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Preventive health care policies in the Council of Europe member states

Report[1]
Social, Health and Family Affairs Committee
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Summary

This report is based on the necessity to explain the reluctance of the Council of Europe member states to develop policies to make preventive health care a high priority. Inequalities in access to health education, information and care still exist, with a well-educated part of the population who enjoy easy access to the resources allocated and disadvantaged groups who experience greater difficulties. The real issue is therefore how to secure access to the available resources by all population groups, irrespective of their origin or socio-economic status.

International data indicate that the cost/effectiveness ratio of health care systems can be improved. However, it is not sufficient to reduce costs; it is also necessary to spend money differently and to look at health policy from an overall perspective, incorporating an ethical, social and human rights dimension in the reforms to be undertaken.

1. Reference to committee: Doc. 11544 and Reference 3436 of 18 April 2008.

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A. Draft recommendation[2]

1. The Parliamentary Assembly notes that over the last century Europe has experienced extraordinary gains in health and longevity. European health systems are appreciated worldwide for their equity and the ability to make treatment available to the population free of charge or at a reasonable cost. At the same time, our global consumer society has brought about new illnesses, such as obesity, heart disease, cancer, diabetes and mental health issues, and new health inequalities have emerged.

2. Population ageing will also have serious consequences for individuals, communities and states, altering disease patterns and affecting the viability of health systems. Chronic conditions are projected to be the leading cause of disability throughout the world by the year 2020. Some warning voices state that the present generation of children might be the first to have a lower life expectancy than their parents. Worrying data show for instance that diabetes in children has significantly increased in the past ten years. If not successfully prevented and managed, these chronic conditions will become the thorniest problems faced by our health care systems.

3. The health promotion lessons of the past thirty years have often been forgotten, overlooked or disregarded in policy implementation. Today's European health systems reward and nurture a therapeutic culture in which the goal is primarily to fix what goes wrong. As a consequence, the competent authorities face a strong and steadily increasing demand for an increase in the capacity of health systems to meet the needs of an ageing population and improve care quality. The existing knowledge of what ensures health – the so-called health determinants – societal changes as well as the exponentially rising rates of chronic diseases indicate that national health systems need to shift course and apply a new mindset to health.

4. The Assembly draws attention to the fact that inequalities in access to health care and health education and information still exist, with a well educated part of the population who enjoy easy access to the resources allocated and disadvantaged groups who experience greater difficulties. Some types of health inequalities have obvious spillover effects on the rest of society, for example, the spread of infectious diseases, the consequences of alcohol and drug misuse, or the occurrence of violence and crime. The real issue is therefore how to secure access to the available resources by all population groups, irrespective of socio-economic status.

5. The Assembly considers that disparities in health are partially avoidable to the extent that they stem from identifiable policy options exercised by governments, in particular education, regulation of business and industry, nutrition, agriculture, chemical production, environmental protection, road traffic, transport, alcohol, tobacco or drugs consumptions. It follows that health inequalities are, in principle, amenable to policy interventions.

6. Governments that care about improving the health of the population must incorporate to a much greater degree considerations of preventive health care policies in their policy setting process. There is a critical window of opportunity for European governments to make an important difference that can affect the lives of millions of Europeans by strengthening preventive and participatory medicine approaches.

7. Current knowledge on the social determinants of health, and the fact that an improvement in general health represents an additional asset to economic growth, are so well established that they are rarely questioned. The Assembly nevertheless regrets that, despite calls for better prevention policies and despite all the recommendations and a number of statutory and legislative advances, there is still little reaction to known or emerging health risks, in particular those relating to non-communicable diseases. Health promotion policies require long-term vision and the implementation of strategies and concrete measures, which are consistently under-prioritised in many national responses.

8. The Assembly therefore urges Council of Europe member states to examine and evaluate their preventive health care strategies, paying renewed attention to the social determinants of health and health inequalities and focusing on health gains, and to renew their commitment towards the health goals of the World Health Organization (WHO).

9. Furthermore, the Assembly asks the Committee of Ministers to invite member and observer states of the Council of Europe to:

9.1. define minimum standards of access to health care based on fundamental human rights and sound public health policies and practices, bearing in mind that the right to health applies to the whole population, including all migrants, irrespective of their migratory status;

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2. Draft recommendation adopted unanimously by the committee on 29 March 2010.

9.2. promote better health and close the health gaps as a shared goal across various policies and incorporate a concern with health impacts into the policy development process of all sectors and agencies, by adopting the so-called “health in all policies” approach;

9.3. strengthen risk prevention and reduction mechanisms of environment-related health hazards due to air, water, food, noise and soil pollution and promote the positive health effects of access to a good quality environment, as stressed in the Assembly Recommendation 1863 (2009) on environment and health: better prevention of environment-related health hazards;

9.4. improve early screening and detection mechanisms for diseases and conditions, including HIV/AIDS, and tuberculosis, to enable illnesses to be treated promptly and to provide the means by which each individual may be oriented to complementary services and support. Furthermore, actively co-operate with the WHO and the global surveillance system in order to halt the expansion of infectious diseases;

9.5. promote a comprehensive sex and health education, including abstinence, to prevent the spread of sexually transmitted diseases;

9.6. promoteuniversal screening for non-infectious diseases and for risk factors at key ages or in specific situations, for the prevention of certain genetic or environmental related risks;

9.7. incorporate preventive heath care policies explicitly in poverty reduction strategies and in relevant socio-economic policies so as to tackle inequalities in access to health information and protection, risk exposure and access to care which lead to major inequalities in the emergence and outcome of diseases, paying particular attention to the situation of vulnerable people in Europe;

9.8. support a good start in life for families and young children, by strengthening preventive health care before pregnancy and for mothers and babies in pre- and post-natal, infant welfare and school clinics, and through improvements in the educational levels of parents and children;

9.9. intensify the efforts to make health education and health literacy a priority for public health policy and in particular make sure that they form part of the school curricula, exploring the possibilities offered by new technologies in the learning context;

9.10. develop independent research, based on scientific criteria, free from economic lobbying pressure, in particular the food, pharmaceutical and tobacco industries;

9.11. ensure transparent decision-making and accountability in all food regulation matters, support sustainable agriculture and food production methods that conserve natural resources, develop a strong food culture for health and foster people’s knowledge of food and nutrition;

9.12. pay attention to the risks of stigmatisation when planning campaigns on nutrition and healthy body weight, which could have unintended negative consequences for overweight people or people at risks of developing body image and eating disorders;

9.13. encourage the private sector, as well as the media, to increase their commitment to health issues and make the riskiest industries aware of their responsibilities through negotiation, encouraging transparency and fostering a culture of corporate social responsibility, in particular with regard to the less-privileged segments of the population;

9.14. work with the food and advertising industries to encourage the inclusion of key data, facts and figures on non-communicable diseases and to ban advertising of harmful products; make recommendations for reductions in levels of saturated fat and added sugar and increased marketing of reduced/low saturated fat and reduced/low/no sugar versions of certain food products;

9.15. promote the development of indoor and outdoor facilities for more physical recreation, including gymnasia, pools, playing fields and arenas; reinforce support for sport programmes, in particular those accessible to the whole population, irrespective of age, sex and origin, and encourage the private sector to accept more social responsibility for extending the use of their facilities to less-privileged people;

9.16. strengthen integration between care and prevention by enlisting the support of health professionals. Furthermore, support health education as a key element of initial and continuing medical training, including in particular nutrition, health and human rights education. In addition, introduce health literacy as a key indicator of good hospital care;

9.17. deal with the wider social setting that influence a problematic use of alcohol, tobacco and drugs (including psychotropic medicines whose regular use also presents risks of addiction) and support addiction policies with a broad framework of social and economic policies;

9.18. actively support the WHO efforts in establishing an international framework to deal with the harmful use of alcohol, following the example of the WHO Framework Convention on Tobacco Control;

9.19. promote educational campaigns to increase awareness of the gravity and underlying causes of traffic accidents, deaths and injuries;

9.20. adopt appropriate measures to enable elderly persons to lead independent lives and to continue to live in their familiar surroundings as long as they wish and are able to, and provide mental health programmes for any psychological problems in respect of the elderly, together with adequate palliative care services;

9.21. devote special attention to mental and psychic health, including the prevention of mental disorders and suicide. Furthermore, promote well-being, including a good work-life balance and support the social integration of highly marginalised groups such as refugees, disaster victims, the socially excluded, the mentally disabled, the elderly and frail, women and children suffering violence and the very poor;

9.22. formulate, implement and periodically review a coherent national policy on occupational health and safety in consultation with employers' and workers' organisations;

9.23. develop "soft" mobility and healthy and environmental-friendly transport policies, such as public transports, car-sharing and carpooling initiatives, with a view to creating pedestrian/cyclist-friendly towns, in co-operation with local and regional authorities;

9.24. encourage the participation of civil society organisations, such as patients' and consumers' associations, registered charitable bodies and non-governmental organisations and actively support them;

9.25. set-up evaluation systems and promote standardisation of data, information collection and relevant indicators, in accordance with the WHO recommendations.

10. Finally, the Assembly calls on the Committee of Ministers to:

10.1. review, update and compare Council of Europe member states' national and international preventive health care policies and health promotion strategies, in co-operation with the European Union;

10.2. review and compare policy implementation and encourage the member states to increase the resources allocated to preventive health care and health promotion policies and to ensure their sustainability;

10.3. examine the role played by national, European and international organisations engaged in health promotion policies and explore plans for a more strategic interaction based on each organisation's area of specialisation;

10.4. engage in constructive dialogue with the European Commission, with a view to strengthening solidarity in health and tackling health inequalities in Europe by focusing in particular on non-European Union countries in close co-operation with the WHO;

10.5. instruct a committee of experts to elaborate a draft recommendation based on the elements above within the next two years.

B. Explanatory memorandum by Ms Maury Pasquier, rapporteur[3]

1. Introduction

1. The right to protection of health is enshrined in Article 11 of the revised European Social Charter, which is worth recalling: “With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed *inter alia*: to remove as far as possible the causes of ill-health; to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; to prevent as far as possible epidemic, endemic and other diseases, as well as accidents”.[4]

2. Following Recommendation 1626 (2003) of the Council of Europe’s Parliamentary Assembly on the reform of health care systems in Europe: reconciling equity, quality and efficiency, the Committee of Ministers declared in 2004 that “the Council of Europe will continue to play an important role in assisting member states to incorporate the ethical, social and human rights dimension in health policies and in reforms of their health care systems. Continuing attention will be paid to access for the vulnerable and in finding a new balance between curative, preventive and promotive health care”.[5]

3. In the Oslo Declaration on Health, Dignity and Human Rights, the European Health Ministers meeting in Oslo on 12 and 13 June 2003 called for “a proper balance between preventive and curative care, with a marked insistence on the development of healthy lifestyles. For this purpose measures should be taken to develop individual responsibility towards one’s own health, and ensure citizen participation in the decision-making process concerning health care lifestyles”.[6]

4. Budget constraints in the majority of Council of Europe member countries weigh heavily on the public funding of health systems as currently organised. The various budgetary contexts therefore produce health policies based more on the treatment of disease and on health care systems than on preventive policies.

5. The European population is undergoing demographic changes, including population ageing, which will have serious consequences for individuals, communities and states, alter disease patterns, particularly as regards chronic and non-communicable diseases, and affect the viability of health systems. Chronic conditions are projected to be the leading cause of disability throughout the world by the year 2020. If not successfully prevented and managed, they will become the most expensive problems faced by our health care systems.

6. Because of growing pressure on public finances as a result of demographic change, it is becoming vital to develop a fresh approach that will enable every individual to enjoy the highest possible standard of health attainable and ensure that everyone has equitable access to it whilst maintaining budgetary balance.

7. If health policies in Europe are to be effective, therefore, they need to incorporate an overall preventive approach so as to be able to assimilate and address health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

8. The rapporteur believes that investing in prevention offers obvious economic and financial benefits. Investment in disease prevention and health promotion can not only preserve and improve an individual’s health and quality of life but also increase the productivity of society and maintain a population’s work capacity. It can prevent early death and early retirement resulting from disease, reduce business production losses, maintain the independence of the elderly and avoid or delay care needs.

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3. The rapporteur wishes to thank the “prevention and health” working group of the Conference of INGOs of the Council of Europe for their contribution (in appendix), the WHO experts for their participation in the meeting of the Sub-Committee on Health, held in Geneva on 24 November 2008, as well as Professor Dragan Gjorgjev and Dr Peter Makara.

4. The Charter has several provisions which guarantee, expressly or implicitly, the right to health. Article 11 covers numerous issues relating to public health, such as food safety, protection of the environment, vaccination programmes and alcoholism. Article 3 concerns health and safety at work. The health and well-being of children and young persons are protected by Articles 7 and 17. The health of pregnant women is covered by Article 8. The health of elderly persons is dealt with in Article 23.

5. Reply adopted by the Committee of Ministers on 3 June 2004 at the 886th meeting of the Ministers’ Deputies to Parliamentary Assembly Recommendation 1626 (2003) on reform of health care systems in Europe: reconciling equity, quality and efficiency (Rapporteur: Mr Brînzan, Romania, Socialist Group). See also the Recommendation Rec(2000)18 of the Committee of Ministers to the member states on criteria for the development of health promotion policies.

6. 7th Conference of European Health Ministers on Health, Dignity and Human Rights (Oslo, 12-13 June 2003).

9. At the same time, disease prevention and health promotion enhance the population's health competence and can thus lead to a more highly differentiated demand for and use of health provision, which can help to reduce the rising cost of health systems in the long term.

10. However, inequalities in access to health education, information and care still exist, with a well educated part of the population who enjoy easy access to the resources allocated and disadvantaged groups who experience greater difficulties. The real issue is therefore how to secure access to the available resources for those most in need.

11. An ever increasing percent of health care costs in all European countries are attributable to chronic and preventable diseases the kind that conventional medicine does very badly with. Our system rewards and nurtures a therapeutic culture in which the goal is primarily to fix what goes wrong. We have a "sickness culture" and we need to get into a "health culture", which must remain accessible to the whole population.

12. This report will review existing preventive approaches to health care and health promotion. These policies require a long-term vision which is not completely the case yet in the Council of Europe member states, despite existing recommendations made by several international organisations. The rapporteur will also probe into the costs of inaction, the advantages of prevention and the obstacles to a genuine and comprehensive preventive health care policy. Finally the report will discuss a number of policy pointers to take into account when designing health promotion strategies, drawing from the recommendations of the World Health Organization (WHO), the conclusions of the Council of Europe European Committee of Social Rights as well as recent public health research reports.

2. Who does what at the international level

13. Disease prevention and health promotion have assumed increased importance in international health policies. However, national health policies and structures reflect deeply rooted values and norms which differ between societies. Because of substantial inter-country differences, it cannot be assumed that concepts are shared: terms such as prevention, health promotion and public health are used differently, which prevents direct comparison.

14. However, certain clear tendencies, as reflected in important policy documents and in recommendations by European and international organisations – in particular WHO, the Organisation for Economic Co-operation and Development (OECD), the European Commission and the Council of Europe – can be discerned.

15. Policy approaches are increasingly aimed at more than changing behaviour patterns and concern themselves with health inequalities and health determinants, that is, with the underlying causes of health and disease. This means that other political and social fields must be incorporated in a forward-looking health policy.

16. Although comparisons can be made between health care systems, there is as yet no comprehensive plan for the systematic listing and analysis of the wide range of draft laws, policies and programmes in the fields of disease prevention and health promotion.[7] Here follows a brief overview of activities of the main international organisations dealing with preventive health care policies and health promotion actions.

2.1. World Health Organization (WHO)

17. For many years WHO has been stressing the need for investment in health and has published documents which are among the most influential in the fields of disease prevention and health promotion, such as the Ottawa Charter for Health Promotion, the Framework Convention on Tobacco Control, the Global strategy on Diet, Physical Activity and Health and the 2008-2013 Action plan for the global strategy for the prevention and control of noncommunicable diseases. As regards infectious diseases, WHO has created a global surveillance system by setting up a "network of networks" which combines the networks of medical laboratories and centres already existing at the local, regional, national and international levels.

2.2. Organisation for Economic Co-operation and Development (OECD)

18. The central theme of OECD work on health policy is the measurement and improvement of the performance of health care systems in member countries. Many countries possess a national framework for measuring the performance of their health systems and have carried out reforms. In its publication Health at a

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7. The WHO European Observatory on Health Systems and Policies plays this role only to a partial extent.

Glance 2007, the OECD shows that health care quality, as measured by the provision of suitable care or actual improvements in health, is making progress in the OECD countries. However, the prevention and management of chronic diseases pose an increasingly formidable challenge to health policies.

2.3. European Union (EU)

19. The EU's health strategy focuses on health as a precondition for economic progress, health inequalities between and within the 27 EU member states, health promotion in all policy sectors and the mobilisation of all the parties involved. A programme of community action in the field of public health for 2008-2013 is intended to promote health in an ageing Europe, protect the public from threats to health and encourage dynamic health systems and new technology. Actions in the field of health and consumer protection are also carried out and a European pact for mental health and well-being helps to increase the population's awareness of mental disorders.

2.4. Council of Europe

20. National representatives from 47 member states work together with specialist experts to set out minimum guarantees to safeguard human rights, the right to the protection of health and indeed patients' rights at the European level. Health protection and promotion are two lines of action used to develop an ethical European health policy. This is carried out by combining human rights, social cohesion and health agendas, harmonising member states' health policies in terms of safety and quality, developing preventive medicine and health education, and promoting patients' rights, access to health care, citizen participation and protection for vulnerable groups. Co-operation activities carried out in co-operation with WHO and the European Commission, such as the Schools for Health in Europe Network and the South-Eastern Europe Health Network,aim at bridging the principles and standards with real life practical situations.

21. Preventive health care and health promotion policies certainly benefit from transnational sharing of information and global co-operation. However, while some overlap of activities from different organisations is inevitable and different perspectives desirable, it would be useful to ensure a more strategic interaction based on each organisation's area of specialisation. The existence of many interrelated mandates can be confusing and redundant, especially when these must be implemented within resource constraints that do not keep pace.

22. Efforts made by international and supranational organisations as well as collaborative advocacy among NGOs have led to greater recognition of the importance of health promotion policies, thus showing a trend of policy convergence. However, there appears to be convergence in officially stated policy but considerable divergence in the willingness to actually implement that policy.[8]

23. It is important to stress that health is essentially a state responsibility and access to care remains a major concern that takes precedence over the development of a prevention culture. While European health systems are appreciated for their ability to make treatment available to users at a reasonable cost, prevention policy, which requires vision and the implementation of longer-term strategies, does not seem to constitute a policy priority.

3. Costs of inaction and advantages of prevention

24. At a time when budgetary pressures are having an ever-increasing impact on how our health systems are organised, it could be worthwhile to step up prevention policy in the hope of making savings. One only has to take a look at the epidemiological data to realise this.

25. Additional problems are raised by the ageing of the population. By 2050 over a quarter of the population of the WHO European region will be more than 65 years old. At least 35% of men over 60 suffer from a number of chronic ailments; the number of co-morbidities increases progressively with age and levels are higher in women. The care of patients suffering from chronic diseases requires effective health care services which promote health and are capable of managing complex long-term diseases which require a patient-based approach.[9]

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8. Richard B. Saltman, Convergence versus social embeddedness – debating the future direction of health care systems, European Journal of Public Health 1997.
9. WHO, Tackling Europe's major diseases: the challenges and the solutions, Fact sheet EURO/03/06, Copenhagen, 11 September 2006.

26. Health indicators show a rise in chronic diseases and lifestyles which are harmful to health. These are the symbolic diseases of a global consumer society. Non-communicable diseases are currently responsible for 86% of deaths and 77% of the burden of disease. This group of conditions includes cardiovascular diseases, cancer, mental health problems, diabetes mellitus, chronic respiratory diseases and muscular/ skeletal disorders. Cardiovascular diseases are the chief cause of death inasmuch as they are responsible for half the deaths in the region as a whole, with heart failure and stroke forming the main cause of death in all countries.

27. According to WHO, seven risk factors account for nearly 60% of the burden of disease in Europe: hypertension (12.8%), smoking (12.3%), alcohol abuse (10.1%), raised cholesterol (8.7%), excessive weight (7.8%), inadequate fruit and vegetable consumption (4.4%) and lack of physical exercise (3.5%).

28. These common risk factors have economic, social, gender-linked, political, behavioural and environmental determinants.[10] For example, differences between socio-economic groups in regard to mortality from cardiovascular diseases and risk factors giving rise to the latter have been reported in numerous countries. Elimination of the gap between lower and upper socio-economic groups offers considerable scope for reducing mortality due to cardiovascular disease and other non-communicable conditions.

29. By way of illustration, in addition to the health problems linked to tobacco consumption, about 650 000 smoking-related deaths occur every year in the EU. Nearly half the victims are between 35 and 69, well below average life expectancy. The direct and indirect costs in Europe were estimated by WHO at between €97.7 and €130.3 billion in 2000, which represents between 1.04% and 1.39% of the EU's Gross Domestic Product (GDP).[11]

30. People die from all chronic diseases at much lower ages in central and eastern European countries than in Western Europe. For example, in Hungary the cost of tobacco addiction amounted to 3.2% of GDP in 1998, while in Finland and France the cost was estimated at between 1.1% and 1.3% of GDP. In Sweden, the overall cost of health care and smoking-related losses in productivity came to 26 billion Swedish kroner in 2001, which is comparable to the national contribution to international aid (21 billion) or to the operation of the legal system (23 billion).[12]

31. In addition, the economic consequences of non-communicable diseases exceed the direct cost of health services. It has been estimated that in Sweden over 90% of total expenditure on muscular/skeletal disorders are of an indirect nature (sick leave: 31.5%; early retirement: 59%). Premature death of the main breadwinner and of skilled workers affects not only household income but also the national economy. It has been estimated that the GDP of the Russian Federation was reduced by 1% in 2005 as a result of non-communicable diseases.[13]

32. WHO calls on countries to take measures and implement collective action programmes aimed at the public at large, such as reduction of the amount of salt in processed foods, reduction of the quantity of fat in the diet, promotion of physical exercise and the consumption of fruit and vegetables and smoking control. These actions are recognised as the most effective ways of controlling cardiovascular diseases.

33. The first effect of prevention is to give the population as a whole an improved quality of life by reducing the occurrence or severity of disease and by allowing individuals to take control over their health and well-being. Prevention also has substantial financial effects in addition to these intangible benefits, as it can lead to social security savings by reducing the length of time workers are absent. A targeted prevention policy can also produce savings in sickness insurance as such by avoiding or reducing the cost of future treatment.

34. The competent authorities face a strong and steadily increasing demand for an increase in the capacity of health systems to meet the needs of consumers and patients, improve care quality and correct disparities in health and access to care. The fact that an improvement in general health represents an additional asset to economic growth and therefore a further source of income is so well established that one rarely sees it questioned. However, the rapporteur believes that analysis of the role of power in influencing what policies gain and lose remains currently neglected.

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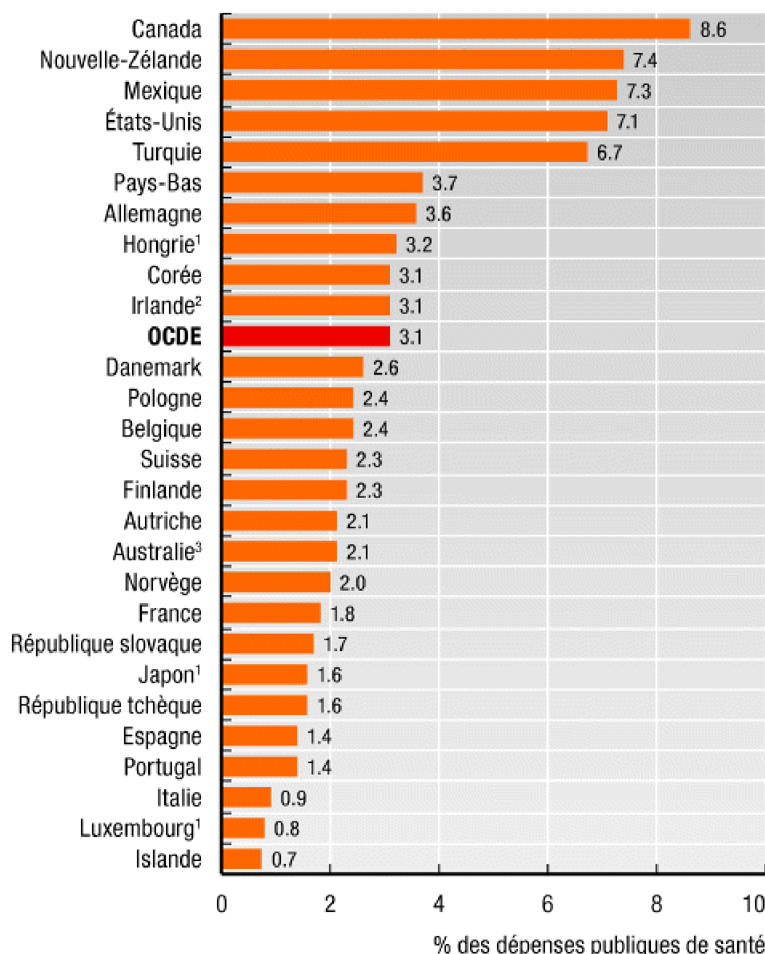
10. R. G. Wilkinson and M. Marmot (eds), Social Determinants of Health. The Solid Facts. Copenhagen, WHO Regional Office for Europe, 2003.
11. WHO, European Tobacco Control Report 2007, Regional Office for Europe.
12. Ibid.
13. WHO-Europe, Strategy for the Prevention and Control of Non-communicable Diseases 2006; WHO-Europe, Non-communicable Diseases in the WHO European Region: a Challenge 2004.

4. Obstacles to implementing a genuine prevention policy

35. Data show that resources are allocated chiefly, and at great expense, to the curative services and traditional medical care, while primary prevention and health promotion are neglected. On average, the OECD countries have earmarked scarcely more than 3% of their public health expenditure for a wide range of activities such as vaccination programmes and public health campaigns against alcohol and tobacco abuse. The great disparity largely reflects the way prevention campaigns are organised nationally.[14]

Proportion of public health expenditure allocated to public health and prevention in OECD countries (2005)



% of public health expenditure

Source: OECD Health 2007

36. It seems, moreover, that compared with the budget for curative medicine the public authorities' efforts regarding disease prevention and health promotions are minimal. Public expenditure on disease prevention in the European area represented between 0.1% and 0.5% of GDP. By way of comparison, the Czech Republic, Iceland, Luxembourg and Poland devoted 0.1% of GDP in the same year. The figures were 0.2% for France, Austria, Denmark, Norway, Portugal, the Slovak Republic, Spain, Sweden and Switzerland, 0.3% for Germany, 0.4% for Finland, Belgium and the Netherlands and 0.5% for Hungary.[15] What are the reasons for this imbalance between the funds allocated to prevention and those for the treatment of disease?

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14. According to OECD analyses, when these initiatives are carried out at the primary care level, as happens in Spain, the prevention function is not identified separately and is generally included in expenditure on curative care. Other countries adopting a more centralised approach to public health and prevention campaigns are able to identify expenditure under these programmes more clearly.
15. OECD Health Data 2008 (December 2008).

37. A co-ordinated overall approach to prevention, a propercontinuumbased on the participation of all parties concerned with health, education and welfare and on the need for everyone to be aware of the importance of health capital, encounters a number of obstacles, which are outlined as follows:

37.1. A short-term vision: expenditure on prevention presents a disadvantage for the competent health authorities in that the effects of prevention efforts are often only visible in the long term. Authorities embarking on a large-scale prevention programme therefore run the risk of never seeing the benefits of their policy (which are often reaped by their successors);

37.2. Limited financial and human resources: most current health care systems are based on responding to acute problems, urgent needs of patients, and pressing concerns. Preventive health care is inherently different from health care for acute problems, and in this regard, current health care systems worldwide fall remarkably short. Prevention budgets are always difficult to evaluate but are in any case modest. The same applies to the staff allocated to prevention, whether they are in school medicine, industrial medicine or public health medicine. The training of staff not dedicated exclusively to prevention is, furthermore, often inadequate;

37.3. The difficulty of enacting or enforcing binding rules: this is sometimes due to the influence of powerful lobbies and economic interests which have been able to prevent the passing of laws in sectors such as food hygiene, agriculture, transport, industry, tobacco and alcohol. Even when such laws exist they are often bypassed and their application is sometimes left to the good will of the parties involved;

37.4. The absence of genuine policy continuity and involvement of the local authorities: prevention all too often consists of large-scale national media campaigns without any real impact on action at the local or field levels. Failure to assess the actions undertaken has prevented certain innovative approaches from being pursued and made a part of general practice;

37.5. The question of the role of the media: the information they deliver to the general public sometimes interferes with the perception of certain risks or of the true issues involved in disease prevention. The close dependence between the issues on which public opinion is focused, the policy decisions and budget allocations often leads to a disproportion between the sums earmarked for the reduction of certain risks and the seriousness of those risks.[16]

38. Despite these obstacles, positive trends can be discerned, particularly an increase in attention to strategies that concentrate on health determinants and inequalities and focus on health gains. Similarly, mental health is becoming more important, the introduction of new partners is encouraging intersectoral collaboration and new forms of organisation and financing, for example foundations, are being tested in several countries.

39. Generally speaking, preventive actions remain all too often based on a biomedical vision of health. Prevention can only be genuinely effective in the health field if the living conditions available to the population are such that it can avoid exposure to a number of risks and is able to receive a preventive message.

5. A comprehensive approach to preventive health care and health promotion policies: some policy pointers

40. A country's unique circumstances must be taken into account when the time comes to decide on appropriate policies. National, European and international studies and action plans on disease prevention indicate a number of avenues to be explored or possibly useful approaches for improving the performance of national health systems.

41. An increasing number of countries today are developing policies and programmes that explicitly address the root causes of ill health, health inequalities and the needs of those who are affected by poverty and social disadvantage. This has led to a growing understanding of the sensitivity of health to the social environment and to the so-called social determinant of health.[17] Here follows a series of key actions, policy pointers and challenges faced by policymakers:

41.1. Promoting better co-ordination between the various policies and the so-called "health in all policies" approach: an effective and innovative prevention policy must provide a continuous cradle-to-grave strategy covering the preventive and curative aspects and taking account particularly of the different policies. Public policy can shape the social environment in ways conducive to better health. Policies on social inclusion, education, nutrition, agriculture, chemical production, industry, road traffic,

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16. David Crainich, "Toward a more substantial disease prevention policy", Itinera Institute, 2007.

transport, alcohol or tobacco consumption or other fields which are not strictly part of the health authorities' responsibility have to be adapted accordingly. The carrying out of health impact studies, for example when a public policy is introduced, could assist such co-ordination without endangering budgetary balance.

41.2. Actively co-operating with WHO and the global surveillance system in order to halt the expansion of infectious diseases: globalisation has brought about the rapid spread of new infectious disease, such as SARS and HIV Aids and the re-emergence of others, such as tuberculosis and malaria. HIV prevention, in particular, is consistently under-prioritised in many national responses.[18] There is increasing fear of global influenza pandemic and preparedness is critical at all levels of health governance, in particular at the international level.

41.3. Influencing risk prevention and reduction at the environmental level (pollution, intensive use of antibiotics in livestock raising, use of pesticides in agriculture, etc.): numerous measures aimed at environmental hygiene are economical compared with more conventional curative action in the health sector. To take the example of the gradual elimination of leaded petrol, it is estimated that mental retardation caused by exposure to lead in general is nearly 30 times higher in regions where leaded petrol is still used than in those where such use has ceased. The Assembly has recently examined this issue with the Recommendation 1863 (2009) on environment and health: better prevention of environment-related health hazards, which are referred to for further information.[19]

41.4. Incorporating prevention policies explicitly in poverty reduction strategies and in relevant socio-economic policies: inequalities in access to protection, risk exposure and access to care lead to major inequalities in the emergence and outcome of disease. Disadvantages tend to concentrate among the same people and their effects on health accumulate during life. They can include having few family assets, having a poorer education during adolescence, having insecure employment, becoming stuck in a hazardous or dead-end job, living in poor housing, trying to bring up a family in difficult circumstances and living on an inadequate retirement pension. The longer people live in stressful economic and social circumstances, the greater the physiological wear and tear they suffer, and the less likely they are to enjoy a healthy old age. Reducing educational failure, insecurity and unemployment, improving housing standards, introducing minimum income guarantees, minimum wages legislation and access to services can help to redress the balance.

41.5. Supporting a good start in life for families and young children: research shows that the foundations of adult health are laid in early childhood and before birth. Slow growth and poor emotional support raise the lifetime risk of poor physical health and reduce physical, cognitive and emotional functioning in adulthood. Insecure emotional attachment and poor stimulation can lead to reduced readiness for school, low educational attainment, problem behaviour and the risk of social marginalization in adulthood. Good health-related habits, such as eating sensibly, exercising and not smoking, are associated with parental and peer group examples, and with good education. Slow or retarded physical growth in infancy is associated with reduced cardiovascular, respiratory, pancreatic and kidney development and function, which increase the risk of illness in adulthood. It is critical to strengthen preventive health care before the first pregnancy and for mothers and babies in pre- and postnatal, infant welfare and school clinics, and through improvements in the educational levels of parents and children.

41.6. Health education and health literacy must be a priority of public health policy: people, children in particular, have a right to learn about health and gain the health literacy skills to lead a healthy lifestyle and navigate the consumer society. Health literacy should form part of the curricula and explore the possibilities offered by the new technologies, with a particular focus on smoking, drugs, alcohol abuse, nutrition, mobility and safety, sport and sex education. Participation of young people in shaping solutions to their particular education needs is critical. Conditions at school should also encourage the adoption of healthy behaviour through pupils' working, hygiene and dietary conditions. Periodical medical examinations should be carried out throughout schooling. Immunisation programmes should be widely accessible with high vaccination coverage rates. Health care must be available to all children without discrimination, including children of illegal and undocumented migrants.

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17. WHO, Social determinants of health, The solid facts, second edition, 2003; WHO-Commission on Social Determinants of Health, Closing the gap in a generation – Health equity through action on the social determinants of health, 2008.
18. UNAIDS, 2008 Report on the global Aids epidemic.
19. See also the Parma Declaration on Environment and Health, WHO Europe – Fifth Ministerial Conference on Environment and Health "Protecting children's health in a changing environment", Parma, Italy, 10-12 March 2010.

41.7. Ensuring transparent decision making and accountability in all food regulation matters, to provide affordable and nutritious fresh food for all: a shortage of food and lack of variety cause malnutrition and deficiency diseases. Excess intake, also a form of malnutrition, contributes to cardiovascular diseases, diabetes, cancer, degenerative eye diseases, obesity and dental caries. Food poverty exists side by side with food plenty. There is confirmed link between childhood obesity and deprivation. The important public health issue is the availability and cost of healthy, nutritious food. Sustainable agriculture and food production methods that conserve natural resources and the environment should be further supported; developing a stronger food culture for health, to foster people's knowledge of food and nutrition, especially aiming at children, remains critical.

41.8. Paying attention to the risks of stigmatisation: campaigns on nutrition and healthy body weight may have unintended negative consequences and should not stigmatise overweight people, who are likely to deny their problem; they should also keep a watchful eye on people at risks of developing body image and eating disorders, such as bulimia and anorexia. Efforts should be put into identifying opportunities for partnerships with the media and fashion industries that promote positive body image.

41.9. Encouraging the private sector to increase its commitment to health issues: making the industries involving potential risks aware of their responsibilities through negotiation, fostering a culture of corporate social responsibility; working with the food and advertising industries to encourage the inclusion of key data, facts and figures on non-communicable diseases and to improve the nutrition environment, including production, supply and marketing of food; making recommendations for reductions in levels of saturated fat and added sugar and increased marketing of reduced/low saturated fat and reduced/low/no sugar versions of certain food products; standards for marketing, advertising and body image should be also explored; advertising of harmful products should be banned.

41.10. Strengthening integration between care and prevention by enlisting the support of health professionals: introducing health education as a key element of initial and continuing medical training, including in particular nutrition, health and human rights education; introducing health literacy as a key indicator of good hospital care. This includes a strong interest in the determinants of health and a reduction in the routine and excessive use of medication which can be expensive, pointless and/or harmful or even dangerous.

41.11. Promoting universal screening for risk factors at key ages or in specific situations: facilitating family consultations for the prevention of certain genetic or environmental risks; applying cost-effective approaches for oral and dental disease prevention and the early detection of breast and cervical cancer, diabetes, hypertension and other cardiovascular risk factors. Checks and disease testing are still sadly patchy and biased to the more affluent areas: a universal risk assessment and management programme could significantly increase uptake of the preventative interventions and offer a real opportunity to reduce health inequalities.

41.12. Dealing with the wider social setting that influence use of alcohol, drugs and tobacco: addiction is often closely associated with markers of social and economic disadvantage; policies need to regulate availability through pricing and licensing, to inform people about less harmful forms of use, to use health education to reduce recruitment of young people and to provide effective treatment services for addicts. Trying to shift the whole responsibility on to the user is clearly an inadequate response. This blames the victim, rather than addressing the complexities of the social circumstances that generate legal or illegal drug use. Effective addiction policy must therefore be supported by the broad framework of social and economic policy.

41.13. Adopting appropriate measures to enable elderly persons to lead independent lives: policies should enable the elderly to choose their life-style freely and to continue to live in their familiar surroundings for as long as they wish and are able to, by means of the health care and the services necessitated by their state. In the context of a right to adequate health care for elderly persons, Article 23 of the (revised) European Social Charter calls for the setting-up of health care programmes and services (in particular nursing and domiciliary care) specifically aimed at the elderly. In addition, there should be mental health programmes for any psychological problems in respect of the elderly and adequate palliative care services.

41.14. Devoting special attention to mental and psychic health: this includes the promotion of well-being, the prevention of mental disorders, the treatment and rehabilitation of people suffering from such disorders, and the promotion of a culture of work-life balance; the range of suicide prevention initiatives should be extended particularly among young people, by opting for a more comprehensive approach to mental health in its various components (biological, psychological and social). A national mental health

policy should also involve the social integration of highly marginalised groups such as refugees, disaster victims, the socially excluded, the mentally disabled, very elderly and frail people, women and children suffering violence and the very poor.

41.15. Formulating, implementing and periodically reviewing a coherent national policy on occupational health and safety in consultation with employers' and workers' organisations: building an effective infrastructure of workplace health protection, with legal controls and power of inspection; promoting the right to health at work and influencing the prevention and reduction of risks at the workplace, which is also a suitable place from many points of view for the prevention and early detection of non-communicable diseases; encouraging access to sport and an active lifestyle at the workplace; promoting workplaces which are safe, healthy and ergonomically appropriate to reduce the burden of musculoskeletal disorders.

41.16. Developing healthy transport policies and pedestrian/cyclist-friendly towns, in co-operation with local and regional authorities: people's most immediate environment is critical for their health and well-being; better public transport translates into less driving and more walking and cycling; increasing financial support for public transport instead of road building; introducing the "polluter pays" principle setting tax to the pollution caused by the use of vehicles; changing land use, such as converting road space into green spaces, increasing bus and cycle lanes, encouraging in-town retail trade, instead of out-of-town supermarkets.

41.17. 41.17. Encouraging the participation of civil society organisations: patients' and consumers' associations, registered charitable bodies and non-governmental and intergovernmental organisations can help to disseminate information and raise awareness. In addition, participation of patients, consumers, citizens in decisions regarding their health is a key principle of a modern public health, which encourages co-operation, negotiation and problem-solving.

41.18. Setting-up evaluation systems for prevention policies: it is critical to measure the evolving situation and the results with a view to reliable monitoring of the measures taken and their effects on the basis of indicators developed by each country; standardised data and information collection should be promoted, encouraging standardisation of the relevant indicators for evaluation of these policies.[20]

6. Conclusions

42. Prevention is primarily a way of acting and a question of attitude as much as of means. Governments can help through certain measures to bring about changes in representations and mentalities, create a social, economic and environmental context that encourages health and pave the way for a disease prevention and health promotion culture.

43. The rapporteur believes that tomorrow's medicine will be about looking through a new pair of glasses which reveal the true causes of disease. In most cases these lie in faulty nutrition, pollution, stress, negativity, addiction and lack of exercise – the greatest cause of all being ignorance. The original meaning of the word "doctor" is "teacher or learned man" and that is perhaps the most important role a health professional can perform.

44. With the 2005 Warsaw Action Plan, the Council of Europe member states agreed that protection of health as a social human right is an essential condition for social cohesion and economic stability. They supported the implementation of a strategic integrated approach to health and health-related activities. Social support is an essential determinant of health. The chief criterion for gauging the success of health system reform remains effective access to health care services, including disease prevention and health promotion, for all, without discrimination, as an individual's fundamental right.

45. The rapporteur considers that the health sector, which is particularly characterised by powerful pharmaceutical lobbies and is thus subject to market laws, only seldom questions the cost/benefit ratio of advanced techniques, which are becoming ever more expensive. It also suffers from the lack of importance attributed to patients' organisations, NGOs and health professionals, who could make a valuable contribution to prevention in terms of resources and human capital.

20. For example, WHO possesses reference values for a very large number of indicators and has set up a statistical information system and the STEPwise approach to Surveillance (STEPS), together with surveys of national capacity for the control of non-communicable diseases.

46. International data indicate that the cost/effectiveness ratio of health care systems can be improved.[21] However, it is not sufficient to reduce costs; it is also necessary to spend money differently and to look at health policy from an overall perspective, incorporating an ethical, social and human rights dimension in the reforms to be undertaken.

47. In conclusion, it seems justified to recommend concerted and concrete action in the field of prevention by Council of Europe member states with the aim of allocating a minimum of 0.5% of GDP to preventive health policies.

48. It would be also desirable to further strengthen the co-operation between the Council of Europe and WHO on health matters, inasmuch as the Council of Europe provides a parliamentary and civil society platform for the wider Europe.

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21. In this connection, OECD work on measuring and analysing the performance of health systems in its member states is highly appreciated.

Appendix – Recommendations by the International Non-governmental Organisations (INGOs) of the Council of Europe for a "Health Prevention Policy in member states of the Council of Europe" (Strasbourg, 04/12/2009)

Several INGOs[22] from different horizons have pooled their experiences in the field of prevention in healthcare. Their findings and proposals are as follows:

– Given that equality of access to health and to care constitutes a fundamental right;

– Given that the promotion of health and the prevention of disease are essential elements in health policy;

– Given that the rising cost of curative care is already creating difficulties for our systems of health insurance and constitutes a threat to the economy of our countries;

– Given that, as stated by WHO, better recourse to existing preventive measures would allow morbidity to be reduced worldwide by almost 70 % (World Health Report 2008);

– Given that prevention allows suffering due to illness to be avoided, while reducing expense linked to curative care;

– Given the clear lack of funds allocated to prevention (in the OECD countries, 97% of expenditure goes on curative care and only 3% on prevention);

– Given that inequality in access to care as well as access to prevention and to the promotion of health threaten social cohesion;

– Given that the health level of a population is linked with its living standards, even in the well-developed countries;

We suggest a reinforcement of policies of prevention and recommend in particular:

– that prevention programmes be based on scientific criteriaindependent of pressures of all kinds and of political power or economic lobbies. Epidemiology is one of the best means of isolating risk factors which are often linked to behaviour (smoking, alcohol, drugs, obesity, diabetes, sexual risk behaviour) and evaluating them with accuracy.

– a better organisation of preventive programmes whether at local, regional, national or international level. Spreading prevention campaigns too thinly among the various stakeholders in the field of health results, in our opinion, in waste of money and lost efficiency. It is necessary to harmonise and to co-ordinate health policies. An integrated structure at national or regional level would probably allow prevention in health to be approached globally rather than in a piecemeal or fragmentary fashion. Having a genuine stakeholder participatory approach is crucial to ensure efficient policies. Preventive programmes must take into account the cultural specificities and the age brackets of different populations. Regarding young people, they must take into account their diversity, gender differences, maturity and ability to make healthy choices and adapt to their personality. Particular attention must be paid to reach underprivileged groups, who are often badly informed and poorly motivated. People with learning disabilities are also among the most vulnerable to social exclusion.

– that interventions be focused on to the empowerment of target groups and based on a participatory approach.

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22. INGOs participating in the working group "prevention in health matters": Alzheimer Europe – Dianne Gove; European Association for Education in the Audiovisual Media (EAEAM) – Christiaan Colpaert; International Association for Research in Hospital Hygiene (IARHH) – Franco Marziale , Henri de Monclos; International Council of B'Nai B'Rith (ICBB) – Gilbert Nerson; European Committee for the Education of Children and Adolescent who are Intellectually Advanced, Highly Gifted, Talented (Eurotalent) – Jean Brunault, Mohamed Derghal; European Central Council of Homeopaths (ECCH) – Stephen Gordon; International Abolitionist Federation (IAF) – Roger Beaufils; International Federation for Therapy and Assistance through Mediation (IFTAM) – Marguerite Weith, Jean-Pierre Klein; International Diabetes Federation – European Region (IDF-Europe) – Frédérique Duval, Marjatta Stenius-Kaukonen and André Hervouët; International Federation for Home Economics (IFHE) – Chantal Hueber; International Planned Parenthood Federation European Network (IPPF EN) – Irène Donadio; European Democracy Forum – Michèle Muhlmann-Weill; International Movement of Apostolate in Middle and Upper Classes (MIAMSI) – Sylvie Colle; Cardiovascular prevention – Jean-Marie Mossard; European Union of Dentists (EUD) – Joachim Josch, Christiaan Colpaert and Bogdan Vladila; International Union of European Guides and Scouts (IUEGS) – Rémy Berthier; International Humanist and Ethical Union (IHEU) – Michel Grosmann; International Professional Union of Gynecologists and Obstetricians (UPIGO): Guy Schlaeder (co-ordinator).

– theevaluation of prevention programmes, in particular with regard to cost-effectiveness. This point seems to us particularly important during a period of recession.

– a multidisciplinary strategy in prevention, which affects many fields of human endeavour; prevention cannot be limited to the field of medicine only.

– that efforts be made towards health promotion. Citizens and third country nationals living in Europe must be properly informed in order to decide for themselves what they consider beneficial for their health. By participating in the implementation of health policies, the public will become more motivated to look after their own health as well as those of others. Society will become at the same time more democratic and more efficient.

– to all European governments a real effort to promote health education, which in our opinion is the central plank of prevention. This implies co-operation between institutional educational, associative and cultural systems. Education must begin at nursery school and be a lifelong process. Active participation of children and adults in educational programmes will aim to change attitudes. As we have said, individuals must feel responsible for their health and for their “health capital”. Outside school, the family and young people’s movements can work effectively to encourage young people to use basic rules of hygiene and to encourage them to take part in sports, teamwork and associations activities and to make healthy, conscious and informed decisions about their lives.

Drawing on their practical experience, the INGOs of the working group on health prevention would like to focus attention on a number of public health issues in Europe:

Council of Europe INGOs are prepared to contribute to the development of prevention programmes, to work with all the stakeholders in the field of health and in particular with the Council of Europe. Their experience will allow them to understand the reality on the ground and to track the progress of prevention programmes. They are excellent intermediaries between policy makers and citizens and can play a key role in the protection of human rights in the health sector.