

European Public Health Association



President's column

It was about 15 years ago when a group of people representing public health associations in a number of European countries convened in Paris to found a pan-European association of Public health. At that time, it was realized that there was a need for intensified collaboration between public health experts, researchers and professionals across Europe. There was a need for European forums for exchange of knowledge, experiences and ideas in public health. These people who convened in Paris established the European Public Health Association in order to fulfil their dreams on the new time of European collaboration.

Fifteen years have passed and I think that their dreams are on a good way to become true. The development of the European Public Health Association is a European success story. From a small start EUPHA has gradually grown to a substantial organization representing over 40 European countries. Parallel to the development of the Association, the European Conference on Public Health, which was decided to launch in Paris and organized the first time in Maastricht in 1993 is a good example of what we have accomplished. While the Maastricht Conference gathered 216 participants, the EUPHA Conferences have been developed both in terms of numbers and quality of contributions to a major European public health event gathering around and over thousand participants.

As the new President of EUPHA, I am lucky to receive the organization in a good condition. During the presidencies of my predecessors, EUPHA has been strengthened in many ways as follows:

- The content and quality of EUPHA Conferences have been developed tremendously,
- The operation of the European Journal of Public Health has been reformed,
- A new more sustainable financial structure have been built for EUPHA and
- Last but not least, after a thorough preparation the EUPHA Governing Council accepted a new organizational structure for EUPHA at its meeting during the Helsinki Conference.

While we can be proud for the development, in my mind EUPHA is still quite

far from its full potentials as an international public health organization.

To secure the further development of EUPHA in coming years it is of primary importance to finalize EUPHA's restructuring and new constitution as well as to start the assertive implementation of these changes. The original EUPHA Constitution and bylaws were drafted for a relatively small organization having a bit more than ten member associations and the conferences with a few hundreds participants. But now the organization is totally different and developing its functions, activities of EUPHA sections and EUPHA conferences require a new grip. To give a simple example: there is a need for the continuity of the leadership provided by longer, three-year presidencies to be introduced in a few years time.

Another priority for EUPHA's development in coming years is to improve efficiency for managing EUPHA. As said the new Constitution partly supports to this goal by strengthening the leadership but in order to provide better service for the Membership and for improved efficiency of managing everyday business, there is a need to strengthen the resources of the EUPHA Office.

EUPHA is representing a considerable number of European public health researchers, experts and professionals. These people's expertise is vital for formulating new public health policies, implementing public health programmes, and reforming public health practice. I see here an obvious role for EUPHA in providing and facilitating the delivery of this expert contribution to the work of international institutions. EUPHA should take its responsibility for and increase its collaboration with institutions, such as the World Health Organization (WHO), European Union and the Council of Europe. EUPHA and the institutions have the same objectives: to work for improving the populations' health and welfare.

Another direction, EUPHA should strengthen its collaboration with, is other organizations in the field of public health. EUPHA has associate membership agreements with International Union for Health Promotion and Education (IUHPE), Association of Schools of Public Health in the European Region (ASPHER), European Healthcare Management Association (EHMA) and European Association for Communication in Healthcare (EACH).

This collaboration already gives excellent results: a model example is the next year's EUPHA conference in Lisbon, Portugal, which is a joint conference of EUPHA and ASPHER. However, there are other public health organizations, such as EUPHA's US counterpart APHA and the World Federation of Public Health Associations (WHPHA) with which EUPHA has good reasons to intensify collaboration. There are strong synergies between the organizations and working together all would gain.

Ilmo Keskimäki
EUPHA president 2007–2008

NEWS from EUPHA office

Errata to the abstract supplement of the 15th EUPHA conference:

Unfortunately, the abstract supplement was incomplete. Below, you can find the corrections/additions to the abstract supplement with our apologies to the author.

Errata: Workshop on EUnetHTA - European network for HTA

The first abstract entitled 'System for support of countries without institutionalized HTA' had the following authors: Montse Moharra, Nadine Kubesch, Mònica Cortés, Maria Dolors Estrada, Toni Parada, Mireia Espallargues of the Agency for Quality, Research and Assessment in Health (AQuRAHealth).

The following poster abstracts were missing:

A major public health and forensic medicine problem in the future—the acute intoxication in children and adolescents

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Background

The increasing incidence and prevalence of acute intoxication among children and adolescents together with the high incidence of death or the serious consequences of voluntary or accidental ingestion of some toxic substances constitute a major socio-pediatric and public health problem.

Methods

Our descriptive, retrospective, observational study included the cases of acute intoxication in children and adolescents (659 cases = 100%) between 1990 and 2004 requested by pediatric hospitals from Cluj County in order to be analyzed in the forensic toxicology laboratory.

Results

The largest ratio of acute intoxication was held by the age group 15–18 years: 51.75%, followed by children (0–4 years) with 21.70% from the total of cases. The urban environment was prevalent in all cases. Central nervous system depressants (benzodiazepines, phenothiazines, barbiturates, etc.) were the most frequent cause of acute intoxication 45.75%, followed by alcohol alone or associated with other toxic substances 20.88% and insecticides 10.86%. The average starting age for this bad habit has decreased; thus, from the total number of intoxication cases in which alcohol was present, 22.00% were in the group aged 5–14 years and 77.00% in the group aged 15–18 years.

Conclusions

The family, along with the interdisciplinary team (physicians, pharmacists, teachers, psychologists, clergymen) must be involved more actively in order to have a major role in the preventive education concerning consumption of alcohol, drugs and toxic substances, so as to prevent acute intoxication and addiction.

Is a EUPHA conference evaluation standard needed?

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Issue

EUPHA organizations regularly arrange local events, such as conferences, work-

shops and seminars. Many of these are followed by evaluation forms in paper or electronic form. How do we use these forms, do we ask the right questions, how can we make better use of the information we obtain and should we develop a EUPHA evaluation standard?

Description

All EUPHA organizations were contacted by e-mail. A round of follow-up e-mails was planned after one month. The questions asked covered general information on their events (frequency, number of participants), content of evaluation forms and their use afterwards. Copies of the forms were requested. Some informants who replied in detail were questioned on their local practices.

Lessons

Active use of evaluation forms included follow-up meetings and planning of future conferences. Other usage was more passive, simply calculation of ratings and (sometimes) reporting free-text comments. One lesson learned concerns the pros and cons of electronic versus paper evaluation forms. Both may be worthwhile, depending on context. Several informants did not use evaluation forms at all, and asked for recommendations concerning future events. Others had moved from very detailed evaluation forms to simpler ones, finding that this improved the response rate. It is necessary to reach a balance regarding level of details and response rate.

Conclusions

Organizing local events takes up a lot of time and effort from EPHA organizations. To ensure that we deliver to a certain standard, and keep improving, evaluation and follow-up processes are vital. It is hard to compare events when rating systems are different. We should move towards the same numerical scale, or at the very least, use numerical scales and calculate both average rating and standard deviation per rated item. Unstructured information may be a challenge, but often implies that the topic is particularly important to the respondent, considering the extra effort taken. It is therefore important to compile all the unsolicited and/or unstructured remarks, which may contain excellent suggestions. Standardizing the way EUPHA organizations deal with feedback from post-event evaluation

forms, and using similar questions and criteria, make our events comparable over time and across borders. We can avoid repeating mistakes, and learn from each others's best practices.

To evaluate health care systems performance: an international comparison

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Background

This study aims at investigating the characteristics of the different performance frameworks available in the literature and the relationship between models of health care system and dimensions of performance considered.

Methods

An extensive literature search in several electronic databases was carried out, using different search algorithms. We classified performance dimensions and sub-categories according to Hurst and Jee-Hughes approach (2001) that includes four dimensions (effectiveness/health improvement, responsiveness, equity, efficiency) and some subcategories for each dimension. We analysed the recurrence of the subcategories in the frameworks found and the relationship between dimensions/subcategories and health care model classified as Beveridge, Bismarck, private health insurance.

Results

Effectiveness/health improvement and responsiveness were considered by all the health care systems whilst we found different degrees of inclusion for equity and efficiency. The most frequent sub-categories were effectiveness, technical efficiency and accessibility (respectively, 100%, 79% and 77% of the frameworks analysed). By analysing the relationship between sub-categories and health care model, we found that effectiveness was the most frequent subdimension and the allocative efficiency was the less frequent one in all the models. Equity of finance is less analysed in Beveridge and in private insurance countries, if compared with Bismarck models. Equity of access is a frequent dimension in the Beveridge model whilst safety and timeliness are

highly considered in the private insurance countries.

Conclusions

Dimensions and sub-categories of performances have a different coverage in

the conceptual frameworks according to the adopted health care system. Effectiveness is the core subcategory in all the frameworks. Issues related to equity differ in the considered frameworks according to the ethical and social

values of the specific country. Further studies are needed in order to define a common framework about performance evaluation and to identify a basic set of indicators that can be utilized in all the countries.



WHO/EURO COLUMN: 'BRAIN DRAIN' OR ETHICAL RECRUITMENT? THE MIGRATION OF HEALTH PROFESSIONALS RECEIVED SPECIAL ATTENTION AT THE FIFTY-SEVENTH SESSION OF THE WHO REGIONAL COMMITTEE FOR EUROPE, IN BELGRADE, SERBIA, IN SEPTEMBER 2007

The consequences of health workforce mobility have become a prominent public policy concern in the last years. With increased recognition that the international mobility of health professionals is an inescapable feature of the health sector, policy responses today aim to regulate the flows of health professionals to benefit source and destination countries.

While the issue is sometimes presented as a one-way 'brain drain', the dynamics of international mobility, migration and recruitment are complex, comprising individual rights and choice, the motivation and attitudes of health workers, the differing approaches of governments to managing, facilitating or attempting to limit out-flow or in-flow of health workers and the role of recruitment agencies. Although data and knowledge about stocks and flows of health workers remain incomplete and are not compatible between countries, there is a broad consensus that migration is frequently a symptom rather than a cause of the human resource difficulties that confront many health systems in source and destination countries.

In recent years, the migration of health professionals has become an

issue of special attention for WHO. The World Health Assembly endorsed resolutions WHA57.19 (in 2004) and WHA58.17 (in 2005), which urged Member States and requested WHO to develop strategies to mitigate the adverse effects of the migration of health personnel in order to minimize its negative impacts on health systems. In May 2006, the Global Health Workforce Alliance (GHWA) was launched during the Fifty-ninth World Health Assembly to address the health workforce crisis.

The WHO Regional Office for Europe is committed to supporting Member States in their efforts to address their health workforce policy issues, including migration. The topic of health workforce policies in the European Region was high on the agenda of the fifty-seventh session of the WHO Regional Office for Europe, in Belgrade, Serbia in September 2007. A resolution on health workforce policies adopted by Member States in the Regional Committee gives the Regional Office a special mandate to facilitate the development of an ethical guide/framework for international recruitment of health workers into and within the European Region. The Regional Office, in order to move towards a more comprehensive and

inclusive approach to human resources management in the area of health worker migration, is already collaborating with several international organizations and partners, including the International Organization for Migration (IOM), the International Labour Organization (ILO) and the Organization for Economic Co-operation and Development (OECD). In March 2008, WHO and OECD will jointly conduct a high-level forum on health workforce policies and migration in Geneva, Switzerland. Currently, the Regional Office is working on the technical input to the First Global Forum on Human resources for Health of GHWA, to be held on 2–7 March 2008, in Kampala, Uganda. Both forums aim to contribute to the World Health Assembly's discussions on human resources for health in May 2008 and to the development of a health systems charter during the WHO European Ministerial Conference on Health Systems: 'Health Systems, Health and Wealth', which will take place on 25–27 June in Tallinn, Estonia.

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