hospital patients and develop time-series data. Also increase the scope of data collected to meet national and international imperatives for health care planning and patient mobility taking account of the Minimum Data Set on hospital statistics established in the Community Statistical Programme.

- Support all the necessary efforts led by Member States for the implementation of the System of Health Accounts (SHA). A focus will be given to the collection of a minimum dataset of core expenditure, and financing variables ideally to be reported by all Member States in 2005.

- As part of the patient mobility and healthcare development reflection process, actions in the area of health information for improved knowledge of the patient mobility flows and characteristics are necessary. For this purpose a Survey on Patient Mobility focusing on access and quality, coverage, insurance, service provided in Member States of origin, experimental treatment, quality, waiting times, satisfaction and motivation should be envisaged. It should contain survey variables in order to assess effects on inequalities in health care access of patient mobility. The type of care provided can supply information on effects of local shortages in connection to mobility of health professionals in the Member States and their region of origin. A mapping of centres of reference will be established.

2.2. Responding rapidly and in co-ordinated fashion to health threats

Activities under this section aim to support the development and integration of sustainable and Member State-backed or overseen systems for collecting, validating, analysing and disseminating data and information that address the needs for preparedness and rapid response to public health threats and emergencies. Activities would assist in particular the co-operation undertaken under the Community network on communicable diseases[9] [10] [11] [12] [13] and other EC legislation in public health and take account of the International Health Regulations that are being revised. Activities would support the European Community dimension of relevant projects, support the extension and development of surveillance schemes to cover all Member States, Candidate Countries, and EEA/EFTA Countries, be in line with the Regulation establishing the European Centre for Disease Prevention and Control (ECDC)[14], and promote evaluation, rationalisation and integration of existing arrangements for networking and other forms of collaboration.

Essential complementary activities (public information, prevention, education) on HIV/AIDS and sexually transmitted diseases fall under other sections of this work plan.

Activities regarding countering the threat of deliberate release of biological agents will be undertaken in tandem with on-going activities on communicable diseases. These and the activities on deliberate releases of chemical agents are being developed following the conclusions of the Health Ministers of 15 November 2001 and the consequent 'Programme of co-operation on preparedness and response to Biological and Chemical attacks' (Health Security).

Particular attention will be given to avoiding duplication and optimizing the synergies of activities funded by other granting mechanisms of the European Commission.

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9 Decision No 2119/98/EC of the European Parliament and of the Council of 24 September 1998 setting up a network for the epidemiological surveillance and control of communicable diseases in the Community. OJ No L 268, 03.10.1998

10 2000/96/EC: Commission Decision of 22 December 1999 on the communicable diseases to be progressively covered by the Community network under Decision No 2119/98/EC of the European Parliament and of the Council (notified under document number C(1999) 4015). OJ No L 28, 03.02.2000

11 Council Directive 92/117/EEC of 17 December 1992 concerning measures for protection against specified zoonoses and specified zoonotic agents in animals and products of animal origin in order to prevent outbreaks of food-borne infections and intoxications, OJ No L 62, 15.03.1993

12 2002/253/EC: Commission Decision of 19 March 2002 laying down case definitions for reporting communicable diseases to the Community network under Decision No 2119/98/EC of the European Parliament and of the Council (notified under document number C(2002) 1043). OJ No L 86, 03.04.2002

13 2000/57/EC: Commission Decision of 22 December 1999 on the early warning and response system for the prevention and control of communicable diseases under Decision No 2119/98/EC of the European Parliament and of the Council (notified under document number C(1999) 4016). OJ No L 21, 26.01.2000

14 Regulation (EC) No 851/2004 of the European Parliament and of the Council of 21 April 2004 establishing a European Centre for disease prevention and control. OJ No L 142, 30.04.2004

2.2.1. Surveillance (Article 3.2.a., Annex – point 2.1.)

The aim is to facilitate and accelerate co-operation with the Community Network on epidemiological surveillance and control of communicable diseases. Priority will be given to the development of tools, platforms, and multidisciplinary networks to identify, assess, and control communicable diseases and emerging risks.

Of particular interest is the development of integrated activities which link information on diseases with their determinants.

In view of the future operation of the ECDC, emphasis will be put on developing new tools for the monitoring and management of outbreaks of international importance, including geographical tools for timely detection and prediction of spread of disease outbreaks.

2.2.2. Exchanging information on vaccination and immunisation strategies (Article 3.2.a., Annex – points 2.4., 2.5.)

The aim is to promote good practices in vaccinology priority setting, strategic planning and decision-making (based on scientific evidence and rationale) in childhood and adult immunisation policies and in preparedness strategies (such as pre-event vaccinations or stockpiling), especially for serious health threats such as pandemic influenza and bioterrorism. A further priority are projects addressing the perception of immunisation and associated risks in different population groups.

2.2.3. Health security and preparedness (Article 3.2.a., Annex – point 2.4.)

This action aims to develop methods and strategies to prepare Member States, Candidate Countires, and EEA/EFTA Countries, and the Community as a whole, for potential threats of deliberate release of biological or chemical agents. Priority will be given to review, development and evaluation of policies and plans for facing up to health security emergencies with reference to legal instruments and to the incorporation of advances in knowledge and technology. Within this context, the following is of particular interest:

- Development of tools to strengthen networks of legal actors responsible for control measures;
- Isolation and quarantine measures in compliance with legal requirements;
- Building up capacity for communication and crisis management, including establishment and evaluation of pilot platforms;
- Bio-security policies and procedures;
- Assessment of health services priorities in chemical risk, preparedness and response;
- Development of tools, systems, or networks for the timely detection and tracing of chemicals and natural toxins that might be used in one or more scenarios, and for the related health emergency investigations and follow-up.

2.2.4. Safety of blood, tissues and cells, organs (Article 3.2.a., Annex – points 2.6., 2.7.)

(1) **Blood.** The priority action related to blood under the 2005 work plan aims to support the development of tools that will facilitate the implementation of quality systems in blood establishments in the Member States and will promote the optimal use of blood and blood components. Priority in the area of blood safety will be given to projects that:

- Facilitate the implementation of quality systems in blood establishments as required by Directive 2002/98/EC[15] through the preparation of multilingual modules in both paper and electronic form and that are tested in a few environments to gauge whether they can be effectively implemented;

- Develop multilingual modules that address the optimal use of blood and blood components for different surgical procedures or illnesses i.e. best practice. These should be user friendly (i.e. easily accessible in electronic form to anaesthesiologists / surgeons).

(2) **Tissues and cells.** This action aims to facilitate and foster the implementation of Directive 2004/23/EC. Therefore priority will be given to initiatives in the following areas:

- Development and implementation of quality systems in tissues and cells establishments and inspection schemes and practices;

- Development and management of an 'adverse event' registers/systems/communication for tissues and cells.

(3) **Organs**: This action aims to support initiatives in order to increase the availability of organs used for transplantation in the Community. The following areas will be prioritised:

- Pilot studies/projects in local settings that implement and evaluate methodologies and organisational schemes oriented to increase organ donation;

- Identification of models as well as best practices of educational programmes on donation and transplantation for local situations and needs, and to asses the efficacy of such programmes.

2.2.5. Antimicrobial resistance (Article 3.2.a., Annex – point 2.9.)

Activities should support the "Strategy against antimicrobial resistance" as laid down in a Communication of the Commission of July 2001[16]. Priority will be given to developing best practice on the prudent use of antimicrobial agents and infection control measures in human medicine in hospitals and the community. Other priorities are activities at European level to

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15 Directive 2002/98/EC of the European Parliament and of the Council of 27 January 2003 setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components and amending Directive 2001/83/EC. OJ No L 33, 08.02.2003

16 See http://europa.eu.int/comm/health/index_en.html

study (a) resistance to antiviral drugs and (b) burden of antimicrobial resistant infections (morbidity, mortality, costs).

2.2.6. Supporting the networking of laboratories (Article 3.2.a., Annex – point 2.4.)

This action aims to support networking and co-operation between European laboratories (e.g. on External Quality Assurance) with a focus on the integration of the new Member States. Priority will be given to the implementation of agreed methods and protocols for detection of rare high threat bacterial pathogens and toxins and the development of schemes to foster a structure for European reference laboratories for rare bacterial pathogens of public health importance at EU level.

2.2.7. Capacity building (Article 3.2.a., Annex – point 2.2.)

This action aims (a) to develop training programmes (e.g.: train the trainers programmes) and training material relevant to public health involving a variety of specialist services dealing with laboratory issues, first line clinical diagnosis issues, infection control, pharmacology, epidemiology, microbiology, and emergency management (b) to improve public health information exchange among member states.

2.3. Health Determinants

Tackling major health determinants is of great potential for reducing the burden of disease and promoting the health of the general population. Health determinants are factors which determine and influence good or bad health. This can include personal behaviour and lifestyles, influences within communities which can sustain or damage health, living and working conditions and access to health services as well as general socio-economic, cultural and environmental factors and conditions.

Effective work on health determinants calls for combining a variety of approaches. In certain cases and to tackle certain determinants, a settings approach has proven to be particularly effective (e. g. in schools, at the workplace, in health services). In fact, health services are both important contributors to health, and settings for health promotion and disease prevention. Equally, focusing on individual or collective health situations can sometimes be the best approach for achieving concrete results. At the same time, certain factors – including the wider determinants of health such as socio-economic factors and the environment - are best tackled by policy initiatives on a more general level.

The aim of Community action in this area is twofold. First, to encourage and support the development of actions and networks for gathering, providing and exchanging information and good practice in order to assess and prepare the development of Community policies, strategies and measures. Second, to promote and stimulate countries' efforts in this field, for example, by developing innovative projects or by supporting effective networking.

The priorities set out in this area for 2005 have been identified with the following considerations in mind:

- **Linking actions to policy priorities**: Project proposals should be linked to and show awareness of the development of key public health policy priorities, e.g. the strategies on nutrition and alcohol, tobacco and drugs policy, AIDS; work on health inequalities, the wider socio-economic determinants and investing in health;

- Giving attention to **areas not fully covered previously** (e.g. genetic determinants, physical activity),

- Giving priority to cross cutting and integrative approaches to **foster the integration of approaches on lifestyles, integration of environmental and socio-economic considerations**, focus on key target groups and settings. Project proposals should show how their proposed activities link work on different health determinants;

- Strengthening links between projects and **longer-term planning cycles** (e.g. the multi-annual drugs strategy or the environment and health action plan). This link should be clear in project proposals.

Projects should build upon and not duplicate the experience gained under previous Community public health programmes and the previous funding rounds under this programme. Projects should cover a wide range of eligible countries.

The priorities identified for 2005 are the following.

2.3.1. Supporting key Community strategies on addictive substances

The Commission has developed or is in the process of developing comprehensive policies and strategic approaches to address key addictive substances. Actions on specific substances should be linked as appropriate to work on other addictive substances and should take due account of socio-economic factors.

(1) In support of further developing the Community's strategy on **tobacco**, proposals should focus on:

- Mapping, assessment and evaluation of recent developments in Member States including measures and actions *i.a.* on preventing sales to children and adolescents, pricing and taxation, prohibiting certain forms of advertising other than direct advertising and sponsorship of events without cross border effect and environmental tobacco smoke (ETS), in line with the Council Recommendation on the prevention of smoking and on initiatives to improve tobacco control[17];

- Assessing the impact of health warnings and colour photographs on tobacco packages on consumer habits in particular of young people, including recommendations for improvement and adaptation of the warnings based on the latest scientific and technical knowledge;

- Providing advice in adapting to scientific progress the measurement methods for tar, nicotine and carbon monoxide and other substances and the marking for identification and tracing purposes of tobacco products;

- Develop and network prevention activities, focussing on specific settings (e.g. schools, health services and health professionals), de-normalisation, encouraging health professionals' involvement, and reducing exposure to ETS. Collect and disseminate information and best practice on tobacco control to the general public;

- Develop and network activities on best practice regarding tobacco cessation strategies.

Actions on ETS should link to work launched on indoor air pollution.

(2) On **alcohol**, activities will be linked to the overall strategic approach to reduce alcohol-related harm. Initial work in 2005 will focus on

- Innovative actions focusing on drink driving countermeasures and their effects;

- Promote the widespread implementation of screening and brief intervention programmes for hazardous and harmful alcohol consumption in for example primary care settings;

- Innovative and cross-sector awareness raising activities, involving a number of different actors, to improve synergy and coordination of campaigns and consumer

[17] Council Recommendation of 2 December 2002 on the prevention of smoking and on initiatives to improve tobacco control. OJ No L 22, 25.01.2003

information activities to mobilise public support for knowledge on prevention approaches with proven effectiveness;

- Best practice on information to the public, including consumer information and, in particular, health warnings and labelling;

- Best practice on how to reduce excessive and harmful drinking by, for example taking stock of existing preventive actions involving all stakeholders.

Work on drink driving should be linked to activities under injury prevention.

(3) On **drugs**, in line with the Community Strategy on Drugs and the Council Recommendation on Drugs[18], work will focus on: cross cutting health promotion activities (e.g. activities including mental health, social care and specialised approaches in risk reduction) and prevention activities such as the dissemination of reliable and high quality information and good practice, linking work on drug dependence with that on other addictive substances, sexual health and specific activities particularly impacting on youth and vulnerable people.

In 2005, priority will be given to projects on[19]:

- treatment and reinsertion activities covering all Member States and including both misuse/abuse of legal/illegal drugs;

- harm reduction interventions with emphasis on improving the availability of and access to harm reduction services and giving priority to HIV/AIDS and other blood borne infections.

2.3.2. Integrative approaches on lifestyles and sexual health

(1) Regarding **lifestyles**, work in 2005 will focus on integrated projects on healthy lifestyles aiming at inducing changes in certain behavioural patterns (nutrition/physical activity/obesity, leisure activities…). Such projects should take due account of the individual environments (social environment; exposure to marketing/advertising, role models, education/information campaigns, school and parental counselling; availability and accessibility of healthy foods, physical activity opportunities…) and create links to tackling other health determinants where appropriate.

A particular priority is the identification of good practice and networking concerning

- strategies and innovative actions to support physical activity in particular in school settings and at the workplace;

- specific work on obesity prevention, in particular among children and young people, including social and mental health aspects, and

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[18] Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence. OJ L 165, 03.07.2003

[19] Projects focussing on prisons will not be supported in 2005

- assessments of educational programmes and of information campaigns run by the food industry, retailers, consumer organisations, etc. which aim at promoting healthy diets.

(2) Work on **sexual health** will focus on developing strategies to address the observed increase in risk taking behaviours among young people.

(3) Actions to address **HIV/AIDS** continue to be a key priority within public health policy, and will be developed in line with the overall strategy as set out in the paper "*Coordinated approach to combat AIDS within the European Union and in its neighbourhood*".

In 2005, work will focus on public health actions to develop strategies and identify best practice on

- HIV/AIDS prevention in priority areas and/or amongst population groups at high risk;
- Preventing mother-to-child transmission;
- Continuing specific networking activities in regional target areas;
- Maintaining awareness of the need for prevention among lower risk groups.

(4) On **Mental health**, the following actions will be supported:

- Scientific support for networking to promote mental health and to prevent mental disorders;
- Promote positive mental health and prevent mental disorders focusing on children, adolescents and young people in settings such as pre-school, school and further educational settings as well in community settings;
- Identify the situation including policies, strengths, weaknesses and challenges in all Member States, including country analyses;
- Develop evidence based practices for effective mental health promotion and prevention of mental disorders, including actions on suicide prevention and prevention of self harm and substance abuse in children adolescents and young people;
- Special emphasis will be placed on evaluation and evidence of mental health promotion effectiveness.

2.3.3. Public health actions to address wider determinants of health

(1) **Socio-economic determinants** remain a major priority area for the programme. In 2005, work will concentrate on developing actions on **networking, identifying best practice and innovative approaches** in the following fields:

- A specific focus on developing targeted public health response strategies to address vulnerable groups, including access to and to quality of health and social services, as well as information and empowerment activities;

- Addressing specific issues, areas and settings of concern, notably housing and urban development and health, and workplace health and working conditions;

- Develop work on **investing in health** as a means to generate long-term health benefits and economic growth, taking into account the effects on the health sector and the improvement of productivity and economic conditions of citizens in general;

- A special focus should be given on quantifying the cost and benefits of prevention as well as of tackling inequalities.

Work should be linked as appropriate to actions on addiction and lifestyles. This would include developing targeted strategies and spread best practice e.g. on nutrition, drug use (include poly-consumption of legal and illegal drugs) and sexual health. See also § 2.1.8., 4th bullet point.

(2) In line with the Environment and health action plan[20], work on **environmental determinants** will focus on developing networks and identifying best practice regarding

- Public health actions to address indoor air pollution, in particular related to factors other than environmental tobacco smoke;

- Public health issues related to UV and optical radiation (lasers, sunbeds, etc);

- Developing and disseminating best practice on risk communication and awareness raising on environment and health issues.

2.3.4. Disease prevention, and prevention of injuries

(1) Building on the achievements under previous public health programmes specific **disease prevention** actions linked to the development of existing guidelines and best practice recommendations and perspectives for the future addressing main public health relevant diseases, such as cancer, cardiovascular diseases and diabetes, will be supported. In taking forward the Council recommendation on cancer screening[21] the development of a first set of comprehensive EU guidelines on best practice in colorectal cancer screening will be supported with the aim to link it to the follow-up of breast and cervical cancer screening undertaken by the European Cancer Network.

(2) As regards **injury prevention**, support will be given to the organisation of a European conference with a view to building a broader awareness of the European citizens in relation to the burden of injuries and to advocating prevention strategies developed

[20] Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee – "The European Environment & Health Action Plan 2004-2010" COM (2004) 416 final of 09.06.2004

[21] Council Recommendation of 2 December 2003 on cancer screening. OJ L 327, 16.12.2003

under different projects within the Working Party on Accidents and Injuries of the Public Health Programme. Special emphasis shall be paid to the involvement of the new ten Member States and the candidate countries.

To describe the state of the art in all Member States, the EEA countries and the candidate countries in regard to national policies and strategies to reduce risk taking behaviour of young people aged 15 to 25 and to identify existing models of good practice with a view to channelling the energy of young people towards positive objectives and to applying reasonable risks in daily life. Based on a deep analysis, European strategies shall be developed and steps for implementation in all countries shall be initiated with a view to injury prevention and, in particular, avoiding extensive risk taking behaviour of young people.

2.3.5. Genetic determinants for health and application of genetic screening

Genetic Testing, including screening for genetic determinants, is being more and more applied in various fields of medicine and society. Although these applications contribute in many cases already now to the health of the citizen they raise many well known ethical, social and legal concerns. As an initial step, one networking exercise will be supported to lead to an inventory report on genetic determinants relevant to public health. This network should identify public health issues linked to current national practices in applying genetic testing and on that basis should contribute to developing best practice in applying genetic testing.

2.3.6. Capacity building

(1) **Training actions:** in 2005, priority will be given to promote co-operation between educational institutions on the content of training courses and support the development of common European training courses in the field of public health linked to the key strategies set out in 3.1 to 3.3 above.

Moreover, projects to explore the *feasibility* of developing a coordinated approach to the training of environment and health professionals – using the full range of relevant Community policies – will be explored.

(1) A priority for 2005 will be to support the **development of capacities** of selected European networks in public health. These limited funds are destined to give short-term support to networks with high public health importance and very significant European added value to overcome specific geographic or developmental weaknesses.