A widening horizon for European public health practice

In Spring 1998 the previous European Commission (EC), sometime before all the Commissioners resigned en masse, published a discussion document on future directions for European Union (EU) public health strategy.1 EU policies in this field date from 1993, when public health responsibilities were given to the EU by the Maastricht Treaty.2 By 1998, eight separate funded public health programmes had been established, although the overall funding available to support these was rather small. The 1998 discussion document suggested that these eight programmes should be replaced by one funded public health programme, for which there could be more efficient and streamlined administrative arrangements than had been possible for eight different programmes.1 This new programme would also be in a position to support a wider variety of more flexible public health initiatives across the EU. Other proposals included the development of a new information system covering public health across the EU as well as some categories of health service data, so that comparisons between member states would be easier to achieve, and a capacity within to EU to ensure rapid response to new health threats.

Because of the manner in which the old EC was replaced by the new one, definitive proposals did not emerge until earlier this summer.1 However, the new EC has chosen not to change the main substance of its predecessor’s proposals, which had been well received in most quarters, especially by the European Parliament (EP).3 In the meantime, the Amsterdam Treaty4 has been ratified and implemented since May 1999. This has enhanced the public health powers of the EU, especially in two areas, so the new 2000 strategy document has been published in a radically changed environment as compared with that of 1998; the EC has taken note of this, both in the new strategy document, and in other policy proposals published over the past few months, all of which have to be approved by the EP and by the Council.

Probably the most significant enhancement in public health powers brought about by the Amsterdam Treaty is the powerful emphasis on analysis of the public health implications of all EU policies and programmes, and requirements in this area that are now written into the new Treaty.5 It remains to be seen how effectively the Commission and the other institutions make use of these new powers.

The other major change concerns harmonisation of public health protection. The previous Maastricht powers did not permit the EU to harmonise in any way public health protection across the EU.2 Although post-Amsterdam this remains generally the case, there are now exceptions in two important areas.5 One rather specific one concerns minimum standards relating to the collection and use for therapeutic purposes of all human tissue products, including (most obviously) all blood products. The other concerns veterinary and phytosanitary health, in relation therefore to all aspects of food production. It is these new powers that the Commission is using in relation to its food safety white paper,6 published last winter, and the establishment of a European Food Safety Agency.1

For public health professionals, both those in academic and in service posts, the significance of this developing public health scene in Brussels must concern how this can be integrated with the rest of public health practice. Fifty years ago it was possible for a public health physician working at a local level to influence most of the determinants of health relevant to his local population at that level. Food was produced and sold within the local economy of each market town. Most industry, employment and commerce also operated at that level. Thus most decisions affecting health were taken at a local level, in the context of this locally-based economy. Today this has all changed, and continues to change fast. Many decisions are now taken in the context of the global economy, and public health has not yet been very successful at influencing this agenda, as has been discussed previously in this journal.8 9 But for those of us who are EU citizens, an even larger proportion of these health related decisions are taken at EU level. For example, primary legislation affecting agriculture, food and nutrition takes place at EU level (in the context of the Common Agricultural Policy (CAP), and now as a part of EU public health policy), as does that concerning basic standards of environmental protection. Both of these areas incorporate major determinants of health, as does economic development and regeneration, another major area of EU activity. So especially outwith the formal EU public health legislation, policies and programmes, but also within these, the health of all EU citizens is influenced to a major extent by EU decision making. This is very much open to the influence of public health advocacy, especially via the Commission and the Parliament, and already there are organisations, such as the European Public Health Alliance,10 which are trying to tackle this.

Now that EU public health policy is becoming firmly established, and as it is clear that so many of the major decisions which influence the health of all European populations are taken at EU level, one of the implications for regular public health practice in Europe must be that effective health advocacy at this level must come to be accepted as a routine component of public health work. This will necessitate the acceptance of new ways of thinking about public health, and will also result in an essential readiness to participate in alliances, across the EU, of people seeking similar health objectives.

To match this extension of what is seen as routine public health work, new skills will be needed. One new skill, which must be seen increasingly as essential for all public health professionals hoping to be effective health advocates for their populations, must be the skill to integrate public health activity and influence at all levels of the economy (very much including the European level, as well as more local levels), in the interests of the populations whose health it is responsibility of public health professionals to improve. This will include an increasing ability to work effectively within EU-wide public health alliances, as indicated above, so as to achieve improved health status for all Europeans.

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