scientific recommendations for the nutrient intake of the DGE women are working with children at the age of 4 to 10 years in children's institutions and schools as well as with multipliers. From 1997 up to 2000 the Research Association Public Health Saxony has evaluated the project by carrying out an intervention-control-study.

Aim

To promote a nutritional behaviour of children which maintains or enhances well-being, pleasure and health.

The philosophy of the project is best expressed by the German saying: "Things which are not learned by little John are not learned anymore by tall John."

Methods

The project is focusing on the selection of food and the composition of meals.

Children are encouraged to try playfully and to make their own practical experience, especially with the help of their senses.

Results

There is an increase in the number of project women from 23 to 80 during the last years and in the number of project measures from 700 per year to more than 5 000 in 2001.

The evaluation confirmed the effectiveness of the project with regard to children's nutritional knowledge, their attitude and behaviour. The effects on knowledge and attitude have been stronger and more stable than the effects on children's behaviour.

Conclusions

In principle the project is suited to effective health promotion. The evaluation showed that it is more efficient to apply a given project measure to the same selected children several times than to try to reach all children only once. In addition the practical part of the project measures, especially the own doing, should be strengthened furthermore.

Policy health impact assessment for the European Union

Abrahams, D.* – presenting author
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Background

This is a two-year investigation funded under the EC Health Monitoring Programme by DG Sanco. The project commenced in December 2001.

During the last 5 years, systematic methods for assessing the health impact of public policy have begun to emerge. This project builds on the work already undertaken.

Aim

To assess the health impact of EU policy by synthesising a standard generic methodology for Health Impact Assessment (HIA) of EU policies and activities; applying this methodology to selected EU policy at both European Union and individual Member State levels; and actively disseminating the findings and the lessons learnt throughout Europe by means of seminars, publications and high level briefings.

Methods

Phase 1 involved the establishment of an Advisory Group and the reviewing of methodologies already in use in Member States and farther afield. The participating agencies – from Germany, Ireland, the Netherlands and the UK – developed and agreed a generic HIA method.

This is currently being piloted in Phase 2. Criteria have been developed for selecting the EU policy to be assessed by the project. These criteria are being applied to proposed EU policies. The HIAs are being carried out at both pan-European and Member State levels.

In Phase 3 a networked approach will be taken to dissemination. While workshops and seminars will take place in individual Member States, a pan-European dissemination strategy will ensure the co-ordinated production of electronic and paper publications, seminars, and presentations, culminating in a high level presentation for experts and policy-makers and a briefing for the European Parliament.

Workshop structure

Following a short presentation outlining the project, the remainder of the workshop will consist of participatory discussions on the many interesting and controversial conceptual and methodological issues it raises. It is hoped that the views of participants can contribute to the project's second year.

"Population health" in Bismarck systems: how to shift the focus from a healthy workforce to a healthy population Workshop of the EUPHA section on Health Services Research

Martin McKee, Diana Delnoij, Marina Puddu, Eleonore Bachinger, Felix Gurtner, Helmut Brand, Reinhard Busse

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Background

Germany, hosting this year's conference, was the first country to introduce social health insurance for workers. (Social) health insurance can be described as a mechanism by which an individual who falls ill can receive medical care, secure in the knowledge that the care will be paid for by a sickness fund. This simplified description is based on a situation in which an individual becomes ill, recognises the fact, and seeks care. However, in many situations this does not apply. Health systems need to address the needs of *populations*, rather than simply groups of individuals. This "population health" philosophy encompasses two broad areas. Firstly, that of health services that are most appropriately provided collectively (e.g. immunisation and screening). And secondly, that where those who pay for health care become active purchasers of care, seeking to determine the health needs of those for whom they are responsible and defining models of care within which these needs can be met.

Aim of the workshop

This workshop will focus on the extent to which strategic purchasing of care takes place in different social insurance systems, the problems that might occur and the models that are most effective in supporting strategic purchasing.

Programme

The workshop has arisen from a study undertaken by the European Observatory to inform a forthcoming report on social insurance in Europe. This report is based on a combination of published literature, in particular the Observatory's Health System in Transition series, and a structured survey of key informants in six European countries. These key informants will participate in the workshop.

The countries under study are Austria, Belgium, France, Germany, the Netherlands, and Switzerland. The workshop will consist of an initial presentation of the background to the issue and a description of the conceptual model used (15 minutes). This will be followed by a series of case studies from the countries involved presented by the key informants (5–10 minutes depending on time allotted). These presentations are followed by a discussion of the implications for policy (30 minutes).

For an overview of the results that will be presented, see the attached research abstract. This research abstract summarises the content of both the introductory presentation as well as the case studies.

The role of sickness funds in strategic purchasing: an international comparison (note 1)

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Background

Health systems need to address the needs of *populations*, rather than simply groups of individuals. For third-party payers this implies active purchasing of care, determining the health needs of those for

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whom they are responsible and defining models of care that meet these needs. This paper explores the role of social sickness funds in this process.

Aim

Research questions are: To what extent does strategic purchasing of care take place in different social insurance systems? What models are most effective in supporting strategic purchasing?

Method

Data were collected via:

- The published literature, particularly the Health System in Transition series.
- A structured survey (conducted in March–April 2002) of key informants in Austria, Belgium, France, Germany, the Netherlands, and Switzerland.

Results

Strategic purchasing involves:

- *Assessment of health care needs:* Innovative ways of presenting information on population health needs have been developed in many countries.
- *Specifying models of care to meet those needs:* Many countries have seen a growth in health technology assessment. But this has often focused on individual technologies instead of the overall framework of care within which they are used.
- *Purchasing health care that conforms to these models:* This is problematic, e.g. because of the many actors involved, the lack of coherence in the populations covered by the relevant organisations, or the lack of freedom to contract selectively.
- *Monitoring the outcomes achieved:* These challenges are greatest for population based interventions.

Examples of how governments (national/regional), sickness funds, and providers can co-operate to enhance the effectiveness and equity of care include consultative mechanisms (e.g. Germany) and more formal structures (e.g. France).

Conclusion

Social insurance countries differ markedly in the degree to which sickness funds engage in strategic purchasing. Although it is premature to draw firm conclusions, the 1996 reforms in Switzerland, giving insurance funds a greater role in population interventions, have faced problems. In contrast, France provides an example of 'best practice', although the introduction of regional hospital agencies has required the state to play a leading role in a range of activities previously undertaken by sickness funds, so creating a model that is quite distinct from that seen in other social insurance systems.

Note 1: Research abstract of the presentations in the Workshop of the section Health Services Research: "Population health" in Bismarck systems: how to shift the focus from a healthy workforce to a healthy population.

Progress and problems of health promotion in central and Eastern Europe Workshop of the EUPHA section on health promotion

Organisers: Waller, H. *, Trojan, A., Andronache, L.

Healthy Cities in East and West-Germany: a Survey and Comparison of their Performance

Plümer, K.-D., Trojan, A.

Background

Since 1986 there has been a growth of cities and communities which affiliated with the WHO Project 'Healthy Cities'. Though there is sketchy information on many single projects in the cities there is no systematic attempt to evaluate their general structures and policies.

Aim

In a situation of change and decreasing resources the German Network for Healthy Cities is looking for more legitimation of the general approach of promoting health in cities and to find out ways of becoming more effective in the organisation of the network. We thought a general survey the most appropriate way to learn more about the existing structures and processes. We will report in this paper only the most relevant differences between cities in East (n=14) and West-Germany (n=33).

Methods

A written questionnaire was developed in co-operation with some cities and the German Network Coordinator and sent out to the 52 member cities on the coordinator's list in March 2002. The questionnaire contained 78 standardised questions and some (23) open-ended questions for more specific qualitative information. Also included were 27 ten-point-rating-scales to evaluate the coordinators perspective concerning some aspects of their healthy cites work and to assess its progress. Questions referred to status of membership, resources of the city project office, focus on issues addressed, city health profiles, participation of citizens and other policy departments. Particular attention was given to the so-called '9-point-program of minimal standards' and the Cologne-Declaration 'Equity for a healthy life'. 47 cities from the list of 52 answered (90%) until June 2002.

Results

The first impression is that the profile and the identity of the healthy cities project within the cities and communities is not always clear to make out. There is a dominance of project-coordinators who are basically qualified in several social scientists disciplines such as pedagogic, psychology, sociology, education etc. but they are mostly working in medical oriented local public health services. In East 35,7% have and in West-Germany only 9,1% have a medical qualification. Most of the project-coordinators have a great freedom as to conceptions but it seems to be difficult to transfer them in local policies strategies. There are many action-oriented activities which are not always well linked to the healthy cities profile. But there is a lack of evaluation and indicators to evaluate all the measurements which are taken in the cities and communities. The focus on child and adolescent health is on the top (East 71,4% – West 72,7%) followed by local health conferences 72,7,6% in West-Germany (East 28,6%) and participation of citizens (East 57,1% – West 54,5%). Most of the coordinators in East and West-Germany claim to have no sufficient competences to raise money (funding and sponsoring) because their office budget is low (East 88,9% – West 52,1% less than 5.000 Euro p.a.) or doesn't exist (East 30,8% – West 15,6%). Well represented are still the 'holy four': Nutrition (E 57,1% – W 51,5%); Smoking (E 57,1% – W 30,3%); Alcohol and Drugs (E 50,0% – W 45,5%) and physical exercises (E 71,4% – W 36,4%). In general the Healthy Cities Work is in East-Germany slightly better assessed than in West.

Conclusion

The Healthy Cities in Germany (East and West) play an important part in developing local health policies and focussing on health issues on all policies areas. But in order to gain more public attention and influence in local politics it is necessary that they can make clear the evidence of health promotion activities for a healthy community. The decision to establish so-called regional centres of competence in the German Healthy Cities Network might help to make their work more effective in the future. Further results will be presented in the session of the Health Promotion Section of the EUPHA-Meeting.

Challenges for health and health promotion in Central and Eastern Europe

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Background

Health promotion addresses the underlying causes of health and ill-health, with attention to options for action in public policy, the workplace and community, as well as well as by individuals and their families. Formulation of appropriate policies and supportive measures evidently requires good basic information on the social and economic, as well as health, situation of citizens.

Aim

To present new data on the work, household and personal situation of citizens in Central and Eastern Europe with the intention to identify key challenges for health promotion.

Methods

This presentation will report data from two large surveys in the 13 Candidate Countries for accession to the European Union. A survey on working conditions was conducted in June 2001, while a survey of quality of life among adults was carried out in March 2002.

Results

The surveys provide an overview of living and working conditions in the Candidate Countries as well as documenting views and experiences of these conditions. General information on health and

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