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ASPHER

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ANNIVERSARY

ANNIVERSARY BOOK

ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH IN THE EUROPEAN REGION

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Anniversary Book

Association of Schools of Public Health in the European Region
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Edited by Anders Foldspang, Thierry Louvet, Charles Normand and Stojgniew Sitko.

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Foreword

Anders Foldspang
Professor, ASPHER President since 2005

Population health varies considerably across European countries, and so do health systems and systems for prevention and health promotion in- and outside the health systems. Contrasts are evident between affluent and less affluent population groups and countries, both as concerns socio-economic inequity, environmental exposure, and health – and access to relevant health services. Large health challenges are emerging, and health systems are under reform.

In order to be able to address present and future population health challenges and to initiate necessary developments in the organisation and functioning of health systems by use of rational, goal oriented strategies, large numbers of sufficiently trained Public Health professionals are needed on all levels – international, national, regional, community. The production of high quality graduates, trained on a scientific basis, is a prerequisite for the development of the professional public health workforce and thus for the development and implementation of cost-effective interventions.

Some important milestones in the professionalisation of this workforce are the establishment of the London School of Hygiene and Tropical Medicine in 1899, the Andrija Stampar School of Public Health in Zagreb in 1926, the Nordic School of Public Health in 1953; the Braun Hebrew University - Hadassah School of Public Health and Community Medicine officially created in 1980 and delivering an International Master of Public Health since 1970; the upcoming of a number of MPH training programmes in- and outside universities in Western Europe in the late 1980s and the 1990s, and the development of similar programmes in Eastern and Central Europe preferably in the initial years of the new millennium.

One more milestone constitutes the focus of the present book: The founding of the Association of Schools of Public Health in the European Region, ASPHER, in 1966 - a child of visionary personalities, their academic environments, and – not least - the WHO in Europe.

An international organisation like ASPHER is a prerequisite for the development of scientifically sound training programmes. The road to concerted, high-level, scientific and evidence based Public Health professionalisation in the European region is however long. We are not that far, and much has yet to be done to reach what might be considered an acceptable level.

It is in itself an indication of a still only partially developed system that concrete empirical documentation is lacking concerning the actual size of the professionally trained Public Health workforce in European countries – but in general terms this workforce still

seems to be quite unduly limited in numbers. Some countries have no or just one training programme with a limited production, and some programmes are rooted in small and unstable environments with scarce resources as concerns manpower, equipment and finances. Some environments are embedded in cultures posing obstacles to the adequate development of genuine Public Health scientific research and training and to the funding of it. Some programmes have been subject to the strange and often negative scrutiny of evaluation panels whose members did not represent professional Public Health expertise.

Striving to increase Public Health professionalisation denotes a composite, multifaceted task. Public Health needs and management, research and training have to be linked in a dynamic manner. The complex nature of this endeavour is reflected in the concerted activities of ASPHER over the years: The development of a high-quality training programme assessment tool like the PEER evaluation; the initiation of a likewise European accreditation function; the establishment of a European Master of Public Health programme with associated summer schools, aiming at increasing the mobility of the PH workforce across borders; teaching-the-teachers activities; the development of lists of Public Health competencies coordinated with Public Health needs as communicated also by Public Health stakeholders; sustaining the development of a series of MPH training programmes in Central and Eastern Europe; collaboration with other international organisations like the WHO Europe, EU DG-SANCO, ASPH and APHA, APACPH and ALAESP.

Besides supporting the development of strong training environments, future perspectives to be considered could be, e.g., sustaining the development of bachelor degrees and graduate master degrees; sustaining the formation of Faculties of Public Health within universities; organising continuous European forums for Public Health training, with strong Public Health scientific and Public Health stakeholder representation; sustaining the publication of books and other material; etc. And monitoring the production of graduates all over Europe and communicating it to health authorities and other stakeholders.

Clearly, the substantial activity has not been possible without a whole-hearted contribution by many brilliant members, who dedicated their minds and time to Public Health training, or without the professional administrative support by the secretariat headed by the General Secretary/Executive Director.

In respect for the magnificent work they have delivered and the goals they have achieved, and in order to draw a realistic picture of the development over the 40 years, we invited Past Presidents to write a short note on each their contribution. Furthermore, we are proud that a series of excellent colleagues and representatives of collaborative organisations accepted similar invitations. Each one has given her or his version, and the book thus rends a comprehensive, multi-facetted picture – telling the story and contemplating fruitfully over future trends and decisions.

Is this promising for the future? I think so.

Foreword

Markos Kyprianou
EU Commissioner for Health and Consumer Protection

Although health systems are primarily the responsibility of the Member States, they are becoming more interconnected than ever in the past. This is driven by many different factors including movement of patients and professionals, the impact of Community law on health care, an increasingly shared culture creating common expectations, dissemination of new medical technologies and techniques, and the enlargement of the Union. Moreover, as more data comparing health systems becomes publicly available, the variations between them are clearer. Bladder cancer is one example; five year survival rates range from 78 % in Austria to 47 % in Poland and Estonia. This shows the potential to improve outcomes across Europe by levelling up healthcare provisions to the standard of the best.

In response, the Commission convened a high level reflection process on patient mobility and healthcare developments in the European Union. We notably issued a communication on extending the “open method of coordination” to healthcare to support national strategies to reform and develop health and long term care. The response to the challenge of reducing health inequalities in the European Union lie on partnerships with Member States and civil society in order to create synergies. There is a huge potential in learning from each other, looking at the successes in one part of the Union and examining how we can replicate this success elsewhere. Co operation is indeed the key to unlocking the potential to share and promote best practice in health right across the European Union

The European Community is about fostering convergence to ensure a high level of prosperity and well being across Europe. A high-level of health is an essential part of this. I am confident that there is much we can do, all together, to bridge health inequalities and aim at a healthier community.

Foreword

Marc Danzon
Regional Director, WHO Regional Office for Europe

It gives me great pleasure to be given the opportunity to write a foreword to this publication marking ASPHER's 40th anniversary – an important milestone in its history.

The theme of *The world health report 2006* – working together for health – highlighted the central role of health workers in improving the performance of health systems and in advancing the health of populations, including the attainment of the Millennium Development Goals. A strong human infrastructure is the key to closing the gap between health promises and health reality and anticipating the health challenges of the 21st century.

At the WHO Regional Office for Europe, we see our cooperation with ASPHER as making a significant contribution to helping our Member States strengthen their public health workforce. Indeed, ASPHER provides a vital link between policy-making at the international level and training of public health professionals in the countries of the WHO European Region. However well-thought-out and relevant, a policy is of little use if it is not understood and implemented by well educated and qualified professionals, as they face old and new threats to public health, as illustrated by the recent threat of avian influenza to people's health.

We cannot underestimate the role public health professionals play; this is why close cooperation with ASPHER is so valuable to the Regional Office. Our future goal is a substantial increase in the professionalisation of public health analysis, intervention, evaluation and research in all the countries of Europe, for the benefit of its entire population.

I therefore hope that ASPHER and the WHO Regional Office will continue their fruitful collaboration and see it grow over the coming years. Let me finish by wishing ASPHER a happy 40th anniversary and success in the next 40 years!

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PART ONE: 40 YEARS OF ASPHER HISTORY

ASPHER history as mirrored by its Presidents

Contributions from ASPHER Past Presidents (1)

Charles Normand,
Professor, Past President (2003-2005) and Executive Board member (1994-2006)

I was lucky to be elected to the ASPHER board at the meeting in Krakow, and to remain on it till 2006. I was therefore able to participate in making ASPHER more professional, with the appointment of an executive director, and a growing capacity to provide useful support and services for our members. With the hugely valuable support of the French Government we were able to grow and move towards financial independence. The changing face of ASPHER reflects the changing needs of the Schools and the growing importance of public health education, especially in the East of the Region. The most significant single way in which ASPHER worked to strengthen education programmes was through the OSI-ASPHER programme, but in many other ways ASPHER was instrumental in building partnerships and friendships across Europe.

There are many ways in which the changing nature of ASPHER over this period is manifest. The Executive Board has come to operate as an instrument of management, and the General Assembly has much greater focus. The key role of Deans and Directors has been recognised in the annual retreat, and, perhaps most importantly, the vision and drive of the two executive directors has made the organisation work. It is also encouraging that people in leading positions in public health education from across the membership have been willing to give generously of their time to work on the Executive Board. In some ways ASPHER is now less exciting, but it is much more useful.

Contributions from ASPHER Past Presidents (2)

Róza Ádány,
Professor, Past President (2001-2003) and Past Executive Board member (2000 – 2004)

It was a great pleasure for me to be the President of ASPHER as the representative of new, developing Schools of the Central-Eastern European Region and that of women working so hard and enthusiastically not only in public health science and practice, but also in education. Activities during my presidency were continuation of projects initiated by my highly respected predecessors (especially Professor Jose Maria Martin-Moreno), while some of them were based on new initiatives and opened new vistas for development. The OSI (Open Society Institute)-sponsored ASPHER projects targeted building, strengthening and deepening public health education and training capacity of Schools of Public Health in

Central-Eastern Europe operated very effectively and resulted in considerable change in the life of ASPHER by improving partnerships between Schools in the whole European area (supports by PEER Reviews to the developing Schools). The Agreement of Cooperation between the ASPHER and the European Public Health Association (EUPHA) undersigned at the end of 2002 was the declaration of common interest in collaboration for the establishment of the European Accreditation Agency of public health training program, but in addition strongly facilitated the collaboration between ASPHER and EUPHA members in the areas of public health research and practice, too (see EU granted projects launched together). Programs running presently are strongly linked to this initiative emphasizing the importance of common actions by natural partners.

Contributions from ASPHER Past Presidents (3)

A snapshot of ASPHER history in 1999-2001: Crossing Centuries & Crossing Borders

Jose M. Martin-Moreno,
Professor, Past President (1999-2001) and Past Executive Board member (1998-2002)

With Richard Madeley's encouragement to present my candidature for ASPHER Presidency, I was elected at the Annual Conference in Torino (1998). Was I a little too young for this responsibility? Perhaps, but I formally and enthusiastically became President at the 1999 Conference in Madrid, coinciding with 75th anniversary of the National School Public Health. The US Association of Schools of Public Health (ASPH) presidents and the Latin American association (ALAESP) joined us. Sir Richard Doll received the *Stampar award.* It was a wonderful event. I remember how we started a musical tradition with ritual singing at the end of the Conference… In this cheerful context, Jacques Bury suddenly informed me about his willingness to step down as Executive Director. I faced the challenge of not only tackling the strategic goals of strengthening quality, fostering partnership and promoting research in our Schools network, but also of ensuring the basic functioning at the Saint-Maurice office and selecting a new Executive Director. Fortunately, an outstanding candidate emerged: Thierry Louvet. In this period, Caltanissetta (Italy) and Magdeburg (Germany) provided exciting locations for our Deans and Directors Retreats in 2000 and 2001; the Annual Conferences at Aarhus (Denmark) and Hortobagy National Park (Hungary) were just perfect for moving forward as a synergistic network. I remember the cruel, tragic 11th September terrorist acts against New York and Washington. The ASPH President could not join us then, and I expressed our innermost public health solidarity. During this period I was privileged to sign

agreements with the “Fondation Marcel Mérieux” (towards quality and accreditation) and with OSI-Soros (developing fruitful actions for public health education in Central and Eastern Europe). Much more happened during this very exciting period. What I would especially highlight is the outstanding collegial spirit I experienced within ASPHER... Thank you for making this possible.

Contributions from ASPHER Past Presidents (4)

Richard Madeley,
Professor, Past President (1997-1999) and Past Executive Board member (1996-2000)

I enjoyed my time as a member of the ASPHER executive (1996-2000 and President from 1997 to 1999) as much as anything I have done during my professional career. It was a fascinating time marked in particular by the increasing influence of Schools based in Central and Eastern Europe.

The importance of working together with other organisations dedicated to the improvement of public health was clear. The links with EUPHA, the Open Society Institute and the Merieux Foundation have been very valuable.

The continued development of systems of accreditation and peer review seems to me to be of immense importance. This is where the specific role of ASPHER is clear, in order that educational programmes are of a high standard and constantly updated to take account of the new challenges, which we face.

While I was president we received excellent support from the French government and the hospital authorities at Saint-Maurice. The issue of core funding is always a challenge for associations like ASPHER and we should continue to seek ways to increase this, difficult though it is.

ASPHER provides an excellent network. On many occasions I have been able to find out quickly from friends and colleagues things which might not have been easily accessible otherwise and which were relevant to my everyday work.

ASPHER can be proud of its achievements. I’m sure that it will continue to play an important role in the development of a well educated workforce and ultimately in the improvement of the health of our continent.

Contributions from ASPHER Past Presidents (5)

A view on ASPHER History

Franco Cavallo,
Professor, Past President (1995-1997) and Past Executive Board member (1994-2000)

The period of my presidency in ASPHER was a very exciting one and one of a fast development of the Association. ASPHER was finding itself a place in the domain of quality assurance in Public Health education and had just started the first batch of reviews in some of the Public Health Schools in the Eastern and Western part of Europe. At the same time the project on the European Master in Public Health moved its first steps, aggregating around itself some of the most important schools in Europe and setting some first standards in the Public Health education domain. These two lines of activities have been fundamental in positioning ASPHER in Europe among the main Public Health Associations and have allowed it to progress along this line, up to the management of the big project for restructuring Public Health training in Eastern Europe, which has been going on for more than three years in collaboration with OSI. Nowadays, ASPHER has a firm position on all matters dealing with Public Health education in Europe and has become a referral point for all main International Organisations dealing with Public Health.

The challenge ASPHER is facing now is one of coming out from a prosperous youth, to set up itself in a mature adulthood, with the capability to completely self-sustain itself, while maintaining and enlarging its sphere of influence in the European context. The concretisation of the activities concerning the European Master in Public Health are a first milestone in that direction and, hopefully, the setting up of a formal organisation for the Quality Review of Public Health programs in Europe will be a second and fundamental one.

Contribution from ASPHER Past Presidents (6)

Ulrich Laaser,
Professor, Past President (1993-1995) and Past executive Board member (1991-1996)

The early nineties mark a turning point in ASPHER's development, regarding management as well as strategy. The lack of a functional secretariat was the most serious bottleneck. To get *Jacques Bury* moved from WHO-EURO to ASPHER was the big achievement of the time. Through the mediation of *Christian Rollet* the French government provided sufficient and sustainable funds to run the office for more than a decade. New statutes

were adopted and the association registered in France. The inefficient tradition to link the presidency to the parallel organization of the annual conference was dissolved and a newsletter created.

Concerning a corporate strategy the most difficult problem certainly was to give up the long pursued idea of a trans-national EMPH e.g. to be issued by WHO: For legal reasons and to avoid undue competition the EMPH had to be defined as an associate degree. During these debates also preference emerged for the postgraduate academic model of public health training. First PEER Reviews were organized 1993 and 1995.

To promote the evidence base of Public Health an explicitly scientific component was introduced the first time at the conference in Bielefeld 1993 (Laaser, de Leeuw, Stock: Scientific Foundations for a Public Health Policy in Europe. Juventa: 1995). Also the first Andrija Stampar medal (coined in Munich) was awarded at this occasion (to *Leo Kaprio*). The four European Public Health Associations met and established lasting cooperation (ASPHER, EHMA, EPHA, and EUPHA).

Contributions from ASPHER Past Presidents (7)

ASPHER: European Scope and Global Reach

Jeffrey Levett,
Professor, Past President (1992-1993) and Past Executive Board member (1991-1994)

In the 1960's experts struggled with definition, and ways of organizing and governing Schools of Public Health. Outcomes included international seminars (WHO, 1963-67) and the emergence of a European-wide Association (AIRESSPE[1], 1966; ASPHER[2], 1973) to serve as a promotional platform[3]. There were difficulties in conception, birth and growth. Birth took place in Ankara (1966) when statutes were tabled[4] after groundbreaking activities in Rennes (Eugene Aujaleu, Jean Senecal, 1964-66) where a classification of Schools was proposed and the considerable difficulties in the expedition of their mission were outlined (Branco Kesic, Zagreb; Stuart Hinds, London). ASPHER came out of the incubator (Zagreb[5], 1968) with Jean Cayla as first president and Theodore Gjurgjevic Secretary General. Cayla believed that successful coordination of public health depends on the participation of different health related professions and spoke the language of

[1] Association des Institutions Responsables d'un Enseignement Supérieur en Santé Publique (SP) et des Écoles de SP en Europe.
[2] A Dutch artist, Nicolas van Pallandt, designed the homunculus logo, depicting the heart and mind of public health.
[3] Leo Kaprio together with leading personalities in Schools of Public Health and Tropical Hygiene were driving agents. Similar Associations for the African, Eastern Mediterranean, South-East Asia, and Western Pacific Regions were founded during a coincidental meeting (Manila, 1967).
[4] They were written in French based on text and constitution of the International Association of Universities (1950), committed to several languages and deposited with WHO.
[5] Kaprio's words in Zagreb ring true when he said "This General Assembly can be an important milestone to further progress in European Public Health"; see Levett J. p 47 in Scientific Foundations of Public Health Policy in Europe, Editors, Ulrich Laaser, Evelyne de Leeuw, Juventa Verlag Weinheim and Munchen 1995.

"harmonization", while Gjurgjevic encouraged membership of Eastern European Institutions. Even within a polarized cold war world, Eastern European institutions[6] as well as international bodies were represented, suggesting that *public health has special features making it an effective tool in foreign policy, a catalyst for peace and conflict reduction*. The founding fathers[7] resisted a totally American type structure for ASPHER while maintaining close relations with its counterpart (APHA)[8]. This was the result of the limited number of European Schools[9] and the diversity in public health training and practice. With the support of WHO-EURO (Joe Asval, Director General) for the development of a European Masters in Public Health, ASPHER moved forward as a professional organization. The Paris office (Christian Rollet, President), the inauguration of the Stampar Medal[10], the positioning of an Executive Officer and the response to the challenges of the Treaty of Maastricht enabled further evolution of ASPHER. Pillars of strength emerged from the spirit of Alma Ata and the goal oriented strategy of HFA. Development of peer review (PEER) edged ASPHER a step closer to the American scene. Today ASPHER's strength lies in its many kindred voices and the implicit value system of public health. On the European scene it can make a difference by educating policy makers, advancing public health scholarship and reinforcing European solidarity. To do so, *links to WHO and the European Union as well as to other international public health organizations need considerable reinvigoration*[11].

Contribution from ASPHER Past Presidents (8)

A few words from a former President

Christian Rollet,
Professor, Past President (1990-1991) and Past Executive Board member (1989-1992)

When ASPHER was created, Doctor CAYLA was leading the National School of Public Health (ENSP) newly settled in Rennes, and he was strongly involved in the first steps of the young association. Unfortunately, when I became Director of ENSP, in 1986, the links between the French school and ASPHER were not effective; so, when attending the next ASPHER meeting in Gothenburg, I was warmly welcome.

[6] USSR, Romania, Czechoslovakia, Bulgaria, Yugoslavia.
[7] Members of a provisional committee consisting of Professor Hans Harmsen, President, Germany, Dr. Frans Doeleman Vice President, Holland and with Secretariat Stuart Hinds (UK), Jean Sénécal (France) and Rahmi Dirican (Turkey).
[8] ASPHER signed a Memorandum of Understanding with the ASPH (President Franco Cavallo & Dean Rosenfeld, 1997).
[9] Evelyne de Leeuw, p 173 in Scientific Foundations of Public Health Policy in Europe. Editors, Ulrich Laaser, Evelyne de Leeuw, Juventa Verlag Weinheim and Munchen 1995.
[10] "Public Health investment harvests rich rewards" is inscribed on the medal and is just one of Stampar's many aphorisms.
[11] While the EU provides a key for progress recognizing public health as a European wide competence, it has not yet provided the "clout" to turn it in the direction of greater development of related Schools. This is today's challenge! See also Levett J., ASPHER: Damp squib or keep of the powder, 27th GA, Yerevan, 2005.

Above all, mutual acknowledgement, informal conversations and sharing experiences are key roles for ASPHER.

Among many others, I wish to select a few topics of the ASPHER agenda, during the last eighties and the early nineties. The discussions we had were usually difficult, sometimes disappointing, but very necessary in order to take into account the extreme diversity of the members. Our aim to set up a European Master's Degree of public health, under the supervision of professor DAVIES, looked like a stimulating but endless debate. This work was proven useful.

I think the programme review that organized by ASPHER was more directly in accordance the needs expressed by the schools; it was a great opportunity for the emerging schools from Central and Eastern Europe; as it was for older schools. I remember a discussion in Prague about the "matrix organization" (crossing academic and professional approaches), totally relevant for the French ENSP.

Generally speaking, ASPHER gave every member pedagogic tools to be rather "learning oriented" than "teaching oriented".

But, ASPHER needs an office and permanent staff in order to provide such services. The settlement in Saint Maurice was a turning point. Whatever the location, this basic need has to be satisfied.

Contribution from ASPHER Past Presidents (9)

Ivan Forgács,
Professor, Past President (1989-1990) and Past Executive Board member (1988-1990)

During my presidency (1989-90) was the most fascinating period in the post war Hungarian history. It may be, that our hopes toward the western-European democracies were somewhat too optimistic and we could not foreseen the socio-economic difficulties as the consequences of the political changes, but we were really optimistic including the relevance to introduce a new public health policy in Hungary.

The coincidence of the profound changes in the Hungarian politics and in the policy of the ASPHER were occasional, but for a new president – as me - interesting and somewhat confusing. The preparation of the most profound changes in the life of ASPHER happened during this period. The General Assembly in Budapest launched the new program in which the former private club character of the ASPHER was restructuralized toward the modern vision of an association which could actively influence the European public health policy and education.

Contribution from ASPHER Past Presidents (10)

Lennart Köhler,
Professor, Past President (1987-1989) and Past executive Board member (1987-1997)

I see these few years as a crucial time both for Public Health in general and for ASPHER. Public Health was fighting for recognition, ASPHER was still a boys' (and girls') club meeting every second year for very pleasant congregations, but in-between nothing much happened. But it was realised more and more that ASPHER in its actual shape was not strong to help develop the new Schools of Public Health that were now emerging in Europe. A professional organisation was needed with strong ambitions, clear goals, substantial capacity and solid structure, i.e. exactly what ASPHER was not.

The first opportunity to enter the road towards professionalism was offered by WHO, which saw training and education in Public Health as an important arena to introduce and promote its new Health for All Strategy, HFA 2000. The ASPHER Board in turn saw the WHO Strategy as a well needed ideological base, on which ASPHER could build a common structure for the Public Health education, a European Master of Public Health. The joint enthusiasm led to the start of a number of courses, covering central topics and ideas of HFA. The plans, however theoretically sound, failed pitifully. Few Schools were ready for the new thinking, and nobody wanted to have their training programmes forces upon them from above.

Other solutions had to be found. The local needs for professionals trained in Public Health meant that a new era of education was introduced and became the lever that started to lift Public Health education and especially the Schools of Public Health. And by creating a Peer Review System ASPHER found a way to help them. The first tentative discussions on this project started in this period, although the decisions and the real reviews did not occur until some years later.

Contribution from ASPHER Past Presidents (11)

Memories of ASPHER

A. Michael Davies,
Professor, Past President (1985-1987) and Past executive Board member (1990-1992)

In many ways 1985 was a pivotal year for ASPHER. WHO/EURO published the 38 European targets of 'Health for All' and we set up a joint Task Force to explore whether public health training could be reorganized around the targets.

The emphasis of ASPHER's activities expanded from collaboration between individual members of a small number of teaching departments to leadership in public health training in the new Europe. Task Force members from several countries collaborated enthusiastically in the design of experimental learning modules to cover cardiovascular diseases, lifestyles, health environment, food safety and hazardous waste. Some modules were designed for self learning and some for teachers who could adapt them to local needs.

Before these modules could be field tested, however, Dr Jo Asvaal, Regional Director of WHO Europe asked us, at the 10th General Assembly in Gothenburg in 1987, to give thought to the development of a European Master's Degree in Public Health. This degree, to be accredited jointly by ASPHER and WHO, would set the European standard. A first draft of a curriculum toward this end was discussed at a WHO-ASPHER Task Force meeting in November 1988, attended by teachers from 25 schools. The second draft, refined and expanded, was endorsed by the 11th ASPHER Assembly in August 1990 (1).

I returned from sabbatical leave at the end of 1989 to take up the post of chairman of the Task Force, generously supported by the first major grant received by ASPHER, given by WHO. Individual teachers and schools undertook to develop and pre-test the core modules and a series of seminars were held at different schools during the next two years to refine and integrate them in an EMPH program.

It was not easy for many schools to accept the concept of a European MPH or even of any general degree, particularly in countries where the training requirements for the different sub-specialties of public health were fixed by regulation. The integration of these new ideas into training became part of the debates in the philosophy, practice and education in public health in a developing Europe. This ferment was reflected at the 13th General Assembly in September 1991 when several veteran members of the committee were not re-elected and I ceased to be active in the Association.

References

1. Eskin F, Davies AM. Steps towards the Development of European Standards for Public Health Training. Eur J Public Health 1991; 1: 110-12.

Contributions from ASPHER Past Presidents (12)

The launching of ASPHER

Frans Doeleman,
Professor, Past President (1981-1983)

Very soon after my appointment in 1964 as head of the department of public health training at the Institute for Preventive Medicine in Leiden, I was delegated to a meeting in Rennes to discuss the desirability and possibility of a European Association of Schools of Public Health. This gathering was based on an initiative of the European Office of the W.H.O. in Geneva where a number of people were impressed by the role of the American Association of S.P.H.s in enhancing the quality of public health training in the U.S.A. The W.H.O. had found professor Cayla, director of the École de la Santé Publique in Rennes, willing to host a small group of representatives of institutions for public health training in Western Europe. At this informal meeting it soon appeared that the situation in Europe, where each state has its own concept of public health, is vastly different from the American situation where the S.P.H.s are organised according to a more or less uniform pattern.

Two years later, in 1966, a *Symposium on the European Schools of Public* Health was held in Ankara. This was a much bigger conference and many institutions for public health training were present. It was well prepared by the Turkish hosts, dominated by the strong personality of a colourful professor of the Haceteppe Medical School. The working language was English. In plenary sessions lectures on public health topics were presented and discussed. I presume that the setting up of an official European organisation was prepared in separate meetings. The Director of the School of Public Health in Zagreb offered to host the next meeting to be held in 1968.

In 1967 I was again asked to represent the Leiden institute at the meeting of a "Comité Provisoire" in Rennes. In the meantime the very dynamic professor Cayla had invented a French name for the intended European organisation : *Association des Institutions Responsables d'un Enseignement Supérieur en Santé Publique et des Écoles de Santé Publique en Europe.* This long name was deemed necessary because in many European countries public health training courses were given by university departments and the number of real Schools of Public Health at the time was very limited. The common language at this meeting was French and so was the adopted acronym: AIRESSPE. The meeting was chaired by professor Harmsen (Hamburg) with professor Cayla (Rennes) acting as secretary general. The other members were professor Primitivo de la Quintana (Madrid), professor Sénécal (Rennes), doctor Olle (WHO, Geneva) and me. Years later these persons were considered to have been the Founding Fathers of ASPHER and I am proud to have been made an Honorary Member at that occasion. But at the time I was relatively young, not (yet) a professor, and with a limited command of the French

language, so you can imagine my difficulties. Professor Cayla reported on his activities on preparing the first Assembly of the new organisation and informed us that already 20 institutions were found willing to participate.

The formal establishment of the intended organisation took place in 1968 and was hosted by the Andrija Stampar School of Public Health in Zagreb. This first General Assembly decided on the name: *Association of Schools of Public Health in the European Region* and the acronym ASPHER was born. We were very well entertained by professor Kesic, director of the Zagreb school, and by the most charming "ancien diplomate" and polyglot Doctor Gjurgjevic who afterwards became secretary-general of ASPHER.

From the beginning ASPHER tried to involve comparable institutions behind the Iron Curtain, but to no avail. But I remember that once an Assembly was graced by the unexpected visit of a director of a Russian research institute who without any regard for the agenda of the day, took the floor, lectured us for an hour about the incomparable virtues of his institute and left right away. A soviet meteor!

The 1981 Assembly was held in Leiden and organised by my department. Accordingly I was President of ASPHER for the year's 1981-'83. I used this occasion to organise the plenary sessions in such a way that after each lecture the participants were spread over small discussion groups each of which got one of my departmental collaborators assigned as a secretary who afterwards reported on the outcome of the discussions. On previous Assemblies I had noticed that many participants with little command of English did not feel secure enough to take the floor in plenary sessions, and I supposed that they would speak up much easier in small groups. This in of fact proved to be the case.

ASPHER history as mirrored by its Secretary General and its Executive Directors

The explosion from a gentlemen's club to a professional association

Evelyne de Leeuw, ASPHER Secretary General 1992-1998

Early 1992 I drove from Maastricht – where I worked – to Paris to meet with the Executive Board of the Association. My Dean had been participating in the 1991 General Assembly and had suggested that I would be interested in engaging with ASPHER. And there I was – 32 years old, with a fresh PhD but without a medical degree, and a woman – meeting with the Grand Old Men of public health training in Europe. They asked me some grilling questions, which I apparently answered to their satisfaction, and at the next Assembly in Athens I was elected Secretary-General (probably, to be honest, by virtue of absence of any competition...).

The idea was that I would cover the Maastricht-Paris drive more regularly to run the secretariat of the association. In actual fact, *'secretariat'* was a grand description for the two rooms and one secretary (the ever efficient but very lonely Ségolène) ASPHER could avail of at the premises of the École Nationale de Santé Publique, and I was amazed to find that the meetings of the Executive Board easily spread out over two or more days (including very pleasant dinners, I must admit): in my earlier management training I had been told that any meeting beyond two hours would be an inefficient meeting.

Things had to change. And things *did* change, but not the way I had optimistically anticipated. With the fall of the Iron Curtain, and the increasing prominence of public health in national politics, ASPHER was most definitely overwhelmed with requests from numerous institutions that wished to become Schools of Public Health. At our next Assembly in Krakow Andrzej Rys had endeavoured to bring many interested parties from Central and Eastern Europe to the meeting, something that was actively supported through WHO/EURO and most notably its Regional Advisor, Jacques Bury. Something was brewing, and the Association had to take urgent action. Two presidents of the time, Jeffrey Levett and Ulrich Laaser, actively engaged with our Central and Eastern European colleagues through the excellent contacts we had with Prague, Krakow, and most notably Debrecen where Ferenc Bojan became a critical driver and inspiration for high quality public health training across Europe.

While Schools continued to emerge in countries like Azerbaijan, Albania, and Kazakhstan we also witnessed an explosion of interest in public health in other parts of Europe at virtually any level of government and education. Public health training obviously was no longer the exclusive remit of departments of social medicine or hygiene within medical schools - colleges and polytechnics across the continent ventured into disease

prevention, environmental health and health management, universities established SPHs in Faculties of Education or Psychology (1), and we saw the establishment and strengthening of fellow associations like the European Public Health Association, the European Healthcare Management Association, and the European Public Health Alliance.

Things had to change. And slowly things *did* change. I managed to make the position of Secretary-General (*'more secretary than general'* as I often jokingly told my friends) redundant, thanks to the excellent negotiating skills of Ulrich Laaser and Franco Cavallo with the French government, which enabled the appointment of the first Executive Director, Jacques Bury. Finally professionalisation of ASPHER became someone's full-time concern! The first Public Health Education European Review documents were published, and we successfully piloted the scheme. When I left the organization at the Torino assembly in 1998 we had evolved from a nice gentlemen's club into a full-fledged service association, ready for the next forty years of excellent public health training on an ever-changing continent!

References

1. Leeuw de E. European Schools of Public Health in a State of Flux. Lancet 1995; 345: 1158-60.

ASPHER history as mirrored by its Executive Directors (1)

Jacques Bury, Professor, ASPHER Executive Director 1995-1999

It was probably the worse time ever for the association when I joined the ASPHER EB as representative of WHO EURO, where I was taking over the responsibility of the training and research in PH. Out of the ashes of the 92 Athens conference (only a dozen of members paying the annual fees, a GA without an agenda among other amazing features and the endpoint of the failure of the joint adventure of the European Master in PH with WHO EURO), several rescue operations luckily emerged: Christian Rollet, head of the French National SPH had decided to finance a half time post for a permanent secretariat in Paris, replacing the running around previous model, and the Maastricht faculty of health sciences to dedicate a half time young academic, Evelyne de Leeuw, to act as secretary general. ASPHER was also lucky enough to get an elected president on board named Ulrich Laaser from Bielefeld, whose commitment never failed. The group, with the ever young Lennart Kohler, was very active and I was able to convince WHO EURO not to withdraw its support for another 2 years, provided there was a concrete outcome. We then agreed to prepare the basis for a peer review process of training programmes: the PEER was born.

Nevertheless in 94, the following director of the French national SPH, Emmanuelle Mengual, wasn't impressed and her views were to close the secretariat in Paris. I argued

that definite progress had been made in transforming a loose association of intelligent academics into an embryo of an organisation, I added that my analysis was that it was a quit or double situation, meaning that if to continue a real development, the need was to have a full time executive director and I convinced her to attend the annual conference in Bielefeld. She came and the conference was very successful: she concluded that she would try to get an ED's post. She did and the EB offered me the position that I accepted in July 95 with enthusiasm.

We, the EB and I, implemented the PEER process in more that ten programmes over the next five years, paving the way for a formal accreditation system. With the support of our US colleague, Michael Gemmel, ED of the ASPH, we organised an annual meeting of the deans and directors of the member schools (usually attended by forty of them), raised the membership to around 60 paying members, published a monthly newsletter, developed a website with among other things an inventory of training programmes in PH in the region, established partnership with the EUPHA (thanks to Klim Mc Pherson and Carlos Alvarez Dardet among others), with EHMA (thanks to Philip Berman) and the EC and get several projects funded including the preparation of the European MPH.

The most exciting side of the job was to work with the respective presidents, Ulrich Laaser, Franco Cavallo, Richard Madeley and finally Jose Martin Moreno, with the various EB members and with the directors of the different schools.

It was a hard decision I had to take at the end of 99 to leave the post for following my wife and kids to Geneva, leaving all the friends made during these years in ASPHER.

ASPHER history as mirrored by its Executive Directors (2)

Thierry Louvet, ASPHER Executive Director since 2000

When I joined ASPHER in September 2000, the Association had been without a Director since end of 1999. Coming from a different professional background compared to my predecessor, Jacques Bury, I had the usual learning curve in front of a newcomer in terms of having to adapt to a new organisation and a new field of work, namely public health. My task had nevertheless been made easier by the fact that quite a lot had been put in place in terms of structure and activities by ASPHER' s first Executive Director. And in spite of having to resolve some tricky financial and administrative issues linked to lingering EU projects, most of the tools and portfolio of activities such as the PEER Review had been tried and tested.

My arrival at ASPHER coincided with the preparation phase or planning and subsequent launch of the OSI-ASPHER programme which was probably one of the biggest, if not the biggest project undertaken by the Association. New members joined

ASPHER on this occasion and it involved at various degrees “older members” ready to share their experience with new colleagues in Central and Eastern Europe. One additional benefit of this programme was in terms of strengthening support to teaching programmes in public health which is one of the core activity of the association.

Of importance, was also the EMPH Network which was in need of adequate coordination from the secretariat and both the funding obtained from DG Sanco and the resolute impulsion from Anders Foldspang greatly helped in this regard.

Accreditation also punctuated my initial years at ASPHER. It went through different phases since the now famous – at least among ASPHER members! – “blue book” on “Quality Improvement and Accreditation of training programmes in Public Health” of July 2001 was first published. It is through the constant and persistent involvement of Stojgniew Sitko that this goal has been kept alive all of these years and that a project funded by Leonardo da Vinci has now started. One now hopes that it will lead to the creation of a European agency dedicated to accrediting public health teaching programmes.

Six years down the road, one has to be modest when it comes to look at what has been achieved and in fact only ASPHER members can say if they think that they have benefited from their membership. The management of an international association is complex and challenging, and it would be presumptuous on my part to draw some wild conclusions one way or another on this period.

One reflection though comes to me as the Association is having to adjust to the end of the generous support given for nearly 10 years by the French authorities and relates to the way organisations such as ASPHER are funded or at least core funded. It is preferable that members take more ownership and therefore more responsibility, including financially, for the organisation which represents them and do not rely solely on one or even two key funders, not to mention one or two key individuals!

The Andrija Stampar Medal

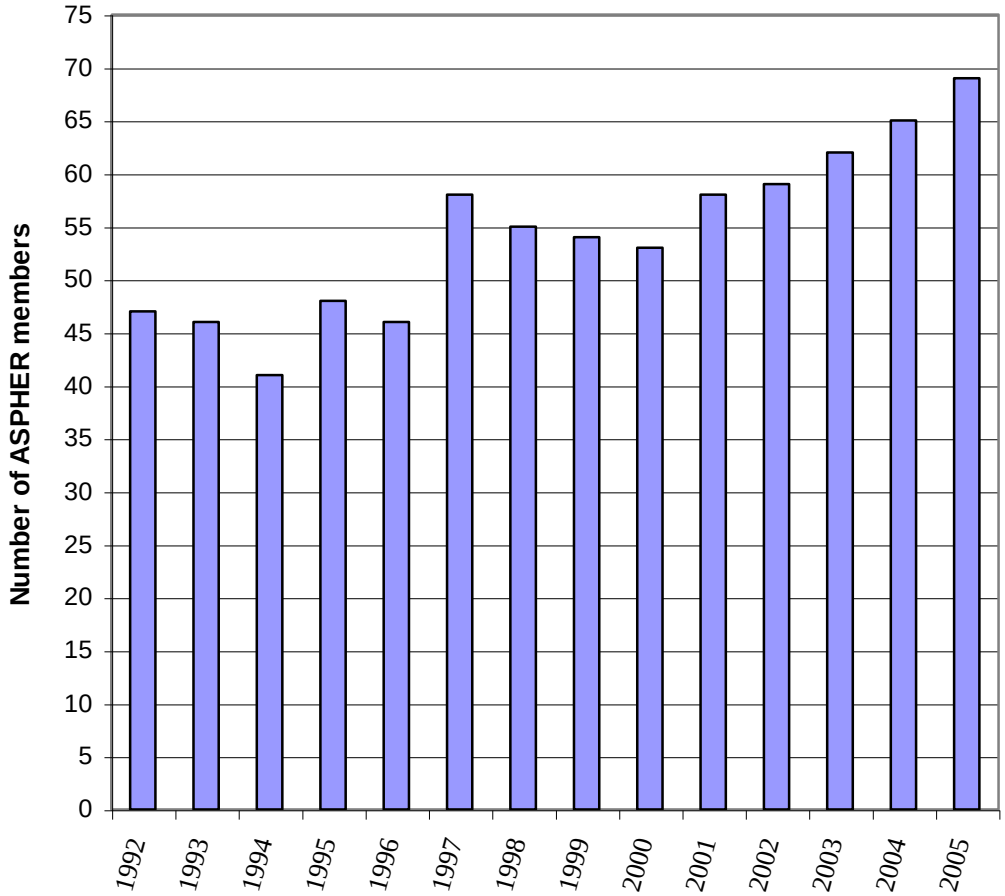
The Stampar Medal was created in 1993 in honour of Doctor Andrija Stampar.
The Medal is awarded each year since 1993 to a distinguished person for excellence in the field of Public Health.

Stampar Medallists

Mr. George Soros, Yerevan 2005
Professor Theodor Abelin, Caltanissetta 2004
Professor Martin McKee, Granada 2003
Sir Alexander Macara, Zagreb 2002
Professor Ilona Kickbusch, Debrecen 2001
Professor Charles Mérieux, Aarhus 2000 († 2000)
Sir Richard Doll, Madrid 1999 († 2005)
Professor Lennart Köhler, Torino 1998
Professor Ferenc Bojan, Prague 1997 († 1997)
Professor Michel Manciaux, Utrecht 1996
Dr. Halfdan J. Mahler, London 1995
Sir Donald Acheson, Krakow 1994
Dr. Léo Kaprio, Bielefeld 1993

Development of the number of ASPHER members

Figure 1: Number of ASPHER Members 1992-2005



PART TWO: DEVELOPMENT OF TRAINING PROGRAMS AND THEIR QUALITY

PH training program quality assessment and development: The PEER Review

Ramune Kalediene

In the context of enlarged Europe, it is an increasing need to train public health professionals, meeting the necessity to respond to emerging new health challenges. New programs of public health training are developing, and the diversity of understanding of public health education curriculum becomes obvious over the Europe.

One of the core concerns of ASPHER is the development of a quality assessment mechanisms of public health education programmes. The PEER – Public Health Education European Review was devised with the aid and support of the WHO EURO, as a voluntary initiative of institutions in 1993. The PEER Review is a supportive and developmental tool based on improving the quality of public health Education throughout the European Region. The PEER operates as a mechanism, in terms of programme content and quality standards, to develop curricula, provide guidance and steering in development and share best practice throughout the region. This procedure combines a self-assessment study and a review by a team of peers based on a list of criteria described in the procedures.

Historical development of the ASPHER PEER review process:

- 1992: The General Assembly gave a mandate to Executive Board to organize a process for mutual recognition;
- 1993-1994: PEER – Public Health Education European Review was devised;
- 2001: "Quality Improvement and Accreditation of Training Programmes in Public Health“ was published;
- 2001: the Executive Board set up an Accreditation Task Force;
- 2002 Accreditation framework document was prepared;
- 2001-2003(4) Program aimed at developing quality in Public Health Teaching Programs, across 13 countries throughout the Central Eastern European region was successfully carried out.The first school to complete PEER Review in 1993 was School of Public Health in Bratislava, Slovakia. Up to now, 21 school or program was reviewed. Many prestigious European schools of public health got involved in this process. The criteria set up by ASPHER are widely used as a standard for development and quality evaluation of public health training programs and schools.

For the assessment of the PEER review and investigation of the major challenges in this process, questionnaire survey was carried out in June 2005 among the member schools of ASPHER. The questions about the major challenges and benefits from PEER review were addressed to the deans and directors of schools of public health. Among 29 schools of public health, which responded to the questionnaire, 17 were interested in performing PEER review in the near future. This shows clear acknowledgement of the review procedure as a valuable tool for quality improvement of public health training

programs. The major challenges faced by the schools undergoing PEER review was rather time consuming process, not well known procedure, and, for some developing schools of public health from Central Eastern European countries – English language. Nevertheless, all reviewed schools acknowledged major benefits gained from the review:

Major benefits gained from the PEER review process:
- possibility to reassess programs critically;
- highlighting strengths and weaknesses of the programs;
- constructive criticism;
- initiation of new activities;
- waking up to the concept of team work and common aim;
- adding an external perspective from highly skilled international experts;
- using it as an essential tool within one's own quality assurance system;
- being useful for communication with local and national authorities;
- serving as a basis for comments to a succeeding national review;
- feeling of international support.

Results from the survey highlighted constructive suggestions for the improvement of PEER review process. One of the major points was to have formal agreement at the European level or among scientific and professional health societies of the review process and formalizing the status of PEER within National accreditation procedures and systems. This would enable to assure more institutional recognition on both national and international horizons. Guarantee of independency of the experts seams to be of great importance. Establishment of close links between PEER and accreditation was emphasised by majority of the respondents. Schools of public health from Central and Eastern European region were willing to have at least partial financial support for the PEER review procedure. It was considered that PEER criteria and methodologies should be upgraded periodically. The most optimistic suggestion was to convince schools that PEER is worthwhile. The public use of the PEER reports by many of the reviewed institutions is a good indicator of the satisfaction with the review.

Generally, great satisfaction was expressed with the review procedure both by the heads of institutions and the staff where programmes had been evaluated. The process of PEER review is now centred not only at quality assurance but also on favouring development of new schools and training programs of public health. Since the procedure of accreditation of schools and programs in Public Health is in the process of establishment, the PEER review should be considered as major developmental stage towards mutual recognition of programs, courses or institutions throughout European region.

Public Health Training Program Accreditation in Europe: Imperative for a Euro-Accreditation in Public Health

Stojgniew J. Sitko

ASPHER has for over the last decade advocated for the establishment of accreditation system of public health (PH) education and is now about to launch – together with other European partners - the European Accreditation Agency for Public Health Education (EAAPHE). This activity is coming very much along with a distinctive European Union policy of improving and regulating the quality of education (e.g. *Copenhagen Declaration*, Nov., 2002). According to the *Lisbon Strategy* (March, 2000) special emphasis is put on vocational training: *access to education, lifelong learning and mutual recognition of diplomas and certificates acquired in different European educational settings*. The diversity of PH training programs between countries resulting in different training products, growing trend towards distance learning and exchange of education as well as a relatively low level of professionalisation of the PH workforce are important reasons for an accreditation scheme to be established.

Cornerstones which are building up the Euro-Accreditation

The current impulses towards accreditation of PH education promoted by ASPHER are based upon years of experiments, discussions and consensuses. One of the cornerstones is a PEER review (*PH Education European Review*) – launched by ASPHER in 1993 and undergone by more than 20 Master of PH programs all over Europe so far. The project of European Master of Public Health (EMPH) (1) [12] constitutes another step towards standardization of the PH education. Foundation Merieux supported the preparation of a significant analysis entitled: *Quality Improvement and Accreditation of training Programs in Public Health* - published as a book in 2001 (2). In Magdeburg, ASPHER Deans and Directors[13] - endorsed the recommendations *to initiate the development of an (independent) accreditation body*. In consequence, in the same year - an international Accreditation Task Force[14] was established by Executive Board of ASPHER and an *Accreditation Framework Document,* was prepared and presented at the DD Retreat in 2002[15] It re-states distinctively that: *ASPHER in recognition of the importance of unified evaluating system of education - decides to initiate the establishment of an European Accreditation Institution of Public Health Education Programmes.*

[12] Where 14 European SPHs cooperating in the network now, see: http://www.aspher.org/C_projects/EMPH/emph.htm

[13] Deans and Director Retreat is a once a year (usually in April/May) meeting of the representatives from all ASPHER members.

[14] *The members of this ATF established on the EB meeting on 31 Nov.2001 – have been:* R.Adany (H) – being that time a President of the Association\and: J.Burry (CH, F.Cavallo (I), J.Meulmeester (NL), G.Magnusson (S), Ch.Normand (GB) and S.Sitko (PL) (chair)

[15] *See: www.aspher.org/C_projects/Accreditation/accreditation.htm*; *this Accreditation Framework Document advanced the idea about details concerning the system and organization of accreditation for PH education and the Agency.*

In December 2002, EUPHA and ASPHER signed a cooperation agreement for the establishment of an EAAPHE[16]. In Athens in 2003, a survey among of 32 delegates from European SPHs showed[17] a definite interest of nearly all towards establishment of such an Euro-Accreditation; a will of undergoing such process in less than 2 yrs – was showed by nearly a half of the represented Schools.

In 2005 a revision of the PEER criterions together with a draft accreditation standards and procedure have been prepared in a form of *Accreditation Procedure Document* (APD)[18]. WHO-Europe in its recent (2006) Discussion Paper: *"Developing the Public Health Workforce in the European Region" (3)* in separate chapter entitled: *Quality Assurance of Public Health Education* - underlined that the: *European wide accreditation should be developed on the bases of previous experiences of quality review processes (as those conducted by ASPHER over the past decade).* End of 2005 a EU-LdV Project[19] was started to elaborate the accreditation system and launch the EAAPHE with the support of WHO-Europe.

The development of the accreditation system and EAAPHE organization was presented and largely discussed, at the numerous meetings, seminars, workshops and conferences for European public and beyond throughout the years[20]. It has been gaining practically everywhere positive reactions, support and in several cases - direct declarations of interest to undergo such an accreditation as soon as it will be available; many SPHs are already willing to let their education in PH go through external, benchmark based European-agreed quality assessment.

Finally, accreditation together with PEER and SAQ (a tool of assessing and improving employability of PH graduates[21]) - are currently recognised as the three major "pillars" of quality improvement of PH education – as can be seen on the picture[22]. This approach emphasizes the importance of quality of *output* of educational process.

How will the Euro-Accreditation work?

Independent status: ASPHER although initiating and intensively attempting to establish the Euro-Accreditation distinctively *does not* want to monopolize it - European organizations

[16] Agreement of Cooperation between the Associations of Schools of Public Health in the European Region (ASPHER) and the European Public Health Association (EUPHA) for the furthering of the establishment of a European Accreditation Agency of Public Health training programmes. http://www.aspher.org/C_projects/Accreditation/ aspher%20eupha%20agreement%20_3_.pdf

[17] *Results of a survey on Euro-Accreditation, Minutes of ASPHER Deans & Directors Meeting, Athens, April 2003.*

[18] Accreditation of Public Health Education Programs - Challenge in Quality Improvement for the SPHs of the European region, Accreditation Procedure Document – APD, S. Sitko (ed) (PL), R.. Adany (H), M.Geraedts (D), A.Krasnik (DK), T.Louvet (F), EU-EMPH Project, ASPHER, 2005 - done in the framework of EU-EMPH Project

[19] Sitko S. et al., Accreditation of Public Health Training Programs in Europe – LdV -Community Vocational Training Action Program, Second phase: 2000-2006, PL-05-B-F-PP-174049 Project Application, IZP CM UJ, Kraków, 2005. Other partner are SPHs from: PL, DK , NL, F, GB, BG. This project is in partnership of ASPHER and EUPHA, together with 5 SPHs from different European countries.

[20] *Sitko S., among others at: EUPHA Annual Conference, Graz, (2005), APACPH Annual Conference Brisbane (2005), WHO- EUPHA-OAQ-ASPHER Seminar, Bern (2003), Brimhealth Seminar, Gotteborg (2003), International Seminar on Accreditation (ISA), Rennes (2003), Meeting on Graduate Public Health Education in CEE and Eurasia, Fogarty International, Bethesda (2004), Annual Conferences of ASPHER in: Zagreb (2002), Granada (2003), Caltanissetta (2004), Yerevan (2005), Deans and Director meetings in: St.Maurice (2003), Lisbon (2004), Bielefeld (2005) and Hall/Insbruck in (2006).*

[21] Improving Employability among Public Health Graduates, EU-LdV Pilot Project no PL/00/B/PP/140155, 2000-2003, by Czabanowska K. et al, partners: IZP CM UJ – Krakow (PL), ScHARR (UK), Maastricht Univ. (NL).

[22] This idea and its illustration (which in between become a kind of a "trademark" of the quality approach of the Association) were drawn by S. Sitko and K. Czabanowska and appeared for the first time in ASPHER-APD document (EU-EMPH Project) in 2005.

active in the area of health, PH and in quality of education are invited to form a partnership in establishing the Agency[23]. What will be accredited? At the beginning - a master (MPH) degree program or equivalent[24]. Accreditation procedure first step will be a PEER or equivalent review - any other quality review (national or international) which fits with the PEER criteria (2) or overcome them. Individual examination of this fitness will be a duty of EAAPHE[25]. Cost - will be composed of two major components PEER review or equivalent, according to the current estimations[26] will not be lower than 10 thousands Euro[27] whereas the actual accreditation - a few thousand Euros being on the top of this of first stage[28]. Standards of Euro-Accreditation - drafted in the APD[18], are in further development (PH-ACCR Project). The tools for constant improvement of these standards, evolution of the procedures and operations – will be elaborated and incorporated in the EAAPHE.

A crucial issue for successfully establishing the Euro-Accreditation is not only the quality of the system and of the EAAPHE itself, but also the harmonizing the national quality educational audits and schemes (especially in PH – if exist) already present to different extend in many courtiers all over Europe. This is not only the case that EAAPHE should adopt the best practices from the (numerous already) national experiences in that matter, but also *vice versa* – that the Euro-Accreditation will be recognized and formally accepted as fully adequate prove of quality of PH education at the *national* level as well.

It seems obvious that, after many years of preparations and already several sound successful experiences in that matter - the "public health educational society", in a big scale represented by ASPHER - is at a time: definitely seeking and ready nowadays for the launch the Euro-Accreditation and the European Accreditation Agency for Public Heath Education.

References

1. Cavallo F, Rimpela A, Normand C, Bury JA. Public health training in Europe - development of European master degrees in public health. Eur J Public Health 2001; 11: 171-73.

2. Bury J, Gliber M. Quality Improvement and Accreditation of training Programs in Public Health. Lyon: Edition Foundation Merieux, 2001.(after a colour of its cover being called a "Blue Book").

3. Perfilieva G, Tulchinsky T, Berry E, Sitko S, Kalediene R, Krasnik A, Kulzhanov M, Boyarsky S, Wiskow CH, Groot W, Bino S. Developing the Public Health Workforce in the European Region - Discussion Paper (draft). WHO Regional Office for Europe, 2005.

[23] The institutional agreement with EUPHA is already signed for this purpose; WHO-Europe is a formal supporter for the project, the consultation with DG-Sanco are encouraging, also a regular research in that area is performed in the framework of mentioned above - PH-ACCR project.

[24] See cited already - APD document (Accreditation of Public Health Education Programs, 2005), for reference about understanding of a MPH and MPH-equivalent program. ASPHER membership will NOT be any prerequisite for Euro-Accreditation.

[25] The overall analysis of these quality review schemes in Europe is currently on going due to of mentioned LdV PH-ACCR Project.

[26] See cited already - APD document (2005), chapter 7.

[27] And may be around the 30000 Euro – when doing the complete PEER review; other (equivalent) review cost may differ, however, various approaches are possible to: lower, spread in time (so called "pre-payment", a sort of yearly installments) or get supported of this costs by a third party institutions; EAAPHE is planned to facilitate this approach, the setting the dependence of these fees to the size of a SPHs an/or GDP of a country of its origin is taken into consideration as well.

[28] Depending on the quality of a basic review; more work will have to be done additionally – more costly the second step will be.

Development of PH training programs in Central and Eastern Europe: The OSI-ASPHER Programme

Theodore Tulchinsky

ASPHER is currently issuing a book on the conclusion of a five-year collaboration with the Open Society Institute (OSI). The book is written by Julien Goodman who was closely associate with this project from its inception, working with an editorial Committee consisting of Jacek Sitko, Judy Overall and myself.

The broad aim of this collaborative project was the "Quality Development of Public Health Training Programs in Central and Eastern Europe". Its goals were to establish and to enhance institutional teaching programs of public health in the region. The program included in excess of forty different schools of public health in over 30 countries and just under two hundred public health academics and professionals in the review and development process.

Originally there were sixteen schools involved in the program but, over the years and for various reasons, this amount reduced to eleven. Thus far there have been six PEER reviews conducted out of a possible seven, three brand new schools of public health have been established and one master level program instigated. The experiences and lessons learned from this program are represented and discussed and presented in such a way as to hopefully be helpful to those new and developing schools that will emerge in the coming years.

The objectives of this book is to document the lessons learnt from the program, and the achievements of the SPH in the region; to provide evidence for policy makers on PH workforce development needs; and to provide a guide for schools wishing to establish or develop themselves.

Over the five years of the program many lessons have been learnt regarding the internal and external operations of the schools of public health, the environments in which they reside and the international context which aims to set the benchmarking standards, in the three categories of practice, priorities and policy. The first section of practice refers to the activities that schools in this region undertook and which are applicable in other countries in transition to either establish or further develop post graduate research, teaching and service capacity in academic centres for public health. The book also addresses the role of public policy and its impact on the future of public health in the European region**.**

Over the five years of this program many lessons have been learnt regarding the internal and external operations of the schools of public health, the environments in which they reside and the international context which aims to set the standards for practice, priorities and policy. This refers to activities that schools undertook and which, potentially,

other countries in transition may need to adapt for their further development for establishing and developing new schools of public health. Further, the book examines the role of policy and its impact on the future of public health in the European region.

Experiential evidence from the project can help in the establishment phase of emerging schools of public health as well as for developing and more mature schools of public health in the region. The key issues in developing new SPHs in Europe are stakeholder promotion (including government, academic centres, NGOs and health insurance networks), structure and organizational issues, capacity building (e.g. faculty preparation), curriculum design and resource procurement. The need is there and the models evolving from this project will be of great importance to the further expansion of the SPH movement in Europe. We believe the project and this book will make important contributions to the continuing development of public health in a rapidly evolving Europe.

Towards a cross-border master's degree in Public Health: The European Master of Public Health (EMPH)

Anders Foldspang & Thierry Louvet

The development of a Master Programme in Public Health with a specific European component is revolutionary in its aim to create a core of public health professionals who are specifically equipped to practice within the European arena - with its most heterogeneous population health situation, often characterised by the consequences of substantial poverty and social inequality, and with its variation in health systems as concerns their history, coverage, access, organisation, functioning and financing.

Over the years, important attempts have been made to convert these considerations into reality. A first concrete response to training in public health was given by ASPHER in collaboration with the World Health Organisation (WHO) in the early nineties by creating a joint task force in order to propose a European Master's Degree in Public Health based on the principles of the Health for All by the Year of 2000 principles. Attempts to develop curricula and learning materials were however not successful, and instead a peer review system, as a means of establishing a European standard in public health training, was suggested and developed.

During 1996-1999, ASPHER, with the financial support of the European Commission, examined the possibility of launching a European degree in Public Health. Two successive phases under the heading of "European Degrees", from 1996 to 1997 and from 1997 to 1999, led to the creation of what later became the EMPH. In the XXI ASPHER Annual Conference in 1999, which took place in Madrid, a proposal was put forward to also develop a European Master in European Public Health (EMEPH); this plan was however never realised.

Since 2002, EMPH network members have met in workshops 1-2 times a year, during 2003-2005 supported by funding from EU DG SANCO. This made possible the development of the concepts, criteria and practical organisation of the current EMPH Programme, in which the student, in order to obtain the qualification of European Master of Public Health (EMPH) or European Certificate of Public Health (ECPH), must fulfil the following four requirements:

- A general degree programme in Public Health of at least 60 ECTS credits;
- At least 12 ECTS credits of "European content", spread out among modules, an internship (if it is requested by the school as a compulsory component), and a thesis;
- At least 12 ECTS credits of study time spent and earned abroad (WHO European Region);
- A thesis with at least 20% of European content.

Thus, to complete the EMPH curriculum, a student must first of all accumulate 60 ECTS credits in a general degree programme in Public Health. This may be completed in one year of full-time study or over a longer period of time.

Under the supervision of the local tutor, each student should set up a personalised curriculum including a core component, concerning the basic knowledge and skills required for a Public Health professional. The chosen courses must cover, in a balanced way, the following five Public Health core domains:

1. Introduction to Public Health and to Europe;
2. Policy, Management and Economics;
3. Epidemiology and Statistics;
4. Environment and Health;
5. Health Promotion/Health Education, Social Sciences.

Furthermore, the student must complete an optional part concerning vocational training, based on the offer of advanced and specialised modules. Each institution may offer its own individualised modules in each of the four core areas and/or in other areas of Public Health.

If requested by the school, an internship/placement dealing with practical training should be organised. This requirement depends mostly on the requirements from the different schools, which vary from one institution to another and from one country to another. Where a placement is required, it is advised, as far as possible, that at least part of this placement be carried out in another European country with a different language.

Finally, the student must complete a thesis work, showing his/her capacity to deal with projects relevant to Public Health practice and research across European countries. As the capacity to manage a project in the field of Public Health constitutes an important part of the learning process, and should remain close to the interests of the student and to the availability of material, it is important that this component be allowed to have great

variation. Therefore, it is advised that a local institutional review mechanism be organised in order to guarantee that the general purposes of the EMPH are fulfilled. For this reason, the participation of an external examiner in the jury is mandatory. It is also strongly advised that the thesis be written in a language different from the student's mother tongue and that an abstract of the thesis be written in English.

The thesis should also demonstrate the competencies acquired regarding European content; it is therefore advisable that it is carried out, either partly or totally, in another country, especially in case no previous experience has been acquired by the student in this respect.

The title will be officially awarded by the School in connection with the EMPH network of schools. It will probably be a specification, or an add-on, that acknowledges a special European competence and its potential value in the European job market.

Besides the series of workshops, which as mentioned allowed for the complicated disentangling of differences in terminology and for the establishment of procedures, a summer school was held in Düsseldorf in July 2005 with the prevention of obesity in European populations as the main theme; the summer school thus covered population health aspects as well as European health services and health systems reforms. Twenty students from a total of 6 countries participated. Students' evaluation was positive. A second summer school was carried out in July 2006 in Debrecen, Hungary, with the participation of 17 students from 5 countries; it covered health inequalities and cardiovascular disease in Europe. In both summer schools, teaching and learning methods consisted of a mixture of presentations and problem based group work.

The first EMPH student graduated from Debrecen University, Hungary, in 2005, and more graduates have followed. The number of students and graduates is however still small. One major problem seems to be the funding of studying abroad. Also a certain amount of exchange of teachers has been initiated. The overwhelming challenge seems to be to increase the student turnover of the programme and to increase and stabilise the programme itself.

References

Foldspang A, Louvet T et al (Eds.). Vademecum, The European Master of Public Health (EMPH). Saint-Maurice: ASPHER, 2005.

PART THREE: THE CHANGING PATTERN OF DISCIPLINES AND THEIR USE IN PUBLIC HEALTH

Public Health research and training

Ulrich Laaser

When ASPHER's development came to a turning point in the early nineties, one of the key debates focused on the role of research on the publics' health. Many feared that if the research component – often cited as the health sciences – would be promoted too much that could be at the expense of the traditional, almost exclusive priority on training. Most of the Schools of Public Health at that time were part of the government or closely linked, very different from the autonomous academic tradition of the American institutions (Johns Hopkins School of Public Health 1916). The first PEER reviews in the mid-nineties excluded by purpose the consideration of research activities and even the famous "Blue Book" published 2001 (1) conceded only a marginal role for research (*Fondation Merieux/ASPHER 2001*). Similarly there was great reluctance to establish in 1999 the Internet journal as a general forum for research hence the naming as Internet Journal of Public Health Education (I-JPHE). Since then the panorama has changed considerably with the academisation of public health education, the internationalisation and globalisation of risks for the public health and the obvious financial constraints which limit increasingly the curative medical sector: We can observe a renaissance of public health and therefore also of the health sciences as the means for public health research. One indicative expression of this is the inauguration of a database for evidence based public health at the WHO-EURO website. Thus as a conclusion of the cited debates the slogan of "Training for Public Health Practice and Research" has been well chosen for the mission of ASPHER.

The health sciences stand for a hybrid field of research, merging the medical and the social paradigm, and grouping several disciplines around the big four namely epidemiology, public health management, health promotion, and environmental health. Public health genetics and Emergency Preparedness may prove to be the fifth and the sixth in the near future. Public health research by principle is applied research and serves the essential public health functions (PAHO et al. 2002) [29] i.e.:

1. Monitoring, Evaluation, and Analysis of Health Status
2. Public Health Surveillance, Research, and Control of Risks and Threats to Public Health
3. Health Promotion
4. Social Participation in Health
5. Development of Policies and Institutional Capacity for Regulation and Enforcement in Public Health
6. Strengthening of Institutional Capacity for Planning and Management in Public Health
7. Valuation and Promotion of Equitable Access to Necessary Health Services

[29] PAHO, WHO, CDC (2002) Public Health in the Americas. Washington DC available at http://www.campusvirtualsp.org/eng/sldpub_eng.html (accessed 16.04.2006)

8. Human Resources Development and Training in Public Health
9. Quality Assurance in Personal and Population-based Health Services
10. Research in Public Health
11. Reduction of the Impact of the Emergencies and Disasters on the Health.

If we analyse working methods in the various interdisciplinary research fields referred to, strictly speaking there is no deviation from the traditional biomedical model to be seen but, rather, an enrichment of this model by means of factors from research into psychology, social sciences, and environmental sciences. There has been no fundamental paradigmatic change, no departure from basic theoretical assumptions, but rather an extension in that mental, social, and ecological factors have been absorbed into the model as additional marginal conditions along with genetic, endocrinological, neurological, and physiological factors. This research mainly uses the risk factor concept as its orientating epistemological model, whereby the risks of the origins, development, and course of a disease and not those of health are the focal point of the research. If health research is to be in the foreground, instead of research into diseases, it will be necessary to construct an interdisciplinary, organizationally independent field of “health sciences” on equal footing between medicine, biology, psychology, sociology, economics, and possibly other fundamental sciences. For that a theoretical orientation point is required that is suitable for, and acceptable to, all participating disciplines. This could be a “bioecopsychosocial” model of the development of health and disease that comprises biomedical, ecological, psychological, and socio-structural components as equally valid constitutive elements (Hurrelmann, Laaser and Bury 1996) (2).

As much as public health research is population research the patient centred biomedical ethics have to be transcended towards population ethics. The simple utilitarian principles, seemingly in line with epidemiological reasoning based on probabilities, have been questioned in the European tradition of collective solidarity. Any interventive public health research needs an equivalent of the patients’ consent in terms of a representative participation of the concerned population groups, it cannot remain a matter between scientists and professionals alone.

It is obvious that this research concept cannot be realized in an ivory tower, interdisciplinary, multi-professional and multilateral institutional collaboration and coordination is required. The schools of public health therefore have to liaise with other research departments and faculties as well as with service institutions providing field experience. This may well take the format of a contractual consortium where thesis research can more easily be arranged and the funding of larger research programmes finds political support. Students who are going to become the leading professionals towards the middle of the century have to learn how evidence in public health is to be generated and evaluated in order to improve the essential public health functions cited

above. Therefore teaching public health without providing opportunities for and developing skills in health research does not come up to the challenges of the 21st century.

References

1. Bury J, Gliber M. Quality Improvement and Accreditation of training Programs in Public Health. Lyon: Edition Foundation Merieux, 2001. P. 81, 95.

2. Hurrelmann K, Laaser U, Bury J. Theory and Training in Public Health, International Handbook of Public Health. Westport, Connecticut and London: Greenwood Press, 1996.

Epidemiology: still the basic science in public health?

Rodolfo Saracci

Is the title of this brief essay a genuine or a rhetoric question? It can be regarded as genuine to the extent that the multiplication of sub-specialties within epidemiology on one side and the even larger multiplication of disciplines and specialized areas of knowledge indispensable to today's practice of public health raises the issue of where the foundations lie. On reflection, however, it is a rhetoric question: epidemiology remains the basic or fundamental science of public health, being constantly and primarily necessary to public health activities. Necessary: in this respect epidemiology is, like many other disciplines, indispensable but not sufficient. Constantly and primarily: unlike other disciplines, however, epidemiology is constantly necessary, albeit to different degrees, as the first or primary step in every circumstance requiring public health. In clinical medicine diagnostic methods have evolved from to the dominance of bedside physical examination to the massive use of laboratory and instrumental tests and imaging techniques, and in this renewed version they remain the foundation of all clinical practice: in the same way epidemiology, evolving in methods and contents, remains fundamental to public health as its diagnostic component. Epidemiology is itself a unique construction build around four key concepts, each originating from a different and historically antecedent scientific stream: *disease and health*, from medicine and biology; *population*, from demography; *probabilit*y, from statistics; and *unbiased comparison*, from the methodology of experiments as transferred to observational studies. Developed as it is around these four interwoven components, epidemiology contributes to the educational, research and day by day practice of public health in three domains.

First, epidemiology continues to provide the frame within which health and disease in the population can be examined and possible determinants searched for, at all scales from a single community to the world. Just as an example, three years ago an epidemiological system of international surveillance, rapidly combined with formal case-

control studies supported by update laboratory investigation allowed to identify the agent of the newly appeared SARS syndrome (and formed an integral part of the successful containment system) (1). Epidemiology is now documenting the dynamics of the global obesity epidemics, exploring its consequences and probing its causal factors at population level. In recent years molecular genetic epidemiology has come to dominate the search of causes of any disease but epidemiologists are fast becoming aware of the inherent limitations of this lopsided approach, particularly as the public health impact of "gene-environment" interactions remains for the time being doubtful. At the other extreme of the scale ranging from molecules to society, social epidemiology and the investigation of social inequalities in health is receiving a fresh impetus in many countries and internationally. In this area a major effort is needed to make routinely usable epidemiological indicators of social inequalities in health incorporated in health monitoring schemes: this points more generally to the permanent necessity of designing epidemiological methods specifically suited to public health practice.

Second, epidemiology has been central to the development of the "evidence based" movement of evaluation of interventions, simple ones as testing a vaccine in an experimental group or complex as applying a screening programme to an entire population. The basic concept of unbiased comparison has been elaborated into designs of randomised field studies and –when these are unfeasible – into designs assuring maximal validity to purely observational studies. Assembling the evidence base has also progressed from traditional reviews of available studies to formal methods of meta-analysis. A standard definition of epidemiology recites "The study of the distribution and determinants of health-related statuses in specific populations etc." (2). Populations can be specified geographically, gender-wise, or in respect to health itself: the particular application of epidemiology to patient populations, with the aim of quantitatively describing the natural history of disease and of evaluating diagnostic an therapeutic interventions has become the blossoming field of clinical epidemiology. It creates, via the common denominator of epidemiological methods, a liaison between clinical medicine and public health.

Although epidemiology is both a methodological and a substantive discipline, the methodological core is of particular relevance from an educational viewpoint. Scientific methodology is the third domain in which epidemiology can contribute to public health. Epidemiology is poised between the natural and the social sciences, but is much more anchored to the former as methods are concerned. The paradigm of the "good" observational study is the investigation of the association at the individual level of exposure(s) with outcomes, taking into account possible biasing and confounding factors in such a way that the study validity approaches as close as possible that of a randomised experiment. The latter is the validity standard of reference and epidemiologists have gone, and are going, at great length in discussing and elaborating explicit and rigorous criteria for

inferring causal links in observational contexts. This is of value not only for epidemiological investigations but also when the actual or projected effects of social and economic changes and manoeuvres need to be assessed. It is inconsistent, for instance, to demand evidence based on hard causation criteria of the efficacy of an intervention to (say) control blood pressure and then to accept that the decision to make it available or not to the population is based on soft economic data maybe mixed with unverified assumptions on how the health service has to be organized.

That epidemiology continues to be the fundamental science in public health is only one term of the relationship between these two disciplines. The other term in represented by the fact that it is hard to imagine, and historically never occurred, that epidemiology can prosper without public health. Epidemiology is not a theoretical science, and it generates "pure" knowledge in the course of what is essentially "applied" research: it takes its problems from public health and returns what answers it can to public health. To paraphrase what A. Lilienfeld once stated: "Without epidemiology there is no public health, without public health there is no epidemiology".

References

1. McLean AR, May RM, Pattison J, Weiss RA (Eds.). SARS: A case study in emerging infections. Oxford: Oxford University Press, 2005.

2. Last J (Ed.). A dictionary of epidemiology. 4th ed. Oxford: Oxford University Press, 2001.

The social sciences in public health training

Johannes Siegrist

The distinction between 'old' and 'new' public health assumes that the latter deals primarily with the chronic diseases that are highly prevalent in developed and rapidly developing countries, with a focus on their environmental and behavioural determinants and the potentials of prevention and health promotion. Conversely, 'old' public health is mainly concerned with traditional infectious diseases and the provision of basic health care including immunization, sanitation and improved hygiene. The inclusion of social sciences into core parts of public health training has been a more recent development that was mainly stimulated by the challenges of 'new' public health. The term 'social sciences' is used as a common denominator of distinct scientific disciplines that deal with collective rather than individual behaviour including organizations and institutions. Examples are anthropology, sociology, and political sciences. Sometimes, economics and management sciences are included as well as behavioural sciences, but here we restrict our comments to the former disciplines as they share important theoretical and methodological properties.

There are two types of scientific contributions provided by social sciences to 'new' public health challenges, first those related to the study of socio-economic and socio-cultural determinants of health and disease including health and illness behaviour, and secondly those related to the organization and provision of health care. In the first case, social determinants of health define a major topic of research and teaching. For instance, patterns of distribution of diseases vary as a consequence of societal change and economic progress, with huge impact of newly emerging life styles ('coca-colonization') and technological developments that are induced by modernization and globalisation. Urbanisation, environmental hazards and pollution, collective violence and poverty threaten the health of large parts of the population in less developed countries. But even in economically most advanced countries social inequalities in health are persisting or even widening (1). There is growing evidence indicating that psychosocial adversity evolving from less privileged living and working environments affects health and well-being, in addition to the more traditional material conditions. Lack of social networks, social support and participation, declining social capital, unfairness and injustice are examples of psychosocial adversity with relevance to health (2). With the advent of elaborated statistical approaches, such as multilevel analysis, these complex associations can now be studied in more appropriate ways.

Social sciences, and in particular sociology, provide the theoretical and methodological tools to assess these conditions and to analyse their effects on health. Expertise on sampling techniques, data collection approaches (surveys, qualitative interviews, observation etc.) and data analysis strategies are an essential part of public health training. Based on analytical knowledge, preventive or intervention trials and programmes can be developed to promote population health. Again, social science training is important to successfully implement and evaluate these interventions.

The second application of social sciences to public health concerns the study of organizations, institutions and professions within the health care sector. Comparative analyses of health care systems at the macro level and in-depth inquiries into the functioning of specific organizations at the micro level are essential components of this approach (3). Analysing the pros and cons of medicalization, identifying unmet health care needs or under- and over utilization, and evaluating the efficacy of medical interventions in a population health perspective are important directions of research. Similarly, the professionalisation and the work contexts of physicians, nurses and other health professionals deserve attention, with a focus on health- promoting work and empowerment of clients. In this regard, expertise from management sciences complements social science competences acquired during public health training.

The extent to which essential contents of social sciences are integrated into regular public health training varies considerably across Europe, and even within single countries (4). In part, this fact indicates a 'cultural lag' in curriculum development that is still

somewhat biased towards 'old' public health, in part it reflects the heterogeneity of the scientific community itself. In view of their promising contributions towards meeting the challenges of 'new' public health, it is hoped that the social sciences may play a more visible role in future public health training in Europe.

References

1. Siegrist J, Marmot M (Eds.). Social inequalities in health: Scientific evidence and policy implications. Oxford: Oxford University Press, (forthcoming).

2. Berkman L, Kawachi I (Eds.). Social epidemiology. New York: Oxford University Press, 2000.

3. Albrecht GL, Fitzpatrick R, Scrimshaw SC (Eds.). The handbook of social studies in health and medicine. London: Sage, 2000.

4. Detels R, McEwen J, Beaglehole R, Tanaka H (Eds.). Oxford textbook of public health. Oxford: Oxford University Press, 2004.

Health Economics and Public Health – a discipline comes of age

Charles Normand

On a visit to Romania in the mid 1990s I was taken between meetings in an ambulance, which used its siren to clear other traffic out of the way. It was urgent to get the health economist to a meeting! In some respects this experience is a useful metaphor for the way in which health economics has moved from the periphery to the centre in research and practice in public health. It has also moved to the core of public health education.

Scarcity has always been with us, but it is only more recently that the need to apply economics to health and health care has been recognised. The growth of health economics in Europe largely reflects the conditions in the different parts of the region. In the Nordic countries and in the UK, where health systems were mainly government funded, and where public providers of care dominated, the main focus for economic enquiry was how to set priorities, and how to apply economics to the evaluation of treatments and programmes. Cost-Benefit techniques in various forms became part of the service planning and development toolkit, and the use of economic techniques became a requirement for approval of new investments and new service developments. As drugs came to be assessed for cost-effectiveness as well as efficacy the pharmaceutical companies started to employ their own economists to recast the message in economic terms. Elsewhere in Europe a wider set of applications was emerging, with more interest in economic aspects of health systems and financing of health care.

As with any sub-discipline, health economics draws heavily on both the core ideas in economics and from the other health sciences. Much of the focus of health research is

the evaluation of treatments through clinical trials and studies, and economics has been firmly integrated into this process. It is interesting to see ways in which epidemiological thinking has infiltrated health economics. In many ways this is an excellent development, since it has brought greater rigour to the assessments made, but to an extent it has also undermined the way economists think. In general economists are optimisers – they believe in maximising the expected outcomes of any spending. In this sense they follow the principles of civil law – on balance what is the most likely truth. Epidemiologists usually like to be more certain, and follow the criminal law principle of beyond reasonable doubt. This is a useful tension, since it forces both to consider more carefully the advice given and recommendations made. It also demonstrates the importance of public health being an agenda that explicitly embraces multidisciplinary working and encourages mutual respect.

What questions can health economics help to answer in the next 40 years? To an extent there will be more of the same – what should be the priorities, how should services be provided and how should they be paid for. It is likely that there will be much more focus on health care as an 'industry' and the associated analysis of efficiency in its production. There is a growing literature on measuring the performance of hospitals and other health care providers, and this is likely to develop further. The early analysis of health systems was largely based on the likelihood of market failure in health systems, and the expectation that that would limit the use of market mechanisms. The advent of new public management ideas and the associated use of managed markets has opened up opportunities for more complex studies of health care markets and market mechanisms. Many countries now require economic studies in the process of approval of new treatments, and this is likely to extend across the continent.

Perhaps the main change is that health economics is now normal. It is no longer necessary to argue for its place in the curriculum, and the only issue is how much. The key constraint to the development of the discipline in public health schools is the shortage of economists willing to work in a relatively low salary branch of the subject. The dissemination of economic ideas may depend on economists not behaving according to their own predictions.

Management in Public Health:
Management - a vital challenge for PH professionals

Stojgniew J. Sitko

Management - a vital challenge for PH professionals

Management is recognized as one of the major Public Health (PH) professional competency and stressed by the numerous ~~most~~ representatives statements. In the ASPHER PEER review Criteria (2001) under the *Relevant areas of public health (1)* - the general and particular management items are enumerated: *health service organization, structure of public health services, evaluation of programs, provisions of health services and care.* These were re-stated in the Accreditation Standards drafted in the Accreditation Procedure Document (APD) (2) in 2005. EUPHA (2004) (3) in the one of the *10 Statements on the Future of Public Health in Europe*, is declaring that: *At the moment, we are only managing risk factors. In the future, we should also include management of conditions and assets.* The recent WHO Europe discussion paper draft *Developing the Public Health Workforce in the European Region (4)* lists several elements among which there are a number of items referring to management - i.e. to: *empower people about health issues, develop (…) plans that support individual and community health efforts, evaluate effectiveness, accessibility, and quality of personal and population-based health services, research for new insights and innovative solutions to health problems.*

A range of other documents discuss the importance of health management - CDC for example is underlining in 2005 that: *Delivering public health programs and services to those who need them requires not only technical expertise in such areas as medicine, nursing, and laboratory science, but also managerial skills to mobilize resources and deploy them effectively (5)*. In the list entitled: *Essential PH Services* - set by joint effort of APHA, ASPH and PAHO in 1995[30]: *monitoring of health status, empowering people, mobilize community partnerships, developing policies and plans, enforce laws and regulations, evaluate effectiveness, accessibility, and quality, research for new insights and innovative solutions* are named. These are in fact core activities for management. Also a scope of journals is dealing with health management, especially in PH worldwide[31], numerous specific dictionaries and thesauruses are available[32] as well as many dedicated database, information pools and toolboxes for management in this sector[33].

[30] Public Health Functions Steering Committee, American Public Health Association, Association of Schools of Public Health, Association of Health Officers, July 1995.
[31] *For the comprehensive list of such journals see for example: MedBioWord, http://www.medbioworld.com/cgi- bin/*
[32] *For example: Glossary of Health Care and Health Care Management Terms, UWSPH, Health Services Library and Information Center, Washington, http://depts.washington.edu/hsic/resource/glossary.html*
[33] See for example: Performance management in action - tools and resources, Public Health Foundation, PHF, http://www.phf.org/Tools-Resources.htm

Currently, a significant project for establishment of public health *core competency* has been got ready with the participation of 20 Schools of Public Health from all over Europe, EUPHA, all - under the patronage of ASPHER [34]

Management education - MPH

Educational programs in PH include usually at least elements of management if not contains it as a one of the main portions; some of them are even oriented towards management offering e.g. the Master of Public Health (MPH) with the label *in Management* or similar[35]. Limiting the overview to the MPH programs or equivalents and searching the ASPHER SPH web sites - one gets some representation of the European range of modules and/or courses offered in the field of management[36] differently shaped and typically as compulsory, also sometimes also as electives, advanced ones. They are: *Organization, Management and economy of health services, Organization of Medical Care (Health Management), Health Policy and Management, Management in organizations, Health services management, Health Systems Research and Economics, Strategic/Operations/HR management, Grundlagen der Organisations- und Management-wissenschaften, and Management in der Gesundheitsförderung or Management in der Gesundheits-förderung, Health services and management* or simply, just called - *Health management.*

These modules/courses have various credit numbers (from over 20 to a few), lengths, position in the program and are in different SPHs set of different specific components like: *strategic, human resources, quality, conflicts, change, project, logistics and operations, health systems – management(s)* as well as: *theory of organization, organization structure, planning and control, decision analysis* or *making, communication, leadership,* sometimes also including such topics as: *personal development, knowledge management, team work, managed care, hospital management.* Occasionally, also the: *information systems, health technology assessment, law and ethics, financial management, controlling* or even *economics, public relations* or others - are integrated into the management modules.

[34] European Public Health Core Competency (EPHCC) Project application in the framework **of** Programs of community action in the field of Public Health DG Sanco, ASPHER, 5/2006.

[35] *See for example: Faculty of Health Sciences, Maastricht University (NL), http://www.unimaas.nl (MSc. Public Health - Health Policy, Economics and Management); University of Sheffield (UK), http://www.shef.ac.uk/scharr/prospective_pg/masters/hem. (MSc .in Health Economics and Management), Department of Public Health, University of Tartu (ES,) http://biomedicum.ut.ee/arth/english/master_of_health_man/*

[36] ASPHER associates over 70 institutional members - SPHs from all over Europe and beyond, not all of them offer master degrees in PH; overall query through Internet gave out over 91 Mio responses for “Master of Public Health Management”, mostly related to the USA programs.

Quo vadis management in PH?

Some attempts are done to project the most important challenges the health management will face in the years to come. Such predictions influence the composition of educational programs. One these list 10 such major problems till the year 2010[37]:

1) Focus on patient safety 2) Electronic medical records. 3) Cost containment 4) Pay for performance - 5) Information technology. 6). Consolidation of 7) Nurse staffing 8) Healthcare professional. 9). The aging "baby boom" generation. 10) The large uninsured and underinsured population.
(Based upon: Top Ten Trends for the Future, Predictions for the year 2010, Applied Management Systems, Inc., 2006[38])

The educational approach to teach management is changing as well. This is demonstrated by use at the wide scope the *active* approaches to teaching like: *problem, community, project - based learning(s), in-field work, work in smaller groups, case study, role playing, putting considerable more importance to management-oriented practices,* improving links between the experience gained during the practical placements and next educational process, involving at large the professional managers in the teaching and so on. Some educational establishments are integrating management with other subjects into the larger modules – as with *health policy, promotion, law, finances* etc., some of them also shaping even the whole learning MPH paths with the constant managerial inclusions.

For the last years some areas of management in the health sector gained a special interest being now and then also incorporated in MPH management courses. These are such as: *disaster management[39], disease management* (especially driven currently by *SARS, avian flu,* but yet by: *HBV, HCV and HIV)[40], risk management* and others.

Management was, is and will be necessary - when not usually even crucial - for the proper tackling the New Public Health challenges in Europe and globally. Therefore it is important to continuously analyze and develop the methods and ways for effective training of the PH professionals in order that they could successfully face these challenges. ASPHER has here a vital role to perform in the European region - now and in future.

References

1. Bury J, Gliber M. Quality Improvement and Accreditation of training Programs in Public Health. Lyon: Edition Foundation Merieux, 2001. Appendix 1, table, position 6.1.1 Training Programs – Curriculum - Coverage of relevant areas of PH.

[37] This projection have been made for the US, however the majority of trends pointed out there are mostly the same in the developed (and even developing) counties of Europe apart from the item nr 6) Consolidation of insurers - which may look different from country to country.
[38] AMS - http://aboutams.com/default.shtml
[39] See for example: Young Landesman L., Public Health Management of Disasters, The Practice Guide, APHA, 2006.
[40] See for example: Alert, verification and public health management of SARS in the post-outbreak period, WHO, 2006, http://www.who.int/csr/sars/postoutbreak/en/, Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis, CDC Recommendations and Report, June, 2001 / 50(RR11).

2. Accreditation Procedure Document – APD, Standards, Accreditation of Public Health Education Programs, Challenge in Quality Improvement for the SPHs of the European region, EU-EMPH Project, ASPHER, 2005.
3. 10 Statements on the Future of Public Health in Europe, EUPHA report, 2004.
4. Developing the Public Health Workforce in the European Region: Discussion Paper. Copenhagen: WHO Regional Office for Europe, 2005.
5. Annual Report, Sustainable Management Development Program, Office of Capacity Development and Program Coordination, Coordinating Office for Global Health. CDC, 2005.

Health Promotion

John Kenneth Davies

Introduction

Good health is seen as a driver of economic growth and prosperity and key policy reports have emphasised the need for a shift from treating ill-health only to pro-actively promoting good health and tackling health inequalities (HM Treasury 2002 (1); 2004 (2)). Health promotion is a field dedicated to combining education and policy initiatives to provide individuals and communities with knowledge and opportunity to enjoy maximal physical, mental and social functioning. Health promotion is not just about individual lifestyle change; it also incorporates political action to bring about structural change in society. It is the process of enabling people to increase control over the determinants of, and improve, their health. Health promotion is based on a universally accepted series of values – these include social justice, participation, empowerment and equity – the principles of Health for All. Health promotion has expanded rapidly over the last quarter century to provide a distinctive perspective to facilitate the maintenance and improvement of health. It has become either overtly or covertly a major influence on the health policies of most western countries.

The Ottawa Charter for Health Promotion The framework offered by the Ottawa Charter (WHO 1986) (3) is accepted internationally. Its five action areas – create supportive environments, build healthy public policy, reorient health services, strengthen community action and develop personal skills can offer us guidance of where to intervene and how to intervene into the health development process. The EUHPID Health Promotion Model (Bauer, Davies & Pelikan 2006) (4) helps by presenting an analytical depiction of health promotion intervening into the health development process. As well as health promotion actions, there is a pressing need to consider building health promotion capacity and ensure that our actions are based on sound health promotion principles.

The Bangkok Charter for Health Promotion the above principles and actions have been endorsed in the Bangkok Charter for Health Promotion (WHO 2005) (5). A key commitment of the WHO Bangkok Charter is to make the promotion of health a focus of countries and civil society: “Communities and civil society often lead in initiating, shaping and undertaking health promotion. They need to have the rights, resources and opportunities to enable their contributions to be amplified and sustained civil society needs to examine its power in the marketplace by giving preference to the goods, services and shares of companies that exemplify corporate social responsibility health professional associations have a special contribution to make”.

The WHO Charter identifies civil society as a critical stakeholder to the achievement of health: “Health must be placed at the centre of development and the active participation of civil society is crucial in this process”.

This reflects the role of health promotion which embraces not only actions to strengthen the skills and capabilities of individuals, but also comprehensive social and political processes to tackle the determinants of health and alleviate growing inequalities. The field of health promotion is well established in Western Europe, North America and Australia, and at various stages of development in other parts of the world. A fundamental weakness is that the knowledge base for effective practice is produced in just a few countries with well-endowed research infrastructures and traditions of international publishing. This inequity related to culture and language is a barrier to health promotion development.

The Growth of European Influence on Healthy Public Policy The context in which we are working in Europe is rapidly transforming and we find ourselves in a dynamic and ever changing environment. The growing influence of European institutions is of central importance to the maintenance and improvement of health for all citizens throughout Europe. We have witnessed a rapid growth in EU competence in public health over the past ten years. The European Parliament and Council specifically requested that an integrated approach to health promotion be developed based on international best practice, and encouraged this health promotion approach, based on multidisciplinary and inter-sectoral approaches to be developed in the health policies of member states. There is a pressing need to develop and strengthen NGO capacity for health promotion, particularly in central and Eastern Europe and within the new member states. We need consolidate our ways of working to effectively contribute to the improvement of capacity-building in health promotion.

Networking the Networks The advancement of public health in Europe can only be achieved by working in partnership.

This is specifically true in relation to the key Pan-European NGO’s active in the public health field. The International Union for Health Promotion & Education (IUHPE) embarks upon its work to achieve its goals and objectives by implementing a set of strategies (www.iuhpe.org).

The IUHPE has six core strategies:

• Advocacy
• Knowledge development
• Professional & technical development
• Networking
• Partnership building
• Strengthening the organisation's capacity

The specific core strategies of networking and partnership-building can help in effectively achieving the others. One of the current 3 core priorities of the IUHPE European Region is to more effectively build mutually beneficial relations with a range of key organizations, including the Association of Schools of Public Health in the European Region (ASPHER), for example. It is hoped that partnership contracts with ASPHER, as well as WHO/Euro, EUPHA, EPHA and trans-national networks of health promotion practitioners in the European region for example can be prepared prior to the next IUHPE European Conference being held in Budapest in October 2006 (see www.equityinhealth2006.hu). In this way, NGO's, such as IUHPE and ASPHER, have potentially powerful roles in partnership with others at national and local level to reduce health inequalities. But the task ahead of us is vast with currently 19 million unemployed within the EU, with a disproportionate number from underprivileged groups. We need far more investment in health promotion – which is often seen as a short-term cost and not long-term investment. Improving health must become an economic priority.

References

1. Wanless D. Securing our Future Health: taking a Long-Term View. London: HM Treasury Stationary Office, 2002.

2. Wanless D. Securing Good Health for the Whole Population. London: HM Treasury Stationary Office, 2004.

3. WHO. The Ottawa Charter for Health Promotion. Geneva: World Health Organization, 1986.

4. Bauer G, Davies JK, Pelikan J. The EUHPID Health Development Model for the Classification of Public Health Indicators, Health Promotion International Advance Access. Oxford: Oxford University Press, 2006.

5. WHO. The Bangkok Charter for Health Promotion. Geneva: World Health Organization, 2005.

Environmental Health

Søren Kjaergaard

New challenges for environmental health in Europe arise paradoxically from the fact that most of the classical environmental health problems have more or less been solved -

although with some geographical variations. The solutions have often been institutionalized though regulatory institutions and legislation. The automation and isolation of industrial processes, cleansing techniques, water treatment systems etc. have resolved several well-known health- threatening exposures like SO_2, physical strain, heavy noise, polluted drinking water, and waterborne infections etc. Other problems are being exported to developing countries as industries relocate. Similarly, exposures like environmental tobacco smoke, and traffic accidents are finding clarification, as do several of the air pollutants in outdoor and public indoor areas. However, some traditional problems e.g. accidents at home and airborne particles, still require solutions, based on the impact they have on disability adjusted life years.

What are the emerging problems then? Very small particles, new substances e.g. phthalates used as softeners in plastics, hormone like substances, nano-particles, radio-frequent electromagnetic fields, new bio-technologies, and stress-related problems at work. There are many others, but one very important characteristic of these exposures is either a very limited factual impact on health or a very uncertain etiology; these two are often interrelated. They also have the keen attention of the public and the press. This is true also for infectious diseases which also have an increasing social and economic on impact on societies e.g. by trade and travel restrictions. Diseases like SARS and Avian Flue are relevant examples, while the real threats at least among immuno-compromised persons may still be the traditional food- related infections from salmonella etc. HIV and AIDS continue to cause manifest problems also in Europe. Also in addition, the increase of allergic disease is a factual problem, which needs attention. I have purposely refrained from mentioning wars, global warming and other catastrophes, which to a high degree threaten human health. Their consequences and subsequent solutions are however, so extensive, that they warrant exclusive discussion.

The progressive transition of environmentally-related problems must be reflected in the PH-curriculum. I will outline some of the problems that need attention in the following.

PH students must still be knowledgeable of the existing structure of preventive measures as they one day could find themselves either collaborating with or working for the further development of these institutions. There is a general trend within these organizations of neglecting the numerous possibilities that exist for using own databases on exposure, health endpoints etc for the strategic development within their field.

However, the new challenges can all be related to the basic concepts of environmental risk analysis and risk management models. They include risk identification, exposure-response assessment, population-exposure assessment unified in the quantitative risk attribution. The more detailed curriculum must include a basic understanding of environmental exposure assessment models, epidemiology, and toxicology. The training of PH students in this general model may be the challenge of future curricula, as it provides a basis for handling all kinds of exposures. By understanding and training this basic concept using relevant examples, the students

should be able to quantify environmentally- induced health problems of all types. The fundamentals of epidemiology and basic toxicology should be a pre-requisite, although the latter may be a part of the curriculum. The problems of assessing the total exposure via major exposure routes (e.g. lungs, skin, and gastrointestinal system), environments (e.g. indoor, outdoor, workplace, and traffic) and types (e.g. physical strain, electromagnetic fields, chemicals, and psychological stress) are a major issue.

The possible internal interaction of exposures and with human genetics and human health status is a long-standing issue within the scientific community and a practical problem for PH professionals. This is a developing field, which should be included in the PhD-curriculum, as this area will advance in the future.

Risk management has until now mostly been based on the reduction of exposures at emission level etc., e.g. by standard settings, under the assumption that the exposure-response curve is based on a true causal relationship, and that emission or even immission reductions are linearly reflected in personal exposure or dose. The challenge will be to develop a tradition of evaluation of the risk management models, and to further develop experimental thinking -looking not only for output parameters, but also looking at costs and outcome. So this is not only a challenge for education, but also in practise and for research. However, it is important that the problems related with risk management are reflected in the curriculum

As many of the new environmental problems are reflected in public awareness and even as public fears, it is important for ensuing health and environment discussions that PhD students are aware of the policies and politics, which play a major role in many of the upcoming new occupational and environmental problems. Risk communication is therefore an important discipline. Professionals must be able to communicate the risks and their solutions to the press, the public and the politicians. This will include scientifically based teaching in the public understanding of risk expressions, e.g. the term relative risk is misunderstood by most people. Also the psychology involved in the general public's reaction to presented risks. For example how the public risk perception may be influenced by the trade-of people make with the perceived gains from the activity. Disparities in risk perception and the recognition of the individuals at risk (e.g. children and adults) and the degree to which the risk is generated from own behaviour or from others behaviour are a scientific issue and should be included in the PH training.

I do suggest that PH training should cover the general methodology of risk analyses with a strong emphasis on exposure assessment, and risk management with a strong emphasis on risk communication. Risk analyses and management should be taught to the handling level, as they are useful in almost every environmental context and will give the students the necessary tools to cope with new and upcoming environmental health issues.

What are PH students being trained to do? The challenge of declaring competencies

Anders Foldspang

The mission of Public Health training institutions is to develop the Public Health (PH) workforce in terms of skills and numbers, so that it complies with PH challenges as well as expectations and demands from the public and its institutions. Besides scientific PH research outcomes, the productivity of Schools of Public Health (SPH) thus can be measured by the number of candidates they graduate with relevant performance profiles.

SPHs train their students to develop, organise, manage, evaluate, and adjust interventions aiming at the promotion of health, and at the reduction and prevention of present and forecasted population health problems. Furthermore, PH graduates must be able not only to manage the health systems of today but also to develop health systems - as well as other systems intended to have health impact - to be able to meet future challenges in adequate manners, based on up-to-date principles, technology and 0knowledge – and, last but certainly not least, based on scientific evidence.

These ambitions can be expressed in terms of the core competencies needed for the PH graduates to meet the challenges. Moreover, lists of competencies achieved in PH training will constitute the relevant interface for communication between those who train PH students to become PH graduates, and those who employ these graduates – including PH stakeholders at large: international, national, regional and local health policy makers, scientific PH associations, managers of health services, future colleagues – and the European populations themselves. Lists of competencies will make possible more flexible systems for evaluation of individual students, and they add to the perspective of accreditation of SPHs.

The development of lists of core competencies is included in the Bologna Declaration of Ministers of Education, 1999. By now, this important task has been seriously dealt with for a couple of years also by our American sister organisation, Association of Schools of Public Health (ASPH) (1), and communication is well established between the two organisations concerning this crucial theme.

Establishing and continuously upgrading lists of core competencies, and managing the organisation and coordination of an interactive production process thus constitute a crucial challenge and responsibility for ASPHER. After some more isolated contributions over the years, including the development of examples of competencies for the European Master of Public Health (EMPH) (2), a comprehensive, organised effort has been initiated in 2006.

As lists of competencies must reflect the general academic and practical PH culture, the process cannot be of the ‘top-down’ type. On the contrary it should include as many SPHs as possible. Accordingly, more than half of ASPHER members have followed the

invitation to volunteer to participate as continuously active partners in the project, and all members will be repeatedly invited to participate also on a more ad hoc basis.

Coordinated by the Finance Committee of the ASPHER Executive Board, six expert committees are planned to cover each a PH main field:

- Methods (epidemiology and biostatistics; quantitative methods)
- Social environment and health
- Physical, chemical and biological environment and health
- Health policy, organisation, management and economics
- Health promotion and prevention
- Cross-disciplinary competencies

An initial three-year process has been planned:

1. Initial production of lists of intellectual and practical core competencies by the SPH based expert groups.
2. Adjustment of the lists based on integration of PH stakeholders in the work.
3. Adding the perspective of standards, i.e. classifying the core competencies according to training level.

Achievements of each of the three years are planned to be published in the form of ASPHER booklets. Following the initial three-year period, core competencies should be continuously scrutinised by SPHs and PH stakeholders, as mentioned followed by periodical publication of results to demonstrate consequences of changing patterns of challenges as concerns population health and health systems development. Further in the future, the expert committees together with European stakeholders may be developed to constitute (a) more permanent European forum(s) for Public Health capacity development. Another straightaway perspective is the future establishment of one or more European functions or boards for the testing of students' performance in Public Health.

The planning situation is as follows: As of December 2005 and March 2006 the Executive Board has approved proposals concerning the conceptual basis and the principles of the process for the development of lists of competencies (3), (4) and during spring 2006 an application for funding has been developed (5).

References

1. ASPH Education Committee. Master's Degree in Public Health, Core Competency Development Project, Version 2.1. Washington: ASPH, 2006.

2. Foldspang A, Louvet T et al (Eds.). Vademecum, The European Master of Public Health (EMPH). Saint-Maurice: ASPHER, 2005.

3. Development of lists of competencies achieved in Public Health training, ASPHER EB meeting 19 December 2005; annex.

4. Development of lists of competencies achieved in Public Health training, ASPHER EB meeting 17 March 2006; annex.

5. Foldspang A, Louvet T. Application for funding for the project "European Public Health Core Competency Project (EPHCC)". Saint-Maurice: ASPHER, 2006.

PART FOUR: THE CROSS-COUNTRY VARIATION OVER EUROPE: VARIATION IN CHALLENGES – VARIATION IN PROGRAMS

Central Europe

Róza Ádány

The countries of Central Europe (CE) are usually defined as countries of the region lying between the variously and vaguely defined areas of Eastern and Western Europe. The region is generally (although not incontestably) considered to contain Poland, the Czech Republic, Slovakia, Hungary, Romania, Slovenia and Croatia. Both the socio-economical status of these countries and the health of their populations have roots in almost five decades of their common political past in which they were locked into the Soviet block. Today they are new member or candidate states of the enlarging European Union, so the EU community should face the problems generated by the "exposures" in the era of building communism in these countries.

Although the anamnesis is almost the same, these countries strongly differ from each other in disease profile as can be well demonstrated by mortality-based indicators. Although since the mid/late 1990s these countries have experienced significant improvements in life expectancy at birth, even now it varies over a wide range, and the gap between their values and the EU15 average is between 3.5-7.7 years for males and 1.5-7.3 years for females (the gap is relatively narrow in case of Slovenia, but very wide for Romania and Hungary). The gap in infant mortality is slowly, but continuously closing for all of the countries, except Romania, where it was over 18/1000 for males even in 2004 (the EU average is less than 5/1000). The main causes of premature death are non-communicable, mainly cardiovascular and malignant, diseases. The relative risk of early death caused by diseases of the circulatory system is more than 3X in Romania and Hungary, more than 2X in Slovakia and Poland and around 2X in Croatia and the Czech Republic (only Slovenia shows figures similar to the EU15 average). Cancer death rates are 1.2-1.5X higher than the EU15 in the CE countries both for females and males, but for Hungarian men is more than 2.2X. The leading causes of cancer death are lung, breast, oral, and colorectal cancers throughout CE, but in Romania a high number of victims are carried away by the "avoidable" cervical cancer (6.5X higher risk of death). The death rates for suicide and self-inflicted injuries are much higher than the EU15 average in Slovenia and Hungary for both males and females (around 3X and 2X, respectively), but in the other countries of the region it does not differ significantly for females, and only moderately higher (never more than 2X) for males. Deaths caused by chronic liver diseases are more frequent in all countries of the region (except Polish females) than in the EU15 member-states, in Hungary the relative risk is as high as 6X for males and almost 5X for females (1).

On the basis of the characteristics of the health (it is better to say mortality) profile the problems resulting in epidemiological crisis in the region can be identified:

Unfavourable health behaviour

The diseases that account for the excess mortality in the Central European region are strongly related to unfavourable health behaviour. In general, alcohol- and smoking related diseases cause 2-3X more early deaths than in the EU15 countries. In addition to the high quantity, the quality of beverages consumed strongly contributes to the high level of mortality from chronic liver diseases. Illegally produced home-made spirits were found to contain hepatotoxic short-chain aliphatic alcohols, the concentrations of methanol, isobutanol, 1-propanol, 1-butanol, 2-butanol and isoamyl alcohol were significantly higher in home-made spirits than those from commercial sources in Hungary. The results suggest that the consumption of spirits from illegal sources is an additional risk factor for the development of alcohol-induced cirrhosis and may have contributed to high levels of liver cirrhosis mortality in Central Europe. Restrictions on supply and sale of alcohol from illicit sources are needed urgently to reduce significantly the mortality from chronic liver disease (2).

Missing monitoring programs

Monitoring the health of the population and the factors influencing it is essential to identify general and local health problems, make decisions to promote public health, evaluate the effectiveness of health promoting programs and to distribute information to decision-makers, public health professionals, actors and individual citizens alike. In the CE countries health monitoring exists in different forms, but the health observatory systems organized at regional level are almost completely missing. The only regional public health observatory, which operates for the North-East Hungarian Region was launched in 2005.

Missing or poorly organized screening programs

In the CE countries screening programs for breast and cervical cancers operate on an opportunistic basis, in general. In Slovenia preventive clinical check-ups for early cancer detection are supposed to be a duty of general practitioners (and gynaecologists), but are not monitored on a regular basis. The only country in the region that has an invitational cervical screening program with a national registration system is Hungary, but the participation rate is very unfavourable (3). This is the reason why in addition to Romania, Hungary and Poland are also among the European countries with very high rates of cervical cancer death. In Hungary, although a population-based invitational screening program was launched in 2003, the rate of participation is less than 10%. Mammography screening is also invitational in Hungary, and the participation rate is more favourable (around 50%). Organized invitational breast cancer screening is missing in the region, in general (4). A “Female Cancer Control Program in Poland” was implemented between 1996-1998, and was followed by a “Mammography machine supply project” till 2000 with significant improving effect on performance (5). In 2005 the European Parliamentary

Group on Breast Cancer discussed how to use EU Structural Funds for mammography screening programmes, which would result in definitive improvement on breast cancer screening in the whole region.

Population-based screening programs to identify hypertension and diabetes are also missing, and no significant change can be expected without changing the paradigm in financing health care services in these countries (capitation based financing of basic health care services does not motivate general practitioners to perform and/or support primary and secondary preventive interventions).

Missing health promotion and education programs for the most vulnerable population

The Roma number between 5 and 10 million people and are the largest minority group of the enlarging EU. The majority of the Roma population lives in CE, in the new member and candidate states, in particular in Hungary, Slovakia and Romania. In 2003-2004 we performed comparative health interview surveys on representative samples of the Hungarian population and inhabitants of Roma settlements in the North-East regions of the country and the proportion of heavy smokers was found to be 2.1-4.9 times higher in Roma settlements than in the general population. The prevalence of severe functional limitation was about twofold higher in the 18-44 years age group of the Roma communities. Roma persons were less likely to use health services than was the general population and of those who used any health services, 35% of Roma persons (in comparison with 4.4% of the general population) experienced some kind of discrimination. In the general population the proportion of persons who thought that they could do very much or much for their own health was 1.3-1.5 times higher than in Roma settlements (6). The Decade of Roma Inclusion is an initiative adopted by eight countries in Central and Southeast Europe, and “represents the first cooperative effort to change the lives of Roma in Europe. An action framework for governments, the Decade, which runs from 2005-2015, will monitor progress in accelerating social inclusion and improving the economic and social status of Roma across the region” (7).

References

1. WHO HFA. January 2006.

2. Szucs S, Sarvary A, McKee M, Adany R. Could the high level of cirrhosis in central and eastern Europe be due partly to the quality of alcohol consumed? An exploratory investigation. Addiction 2005; 100: 536-42.

3. Anttila A, Ronco G, Clifford G, Bray F, Hakama M, Arbyn M, Weiderpass E. Cervical cancer screening programmes and policies in 18 European countries. Br J Cancer 2004; 91: 935-41.

4. Botha JL, Bray F, Sankila R, Parkin DM. Breast cancer incidence and mortality trends in 16 European countries. Int J Cancer 2003; 39: 1718-29.

5. www.bpz.gov.pl/old/file/oncology.final.report.pdf.

6. Kosa Z, Szeles G, Kardos L, Kosa K, Nemeth R, Orszagh S, Fesus G, McKee M, Adany R, Voko Z. Health of the inhabitants of Roma settlements in Hungary – a comparative health survey. Am J Pub Health, in press.

7. www.soros.org/initiatives/roma/focus_areas/decade.

The AUA Public Health Program: Challenges for a New Model in Eastern Europe

Haroutune K. Armenian &. Michael E. Thompson

Public Health in Post Soviet Eastern Europe

The 1990s opened with a massive wave of economic transformation sweeping across Eastern Europe. The collapsing communist systems of government were replaced with nascent market economies over night. Armenia, like many of its peers, saw its health care system, dependent like all other economic sectors on the now nonexistent central government, run bankrupt and disintegrate.

With the collapse of the primary care system, these newly independent states soon experienced a demographic regression: infectious diseases reemerged just as chronic diseases were coming to the fore. This decline was hastened by out dated systems for the financing of services and the distribution of services and health manpower plans which emphasized highly medicalized health services while relegating public health systems to sanitation and communicable disease control. The public health workforce was ill-prepared for the realities it now faced and was usually excluded from discussions of health care reform.

After more than a decade of concerted humanitarian and development assistance from various international agencies, many of these problems persist. Priority issues include:

1. These countries have adopted Western-style market economies without fully embracing its principles and without applying these same principles to the health care economy.
2. Health services have lagged far behind Western standards of quality and remain a specialist driven highly inefficient system.
3. Lacking political will and resources, health services, especially primary care services, are woefully under funded and under utilized
4. Many health professionals are under employed and lack current training; likewise health facilities are under utilized and are quickly becoming antiquated.
5. Health care financing and delivery systems are not grounded upon these new economic and political realities: they are not sustainable in their present form.

6. Lack of a dependable epidemiologic and health services information base for monitoring, evaluation, and decision making – the so-called nervous system of public health - and lack of expertise in using such information among decision-makers constrains reform.

The Development of a Model Public Health Program

The idea of a Western style international graduate level university was developed at the aftermath of the 1988 earthquake in Northern Armenia. The American University of Armenia (AUA) opened in September 1991 with 3 masters' degrees in business and engineering. The University was the result of a partnership between the Armenian Government, the University of California system, and the Armenian General Benevolent Union. Since its founding, the AUA has been a participant in the development of Armenia through its educational programs and its centers for research and development. In its first 15 years it has graduated 1400 young men and women with masters' degrees and implemented a large number of research and development projects.

Resisting donor pressure to open a medical school in a country with thousands of excess providers, the AUA planned a health manpower development program in an effort to reinvigorate the health care system. Planning began in 1993 and in 1995 the College of Health Sciences was established. The core of this program was a Master of Public Health degree that was implemented in partnership with the Johns Hopkins University School of Public Health via a formal affiliation agreement. Over the last decade, this program has produced over 100 MPH graduates who are meeting the health planning and programming needs of Armenia and the region through government, NGO, and IGO service. Several features made this partnership unique and contributed greatly to its quality, its success, and its sustainability:

1. A competency based curriculum and teaching. In addition to a list of competencies that governs the core curriculum, students are encouraged to develop their own educational competency objectives based on their personal professional goals to guide self-directed learning.
2. The use of organizing paradigms. The program is organized around a professional practice "problem solving" paradigm which include problem investigation and project development. These paradigms provide students a conceptual roadmap to their education instilled through tested approaches and methods for professional practice.
3. Teaching in a block course format. Following a logical sequencing based on the organizing paradigms, students work through one course at a time over a three-four week period. The block scheduling requires continuous integration across courses but allows for involvement of more senior faculty visiting from abroad. During the last year of the program students work on a self-directed integrating experience (thesis or project).
4. Engagement of students in the practical learning. The Center for Health Services Research and Development involves students and recent graduates in the constant flow of

(paid) research and development projects. Responsibilities increase as students progress advancing from simple data entry and surveying to project management and proposal development. More than half of the students engage in at least one project while a student.

The College has worked with the Ministry of Health and others to implement a training program (in Russian and Armenian languages) in health care management, ethical conduct of research, and malaria control. Through these synergistic efforts, the College has developed into a major resource for health professions training and for health programming in Armenia and its region

Future Perspective

As we project toward the future of health services in Armenia and the region it is imperative that:

1. Monitoring and surveillance systems are established to support evidence-based practice and policy decisions
2. A trained, competent workforce emerges to assume leadership positions
3. Solutions are found at the local level: a more entrepreneurial approach to system development is needed
4. A culture of quality and accountability is fostered at all levels.
5. The shadow, or the under the table, health care economy is eliminated
6. Networks are built which foster cooperation, support, and information exchange across borders and across disciplines.

These challenges are common throughout Eastern Europe. Engagement within the larger European family of nations will definitely impact how these issues are addressed. The development of effective education programs for public health professionals is the most critical ingredient to fuel this evolution in the health services of Eastern Europe.

References

Agbabian MS. American University of Armenia: A New Beginning for a New Generation. Oakland, California: American University of Armenia Corporation, 2002.

Public health training in Northern Europe; present trends and future challenges

Gudjon Magnusson

ASPHER has truly made an impact on creating a highly competent and modern public health workforce in Europe in its 40 years of existence. My first contacts with ASPHER

were 10 years ago when I took on the challenge as Dean of the Nordic School of Public Health in Gothenburg.

Ever since I have been impressed by the capacity of ASPHER to push for high quality education and research, give valuable support to members e.g. through Peer-Reviews, thematic discussions at General Assemblies and most recently through the creation of an accreditation mechanism to further secure the quality of the work of the member schools and institutions. In addition, ASPHER has in recent years done a lot to foster public health schools and institutions in the central and eastern parts of Europe but that is not within the scope of my short presentation here.

I have been asked to look more closely at the situation in Northern Europe. Let me first say that here we find a variety of educational settings in public health; both undergraduate and postgraduate degrees, full time or part time, modular design or comprehensive, distant learning or in depth studies, programmes with field training or without. Distant learning is on the increase, so much so that the school of Public Health with the highest number of students for postgraduate studies in Northern Europe now has more students in distant learning than attending classes at the school!

We find schools that are independent, those that are a part of medical faculties, and those who are part of a health science faculty .We even find a joint MPH programme for a number of universities that are situated in three different cities and we find a few schools that are a part of a Ministry of Health. No wonder the question regularly pops up: is there a right way of doing public health training?

Basically I believe there will never be a unified way of doing public health training. The national or at least the sub-regional characteristics will prevail and set their marks on how the training is organised as well as on the structure and contents of the curricula. History also plays a role as well as the structure and organisation of health services, societal settings etc.

There are, however, several trends that are common. One is that public health is now broader than before, both in terms of the topics covered, the instruments used and the methodologies.

Being a multidisciplinary topic, not owned by any one discipline, it will continue to have different expressions in different settings, some times with more focus on management, some times with more focus on health promotion and prevention etc.
For instance, the re-emergence of certain infectious diseases and new public health threats has had an influence on public health training. Increasingly we also see qualitative and quantitative research methods being regarded as equally important for public health work and therefore in public health training.

However, the crucial question is: Which are the skills that we should look for in the graduates from schools of Public Health?

Based on my experience, I would list five as crucial:
The ability to:

* Use skilfully the basic methodological tools of public health including epidemiology and qualitative methods
* Make an intelligent analysis of alternative options in addressing a public health issues
* Understand health systems and management of health services and be able to apply that knowledge
* Work with and implement health policies and address the issues of inequalities and social determinants in health
* Work with health promotion and prevention both at the population level and with high risk groups but with emphasis on an upstream approach.

Collectively these skills should equip the graduate to become better at seeing the "big picture" in public health and to work in an analytical manner.

The public health challenges of today are different from those of the past, and the challenges in the future will also differ. This calls for life long learning and an adaptation to new challenges through an update of skills and knowledge. The schools of public health have a very important role to play by contributing to maintaining the technical competence of the public health workforce.

My wish to ASPHER on its 40th birthday would be that in addition to continuing to improve the quality of the public health education in Europe, ASPHER will also take initiatives to promote continuous education in public health.

Southern Europe

Pina Frazzica

The last Forty years have witnessed major changes in Public Health in Europe, in Southern Nations in particular. Improved hygiene and nutrition, improved access to preventive and curative services and to education, a general increase in economic standards which have resulted in a decline in child mortality, an increase in life expectancy and a better overall quality of life for the population.

Though not precisely defined, Southern Europe includes a vast territory, from the Iberian Peninsula to the Balkan Peninsula, to Malta and Cyprus. Most of these Countries share the Mediterranean Sea and have diversified origins, cultures, and levels of development. They derive from a "metissage" of cultures from the various ancient civilizations that have colonized their lands leaving them with rich cultural endowments but also with fragmented and diversified socio-economic conditions. Among these ancient populations, were the Carthaginians, Persians, Greeks, Romans, Visigoths, Arabs and

Normans, to name a few. Just these elements show the strength and the complexity of the historical heritage of Southern Europe.

In modern times, political and social uncertainties have often resulted in destabilizing situations and open conflict in some Nations. These, coupled by inappropriate investments in critical areas such as education, health and development have, in a diversified manner, affected the health and the lives of these populations. In the process, while some Countries have passed from farming to industrial societies, others have lingered in the level of their progress and development. For all these reasons, there are Countries in Southern Europe where a reasonable number of people continues to emigrate, with potential brain drain and consequent further societal depauperization, others have now become lands of immigration, for which they are largely unprepared.

The issue of population movements poses diversified challenges to the Public Health Sector in Southern Europe, in epidemiological and in professional terms. The free movement of persons, services and professionals in Europe poses some exciting questions and yet some destabilising dilemmas. Global movements of populations, through legal or illegal immigration and massive tourism, still present unsolved ethical, economic and public health questions of growing importance. The recrudescence of old communicable diseases and the appearance of new ones, often associated with population movements, can have a devastating impact on the population due to the rapid, global and sensational effects caused by the media.

Training in cross-cultural health, on the disease and behavioural aspects of the phenomenon will increasingly have to be addressed. Likewise, the recognition and the upgrading of levels of education for Public Health practitioners will be necessary in the event of movements on the part of professionals.

Meanwhile, autochthonous populations, more conscious of their rights, will continue to request more, better and safer care in order to attain their desired quality of life. Progressively, they will require that services be based on scientific evidence and, sometimes, they themselves will provide the evidence. Training health personnel in the critical aspects of care quality on one hand and education of the population on the other will pose interesting scenarios for innovative education.

Generally, Health Systems will be confronted with old problems and with new and constantly emerging needs. The ageing of the population, with the heavy load of chronic and degenerating diseases, cancer and other costly health problems, such as the effects of tobacco and alcohol, will require ongoing monitoring and adjustments, both programmatic and educational. Unfortunately, issues related to drug abuse but also emergencies due to natural disasters or those caused by men will also have to be present in the Public Health agendas over the next few years.

Highly skilled personnel, advanced, effective and efficient health and information technologies, and conspicuous financial resources, also for research, will be required to meet the needs and the demands. Personnel must be capable, not only to deal effectively

with clinical cases but, also, to manage human, financial, technological and material resources. Meanwhile, technologies keep on evolving, driven on by research and by the market, while health institutions often lack the evaluation experience that is necessary to effectively manage the offer of and the demand for new technologies. At the same time, an increased need for funds faces diminishing financial availability due to rampant economic conjunctures, hence the need to rationalize scarce resources.

Up to now the “health universe” is a very fragmented space, with each institution working in isolation, sometimes in competition with one another, and certainly, growing more and more distant from the real problems of the community they serve. This results in un-coordinated, ineffective and inefficient services with high economic, but also social, costs to the system and to the population. The latter certainly bears the heaviest burden. This must change in the future, if not only for costing purposes.

Fortunately, politicians are gradually starting to appreciate that health is not a “medical product” and that most health determinants originate in other spheres of life, a good portion of these deriving from socio-economic areas. Therefore, most politicians’ and administrators’ decisions can affect the health of populations, even though these deal with employment, industry, the environment, transport, land tenure, city plans and immigration, among them. Therefore, the need for scientific evidence is becoming more manifest for scientific evidence, also in the political and administrative decision-making process.

These are some of the signs, or results, of macro and micro changes affecting Public Health in Southern Europe. To add to the complexity, there is an urgent necessity for peace, democracy, stability and respect of human rights in this part of Europe, which have a significant impact on Public Health as well.

Schools of Public Health in Southern Europe will have to face the dilemmas posed by old and new paradigms in a dynamic, effective and responsible manner. Established Schools will have to courageously evaluate methods, programs and technologies and determine whether to continue the conventional trends or to re-engineer the system investing in quality and innovation, not only technological but also of contents and methods. The more traditional curricula of Master Courses in Public Health fields may be revised and strengthened by applied research and the Schools activities may include strong programs in Continuing Medical Education. They may also benefit by providing institutional support to policy makers, to health organizations, to the mass media and to the population in terms of assessment and training. New Schools could benefit from the experience of others but could be more daring and become effective actors of change in their communities.

Old and new Schools should meet old and new challenges assuming an enthusiastic and proactive role in foreseeing and in creating changes for better policy, for excellent training and for a higher quality of life for our populations. Finally, a word must be said about the information technology and its use in distance training. Schools of Southern

Europe should strongly consider this mode of education alone or in network with each other, as more professionals will look for cost-effective training closer to home.

The quest for quality in education remains high in the agenda of Schools of Public Health in Southern Europe in order to guarantee the best possible answer in terms of equity, appropriateness, effectiveness, efficiency and ethics to policy makers, administrators, professionals and, mainly to our population.

Public Health Education in Western Europe: Backward Integration and Diversification

André Meijer & Tom Kuiper

Public Health Labour Market and Education

In Western Europe, three dominant trends are apparent in respect of the relationship between the health sector labour market and education in (public) health. The first trend is the diversification of professional structures within health care organisations and institutes. Other disciplines and professionals than those who are traditionally associated with this labour force are entering the health care labour market itself: for example professionals with a health ethics background, health economists, health and medical sociologists, health lawyers, non-medical managers, etc, to accommodate medical and peri-medical educated professionals for non-medical functions in the broader health care sector also.

The second trend is the increased academic content of knowledge used by (public) health professions and disciplines: education replaces training. Societal and European developments, like a focus of genetics, on ageing and on the introduction of free market elements within the health system, are to be responded by new entering graduates.

Finally, the third trend is the internationalisation and individualisation of professions and professional fields within the public health sector, especially in those organisations which focus upon the force field of public health as perceived from an interregional, national and international perspective. The EU principle of free movement of persons, goods, services and capital pave the road for the ongoing internationalisation of professions and functions.

The above-mentioned trends are associated with an increase in the demand for public health capacity within Europe. An increased demand for public health specialists (both at a Bachelor level and Master level) is not only apparent in national and European institutions, but also in the non-governmental organisations active in the field of public health at both national and European levels.

Shifts in the domain of Public Health

In Western Europe we see that PH programmes nowadays most often embrace the concept of New Public Health (with an expansion of the Health Sciences). This broad perspective of New Public Health is defined as the: "(…) *very wide scope of organised activities, concerned not only with the provision of all types of health services, preventive and therapeutic, but also with the many other components relevant to the operation of a national health system. These involve questions on health behaviour and the environment as well as the production of resources (personnel and facilities), the organisation of programmes, the development of economic support, and the many strategies required to ensure equity and quality in the distribution of health services.*" (1) New public health therefore no longer only includes the traditional disciplines of epidemiology, social medicine, microbiology, human biology, socio-medical hygiene and prevention, and is not focussed only on public groups *at risk*. The modern vision includes as its most important areas for attention environmental hygiene, ecology, health promotion, mental and social health hygiene, social sciences such as sociology, economics, psychology, political science and organisation and administrative studies, as well as research and theory in the field of care and health care systems.

The concept of Health Sciences is also relatively new. The concept of Health Sciences is superseding the concept of 'old' public health, integrates and incorporates the sphere of new public health in a comprehensive and unambiguous (scientific) approach. Hurrelmann and Laaser (2) are providing schemes by which the relationship between old and new public health and the health sciences are made visible. In their visualization the health sciences embrace both the concepts and subsequent disciplinary input of old and new public health. Old Public Health is portrayed as *öffentliche Hygienepolitik*, New Public Health as *öffentliche Gesundheitspolitik*, and ultimately Health Sciences is depicted as *angewandte Gesundheitsforschung und Gesundheitssystemforschung*.

Changes in Education in Public Health in Western Europe

Similar but prior[41] to developments in the USA we observe in Europe a flowering of undergraduate public health education on bachelor level. A trend that supports this blossoming of undergraduate programmes is the changing relationship between the health sector labour market and education: firstly, the diversification of the professional structure, expressed for example in considerable growth in the number of courses and the diversity in graduation options[42]; secondly, the increased academic content of professions and disciplines; and finally, the internationalisation and individualisation of professions and professional fields within the public health sector. Generally speaking, one could observe

[41] The Faculty of Health Sciences at Maastricht University was founded in 1980.
[42] RGO (February 2003). Recommendation on Knowledge Infrastructure Public Health: Knowledge acquisition and knowledge application. Publication #39, The Hague.

within Western Europe a process of backward integration of graduate programmes towards undergraduate levels.

We are able to witness this process in at least Austria, Denmark, Germany and the Netherlands[43], but also other countries have developed educational programmes in two cycles. On the other hand we are observing a strong differentiation and diversification of master studies in PH along with the broadening of the concept of 'old' Public Health through New Public Health to the Health Sciences. Good examples of both trends are provided by the University of Copenhagen and the Faculty of Health Sciences at Maastricht University (see overview). After 25 years this last faculty counts a broad range of related bachelor and master studies, organized in a matrix structure of various disciplines

Country (university, institute)	**First Cycle Programme (s): Bachelor**	**Second Cycle Programme (s): Masters**
Denmark University of Copenhagen Institute of Public Health	B.Sc. Public Health Sciences	Public Health Sciences Public Health International Health
Netherlands Maastricht University Faculty Health Sciences	B.Sc. General Health Sciences B.Sc. European Public Health B.Sc. Molecular Life Sciences	Master Public Health; M.Sc. Public Health; specialisations: • Epidemiology • Health Education & Promotion • Health Policy, Economics & Management • Work & Health • Health Care Studies M.Sc. Mental Health Sciences M.Sc. Physical Activity and Health M.Sc. European Public Health (foreseen) M.Sc. Molecular life sciences M.Phil. Health Sciences Research M.Phil. Food and metabolism

[43] In Austria one example is UMIT, they launched as of 05/06 a Bachelor programme in "Betriebswirtschaft im Gesundheitswesen". In Germany, new Bachelor programmes are launched in health care management, "Pflege und Gesundheit", "Angewandete Gesundheitswissenschaften", whilst the University of Bielefeld started with their new Bachelor programme in Health Communication in 2002. In the Netherlands new Bachelor programmes in public health studies and general health sciences are launched in 2004 by the Twente University and the Free University of Amsterdam and in 2005 by the Wageningen University; As of September 2006 Maastricht University will offer a new Bachelor programme in European Public Health, fully focused on cross border PH problems plus European developments in Public Health.

Conclusion

Within the last decades the education and training in Public Health in Western Europe we witnessed a powerful process of backward integration towards the establishment of bachelor programmes and simultaneously we observed a diversification in master programmes.

This increase, in both the number and the range, of educational programmes in PH is not only stemming from the ongoing developments towards a European Higher Education Area, but the increase is also triggered by trends on the labour market, a labour market responding to changes in the health sector structure.

Furthermore, the flourishing of educational programmes in PH is answering to new ideas and paradigms with respect to the content of public health.

In the near future, these processes will foster the need to redefine the core content of Public Health education within the broader domain of Health Sciences, both at bachelor level as well as on master level. Because when you overload the concept, the message is lost!

References

1. Tulchinsky TH, Varavikova EA. The New Public Health: an introduction for the 21st century. San Diego: Academic Press, 2000.

2. Hurrelmann K, Laaser U. Handbuch Gesudheitswissenschaften. 3. Auflage. Weinheim und München: Juventa Verlag, 2003.

PART FIVE: PUBLIC HEALTH WORKFORCE CAPACITY BUILDING IN EUROPE – AND IN THE WORLD: MEETING FUTURE CHALLENGES

PH capacity building and WHO Headquarters

Alena Petrakova

Key role of human resources for health in the 21st century

Human resources for health (HRH) are increasingly recognized as a crucial element in improving health systems and health services, and attaining the Millennium Development Goals (MDGs). Insufficiencies in the health workforce are becoming a major constraint to achieving the MDGs in many developing countries. Furthermore, it is widely recognized that traditional methods of educational delivery are inadequate to produce the health workforce needed in these countries.

Strategies to improve the performance of the health workforce must initially focus on existing staff because of the time lag in training new health workers. Substantial improvements in the availability, competence, responsiveness and productivity of the workforce can be rapidly achieved through an array of low-cost and practical instruments. A strong human infrastructure is fundamental to closing today's gap between health promise and health reality and anticipating the health challenges of the 21St century (1).

The World Health Report 2006 (WHR 2006) includes chapters and recommendations addressing pre-service training of the health workforce and in-service management and training. It confirms that research and policy debates on educating the health workforce focuses on medical and nursing schools, with much less research and debate on public health schools.

The Fifty-ninth World Health Assembly (WHA59) recognized the centrality of human resources for health for the effective operation of country health systems and adopted on 27 May 2006 the resolution WHA59.23 on "Rapid scaling up of health workforce production". It's very important for public health capacity building that public health workers and community health workers are explicitly mentioned in this resolution.[44]

Public Health Knowledge Sharing and Capacity Building

The time is challenging for global public health with the HIV/AIDS pandemic, avian flu, SARS, and other emerging health-related situations. The future of public health lies in the effective translation of research, dissemination and scaling-up of successful experiences, as well as better problem-solving and an improved ability to manage change within complex systems.

The traditional public health paradigm has become less effective, knowledge is not effectively translated into policy and action, and the know-do gap is increasing. In most countries, the public health workforce has a relatively low level of professional recognition when compared to well established professions in and outside the health sector. Professional public health associations at global, regional and local levels look for new

[44] Rapid scaling up of health workforce production: Resolution WHA59.23, 59th World Health Assembly, 2006

ways to strengthen public health role and workforce through inter-regional collaboration on a global scale.

Knowledge management (KM) approaches and practices may play a crucial role by supporting a shift in the way public health professionals act as well as how public health systems perform their functions and deliver their services. KM offers useful principles and tools for public health to better share knowledge and bridge the chronic know-do gap by working towards greater health equity.

The Informal Consultation on the Global Network and Database of Public Health Partners, organized on 7-8 December 2005 by the Knowledge Management and Sharing department (KMS/EIP) at the WHO Headquarters in Geneva, proposed a strategy to create a global network, led by WHO global KM team, working in partnership with public health associations, schools and institutes worldwide. The World Federation of Public Health Associations (WFPHA) and its members are key partners.[45]

Incorporating learning, knowledge sharing and knowledge translation into the work environment of public health schools, institutes and other public health organizations is a seed for change. It means changing our ways of working.

Creating and developing a global knowledge sharing network for public health through close partnership with the professional public health associations, schools, institutes, and others working in the field of public will assist in bridging know-do gap in public health by:

- Leveraging the experiential public health knowledge,
- Leveraging the use of Information and Communication Technologies (ICTs) for public health workforce capacity building, and
- Translating knowledge into the policy making and public health practice.

Moving ahead in the next decade

Public health will benefit greatly from better use of KM approaches. Getting the right knowledge to the right people, such as policy makers, health system managers, public health specialists, public health practitioners and to the general public as well, and doing so at the right time and in the right place, will lead to a strengthening of health systems and significant improvement in health outcomes.

Our vision is that by the year 2010, KM approaches will become an integral part of a core public health curricula and by the year 2015 an integral part of daily public health practice. Public health professionals will take full advantage of their accumulated knowledge, using both explicit and tacit, and ensure that public health interventions are strategically and effectively delivered. Global public health will become a learning community significantly impacting and enhancing health outcomes.

[45]Informal Consultation on Global Network and Database of Public Health, Report, WHO/KMS, 2006: http://www.who.int/kms/initiatives/km4ph/en/index.html

References
1. WHO. The World Health Report 2006: Working together for health. Geneva: World Health Organization, 2006.
2. Bury J, Gliber M. Quality Improvement and Accreditation of training Programs in Public Health.
Lyon: Edition Foundation Merieux, 2001.

Public Health Capacity Building and EU Public Health Policy Development

Clare Siddall & Bernard Merkel

The EU has a long history of action on health. Over the years, and often in response to emerging challenges, the most recent example being avian flu, work on public health at the Community level has grown and developed. The EU has made important progress in areas as diverse as tobacco control, pharmaceuticals, the safety of blood, tissues and cells, patient mobility and cooperation between health systems. In recent years, there has been a move from an approach targeting specific issues to a more strategic approach. Importantly, throughout the process, EU public health policymaking has been supported by experts, whether working within the European institutions of Commission, Council and Parliament, within the national administrations of the 25 Member States in their cooperation at EU level, in non-governmental organisations, or as independent academic advisors. Public health expertise is a necessary cornerstone of effective policymaking in the field of health, and has been present through the history of public health policy development at the European level.

In 1993 the Commission presented its first Public Health Framework, an initial strategy document setting out work to be done on public health at the European level. Eight action programmes were agreed, on health promotion, cancer, drug dependence, AIDS and other communicable diseases, health monitoring, rare diseases, accidents and injuries, and pollution-related diseases. In 1999 the Amsterdam Treaty was signed, which cemented the importance of action in the field of health, particularly in response to the BSE crisis. It emphasised the need for all policy areas to take account of the importance of health, rather than limiting it to the actions of the relatively small part of the European Community which has health as its main focus. Work to mainstream health policy into policy areas as wide as environment, employment, education, research, transport, markets and competitiveness was complemented by the development of a model for Health Impact Assessment (HIA). Now, in 2006, HIA is a formal part of the Commission's wider Impact Assessment procedures which are required for all major new proposals, and further work is taking place to develop a tool for assessing impacts of other policies on health systems.

In 2000, a broad health strategy was adopted[46], and in 2002, the European Parliament and the Council adopted a Community action programme for public health from 2003 – 2008[47], which is still ongoing. The programme is based on three general strands of action: health information, rapid reaction to health threats and health promotion through addressing health determinants. Then, in 2004, the Commission launched a reflection process and an open consultation, called 'Enabling Good Health for All'[48] to prepare the ground for a future EU health strategy which would build upon the 2000 strategy and provide a framework for a more comprehensive approach which could respond to emerging health concerns in a larger EU. It focused on four themes, firstly, health promotion and prevention. The process identified a need for a more pro-active approach to prevent diseases by promoting healthy life styles, health as a shared responsibility and the need to empower citizens to make healthy choices. The second theme was health generates wealth, which identified the need to bridge the health gap by investing in health, and reinforced the fact that health as a long term investment leads to economic growth, drives productivity and impacts on business competitiveness. Thirdly, as described above, the importance of mainstreaming health across policy areas was a key theme. The final theme was partnerships for health, which emphasized the need to involve stakeholders in policy-making, to steer co-operation between the Member States, to strengthen co-operation with international organizations and to foster partnerships to achieve synergies.

The reflection process generated a major debate across the EU and beyond, with roughly 200 contributions from national and regional authorities, NGOs, universities, individual citizens and companies, and including many experts in the field of public health. Contributions expressed widespread support both for the consultation process itself and for the ideas presented. In 2005, the Commission adopted a proposal for a new programme for 2007-13 which reflects ideas generated in this consultation process. This programme, which is currently passing through the European institutions for agreement and modifications, forms part of a new strategic approach which the Commission expects to present in 2007.

What lessons have we learned, and what will the new strategy look like? Based on what we have learned from the reflection process and from the work done on public health at the European level over the last years, the strategy will look ahead to future challenges. Threats to public health will remain an important element of work at European level, and the challenge of demographic change is becoming increasingly important, because supporting European citizens to enjoy a healthy and active old age will be a key factor in the continued prosperity of Europe. A better understanding of health systems will be needed, along with a recognition that investing money and time in making these complex

[46] Com (2000) 285 final
[47] Decision No 1786/2002/EC
[48] http://ec.europa.eu/comm/health/ph_overview/Documents/byrne_reflection_en.pdf

structures more efficient can have a vital impact on health. Mainstreaming health into other policy areas will remain as important as ever.

The EU has achieved a great deal in public health terms over the last decades, from ensuring the quality of blood products to ending tobacco advertising to sharing best practice in health across the culturally, economically and politically diverse countries of Europe. It continues to face great challenges in the field of public health, and in doing so it must continue to be supported by good evidence and understanding. Developing health policy must be supported by reliable expertise, whether at EU, national, regional or local level. But policy development must also go hand in hand with practical measures of implementation. The best plans are of little use if they never get beyond ideas on paper. The work done by Aspher, in training people to be experts in the field of public health is therefore vitally important, not just to provide invaluable support to EU and national public health policy development in the future, but also to ensure that it is translated into concrete actions which will help to improve the health of the population.

PH capacity building: a view from the Asia-Pacific Region (APACPH)

Brian Oldenburg

The WHO in its *Report of the Commission on Macroeconomics and Health* (2001), stated: *Improving the health and longevity of the poor is an end in itself, a fundamental goal of economic development. But it is also a means to achieving the other development goals relating to poverty reduction.*

Nowhere in the world is the pace and influence of rapid socioeconomic change greater than in the countries of the Asia Pacific Region, which is also the most populous region of the world. The impact of this change is also greatest on those individuals and communities who are already the most disadvantaged, as the socioeconomic health inequalities increase further as a result of widening income inequalities and globalisation, more generally. The countries of this region must also deal with the large and growing burden resulting from communicable diseases and injuries (WHO, 2005). Indeed, it is estimated by WHO that by 2020 approximately 80% of all deaths from non-communicable diseases worldwide will occur in developing or newly industrialized countries, and more than one half of all these deaths will occur in countries in Asia and the Pacific (Zhu, Zhen & Oldenburg, 2001). The growing epidemic of chronic disease is against a backdrop of many countries in the region still dealing with persistent health challenges associated with infectious diseases and nutritional disorders that cause unacceptably high rates of childhood mortality and morbidity. This region is now also having to contend with a growing number of emerging infectious diseases, as well as a range of other public health

emergencies and disasters that have afflicted the region in recent years. Finally, rapidly changing ecosystems and environments are not only exacerbating many of the above health threats but are also a health threat in their own right as a result of climate change, the deterioration in air quality and other impacts.

These rapidly changing and very complex health transitions bring into sharp focus the important need in all countries for an appropriate balance to be achieved between health services for both acute and chronic health conditions, as well as prevention and health promotion programs. However, the health systems in most developing countries are 'failing' in terms of funding; whereas, more than 15% of central government expenditure is allocated to health in most developed countries, the figure for most countries in South Asia is 2% and in East Asia and Pacific countries, is only 1% (REF). Such small outlays lead to major inefficiencies and misallocations of resources, with disproportionate support for urban and tertiary-level facilities. There is a chronic shortage of human resources and a largely unregulated private sector that compound the problem. Such systems 'fail' people not only in terms of access, but also, quality.

Public health capacity building and the Asia Pacific Region

There have been many efforts to contribute to public health capacity building in the Asia Pacific Region in recent years. Some of these have involved the aid efforts of specific governments such as the Australian Government's focus on strengthening national health systems (www.ausaid.com.au/keyaid/health.cfm). A significant development in terms of capacity building in the health field in recent years has been the entry of major new funders such as the Gates Foundation and the rapid expansion of global health initiatives, ranging from the large Global Fund to Fight AIDS, TB and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI) to smaller initiatives such as the Global Alliance for TB Drug Development (TB Alliance) and the Health Metrics Network (HMN). However, the majority of such funds have been channelled to Africa, compared to other regions of the world. The remainder of this article will focus on a network which has focused on the ways in which academic public health institutions can contribute to building and sustaining the public health capacity of the Asia Pacific Region.

The Asia Pacific Academic Consortium for Public Health was established over 20 years ago in 1984 in Hawaii following an earlier meeting in Manila (1983) of several deans of Schools of Public Health. The initial organising meeting was sponsored by the University of Hawaii, WHO, USAid, the US Public Health Service and the US Center for Disease Control. This led to the first full meeting of the Consortium in Bangkok in June 1984, attended by public health deans and senior public health faculty from seven universities – Hawaii (USA), Mahidol (Thailand), Tulane (USA), Indonesia, Tribhuvan (Nepal), Phillipines, and Beijing (The People's Republic of China). This initial meeting featured a highly successful symposium on "Postgraduate Training for Leadership in

Public Health". From those beginnings, APACPH has grown considerably and now consists of almost 60 institutions from 20 countries, with the newest members in the last 12 months coming from Australia, Sri Lanka and India. The organisation currently has regional offices in Australia, China, Thailand, Japan and USA, in order to facilitate regional activities and to broaden reach of the organisation. The Consortium has received significant support over the years from USAid, WHO (SEARO, WPRO and Pan American Regional Offices), the US Public Health Services (including CDC), the China Medical Board and AusAid. There has also been significant in-kind and other support from those universities that have hosted the Directorate for the organisation, including University of Hawaii (USA), Mahidol University (Thailand), Curtin University (Australia) and most recently, Queensland University of Technology (Australia). Additionally, a number of collaborative research and other projects among member institutions have been sponsored by health ministries and other agencies, universities and other organisations in member countries.

APACPH is an independent, not-for-profit organisation dedicated to enhancing the role played by academic institutions in workforce development and public health capacity building (http://www.apacph.org/site/index.php). The current aims and objectives of the organisation are summarised in Figure 1. The organisation has recently become formally constituted as an incorporated and independent organisation in Australia. This has required the organisation to develop further its constitution, its procedures for electing its officers and its business procedures and operations. It is expected that the same process will be instituted in other countries in the Region in the coming years.

Capacity building initiatives of APACPH

Michael (2005) provides a detailed analysis of the first ten years of APACPH's development. Liveris (p. 13, 2000) has summarised the work of APACPH as follows:

To achieve its mission, the Consortium fosters and supports joint research, training and service projects among its members to: improve curricula, strengthen faculty research and consultative skills; provide unique and new experiences for students; disseminate and share public health knowledge; and stimulate intersectoral collaboration among government and non-government organisations and academic institutions.

Asia Pacific Journal of Public Health

Beginning in 1987, APACPH commenced publication of its journal, the only English language journal devoted to the public health issues of the region, with its original editorial office at the National University of Singapore, and more recently, the University of Malaya, under the editorship of Dr. Anuar Zaini. Over almost 20 years, the journal has provided an outlet and forum for publishing state-of-the-art research and reviews that have often formed the basis for advocacy and public health action in the region. The Journal has also provided the opportunity for non-English proficient academics and researchers to publish

in English, often for the first time. From 2007, the Asia Pacific Journal of Public Health enter a new phase, as from that time, its publication will be undertaken by a very well known international publishing organisation.

Annual APACPH Conference

The Consortium meets at least annually when the General Assembly meets to conduct its business and associated with the meeting, the host member institution conducts an international conference or regional workshop. Each conference addresses a significant public health issue affecting all member nations and an important outcome is usually a set of recommendations and often a declaration which is referred to relevant health ministries in the Region and where appropriate, the relevant international agencies. The most recent conferences have included the 36th Conference in Brisbane, Australia in 2004 (*Public Health Networks and Alliances: Building Capacity in the Asia-Pacific Region*), the 37th Conference in Taiwan in 2005 (*Health Security in Emerging Disasters in the Asia Pacific Region*) and the forthcoming 38th Conference in Bangkok, Thailand in 2006 (*Partnership for Human Security and Health*). There is no other comparable annual public health conference in the Region, so the annual APACPH Conference is also providing a forum for many other public health researchers, students and bureaucrats to meet and to present their research and other findings.

APACPH Early Career Network

The Asia-Pacific Early Career Network in Public Health (APECNPH) is a recent initiative that aims to support students and early career professionals in the field of public health throughout the Asia-Pacific region. The network provides a forum to discuss, promote understanding of global public health issues and provide guidance and support for individuals in the early stages of their career. To date, its main annual activity has been to provide a workshop prior to each annual APACPH conference, that addresses a topic issue of major interest to the 'early career' participants. The 'early career' workshop at the 37th APACPH Conference in Taiwan focused on *Identifying and understanding the region's major public health issues and challenges* and the workshop for the 2006 38th APACPH Conference will address *Practical Research Skills in resource poor settings: chronic disease surveillance, capacity building and community mobilisation to improve public health.* It is expected that this network will grow in stature and importance in the years ahead as a whole new cohort of students and health professions choose to focus their careers in public health.

Workforce Development and Educational Activities

APACPH has sponsored and coordinated many different conferences, workshops and other activities over the years that have focused on key aspects of public health training

and education. Collaboration between member institutions has also led to the establishment of undergraduate and postgraduate public health coursework programs in member countries, including Thailand and Vietnam. The International Cyber University for Health (ICUH) initiative (http://icuh.yonsei.ac.kr/index.asp) that involves many faculty from APACPH member institutions throughout the region has led to the development and offering of public health courses via the internet and at no cost to students. Another recent initiative has also been reviewing the curriculum and experience of undergraduate public health programs being conducted at member institutions, with the aim being to encourage the further expansion of such programs throughout the region.

Research collaboration and cooperation

Collaboration and cooperation in relation to research has always been a focal activity for APACPH and its member institutions. There have been many examples over the years where research findings have eventually translated into improved public health programs or health policy. Most recently, a joint research initiative between University of Southern California and APACPH has been evaluating the health effects of the Tsunami disaster that occurred in the region a couple of years ago. This project has involved formal collaboration with staff from relevant institutions in both India and Sri Lanka and it will lead to recommendations for reducing the public health impact of similar natural disasters in the future.

References

Asghar RJ. Promoting Regional Health Cooperation: The South Asian Public Health Forum. PLOS Medicine 2006; 3(5): 108.

Australian Government (AusAID). Helping Health Systems Deliver: Australian Development Assistance in Health. www.ausaid.com.au/keyaid/health.cfm, 3 February 2006.

Eade D. Capacity-Building: An approach to People Centred Development. Oxford: Oxfam Development Guidelines, Oxfam Publishing, 1997.

Liveris M. The Role of APACPH (Asia-Pacific Academic Consortium for Public Health) in Addressing Public Health Issues in the Asia-Pacific Region. Asia Pacific Journal of Public Health 2000; 12 (supplement): S13-15.

Michael JM. The Asia-Pacific Consortium for Public Health (APACPH) The first ten years, from 1984 to 1994. Asia Pacific Journal of Public Health 2005; 17(2): 66-70.

World Health Organization. Report of the Commission on Macroeconomics and Health. Geneva: WHO Press, 2001.

World Health Organization. Preventing chronic disease a vital investment: WHO global report. Geneva: WHO Press, 2005.

World Health Organization. Working together for health: World Health Report. Geneva: WHO Press, 2006.

Zhu X, Zhen X, Oldenburg B. Challenges and Strategies for Improving Public Health in Countries undergoing rapid socio-economic transition – lessons from Beijing and China. Asia Pacific Journal of Public Health 2001; 13(1): 1-2.

Meeting Future Challenges. A View from the United States

Geraldine S. Aglipay & Harrisson C. Spencer

An adequate workforce of competent public health professionals is critical to improving the health of the public. The U.S. public health system is in peril: there is a growing public health workforce shortage and most public health workers lack formal public health education. The facts of the U.S. workforce crises are sobering.

- Some states may lose up to 45% of their public health workforce in 2006 due to retirement.[49]
- Up to 50% of the federal of federal public health and health care workers will retire in five years (1).
- Only an estimated 20% of public health professionals have formal public health education and training (2).

The U.S. public health workforce crises are exacerbated by dwindling budgets of state and local health departments. Moreover, the low salaries offered by state and local health departments serve as a dis-incentive for qualified professionals to enter and remain in public service careers. Solving challenges of recruiting and retaining formally trained public health professionals are not simple. However, schools of public health together with their partner organizations are implementing a number of short- and long-term solutions to address the workforce crises.

1) *Competencies for the MPH Degree*. Through the "MPH Core Competency Development Project" (http://www.asph.org/document.cfm?page=851) ASPH is building national consensus around the essential knowledge and skills. The ASPH competency model, still under development, will include the five disciplinary areas (i.e., Biostatistics, Epidemiology, Environmental Health Science, Health Policy and Management, and Social and Behavioral Sciences) and seven cross-cutting areas (Communication & Informatics, Diversity & Culture, Leadership, Professionalism, Program Planning, Systems Thinking, and Public Health Biology).
2) *Certification for Public Health Professionals*. ASPH launched an independent National Board of Public Health Examiners to certify public health professionals based on the MPH competencies. In 2008, the board will initiate a voluntary certification exam to students and graduates of accredited schools and programs of public health. The purpose is to make public health a recognized profession and ensure the competence of graduates.

[49] Council of State Governments, Association of State and Territorial Health Officials, National Association of State Personnel Executives, *State Public Health Employee Worker Shortage: A Civil Recruitment and Retention Crisis* 2004.

3) *Accreditation for Schools of Public Health*. The Council on Education for Public Health (CEPH) accredits schools of public health and programs. CEPH assures that institutions meet baseline criteria of accreditation (www.ceph.org).
4) *Lifelong Professional Learning in Competency-Based Training and All-Hazards Disaster Preparedness*. Schools of public health provide workforce development training in basic public health concepts and all hazards preparedness through several networks of centers. These centers encourage worker retention by providing skills needed to facilitate entry to, or advancement within, public health careers. Many courses and trainings are distance-based (http://www.asph.org/document.cfm?page=718).
    - The Centers for Disease Control and Prevention's *Centers for Public Health Preparedness Network* (http://www.asph.org/acphp/index.cfm) delivers all hazards training—from biological/chemical attacks to hurricanes. These centers link faculty with front-line workers to jointly assess and create preparedness education for the workforce.
    - ASPH helps administer the U.S. Health Resources and Services Administration's *National Public Health Training Center Network* (www.publichealthtrainingcenters.org). Fourteen centers are based at schools of public health that partner with state and local public health agencies. The network provides convenient, affordable, 24-7 distance-based education for public health aimed at current, full-time workers who lack basic formal public health education.
    - Academic Health Departments (AHDs) are formal partnerships between schools of public health and health departments that pool assets of both institutions—similar to the partnership between medical schools and teaching hospitals. AHDs address the Institute of Medicine's (IOM) call to strengthen the education of the public health workforce by providing lifelong learning through alternative means, such as certificate programs, continuing education, and distance education. Other activities include paid internships and engaging health department staff in course development, as well as joint development of community-focused research agendas.
    - Many schools of public health coordinate state, regional and national Public Health Leadership Institutes (http://www.phli.org and http://www.heartlandcenters.slu.edu/nln/). These institutes develop training to increase leadership effectiveness of mid- and upper-level managers within state and local public health, private health care, community leaders, policymakers and academicians.
5) *Undergraduate Public Health.* To strengthen recruitment to public health careers, the IOM recommends that all undergraduates have access to public health education. Approximately 22 accredited schools of public health offer at least one

undergraduate course in public health, and approximately 15 schools offer undergraduate degrees in public health. Undergraduate public health degrees are rapidly increasing across the U.S.

6) *Graduate Education*. Each year, accredited schools of public health graduate approximately 6,500 masters (MPH or equivalent) and doctoral (PhD, DrPH) professionals. CEPH requires that all professional degree students have a planned, supervised, and evaluated practice experience. ASPH provides coordinates national and international internships and fellowships, further assuring that learning is enhanced by real life experiences.
7) *Joint Degrees***.** Joint MPH degree programs are rapidly growing, given the need of other professions to integrate public health training (http://www.asph.org/document.cfm?page=753). Medicine, law, nursing, business, and social work are the disciplines with the most joint degrees.
8) *Public Health Systems Research***.** Solving workforce development challenges also requires national investment in public health systems research. This burgeoning research area focuses on concerns such as workforce enumeration, the assessment of agency workforce needs, and how worker training affects system performance (https://www.academyhealth.org/membership/forum/forum_topics.asp?FID=5).

Schools of public health play a key role in solving workforce challenges through coordinated academic/practice activities. The Association of Schools of Public Health (ASPH) represents the 37 accredited graduate schools of public health in the United States.

References

1. Mahan CS, Malecki JM. Confronting the Public Health Workforce Crisis in America: Perspectives from Academia and Public Health Practice. Florida: Public Health Review 2004; 1: 4-7.

2. Institute of Medicine of the National Academies. Future of the Public's Health in the 21st Century. Washington DC: National Academies Press, 2002.

PH Capacity Building: A View from Latin America

Giorgio Solimano

Since the beginning of the 20th century, public health and academic institutions in Latin America have developed synergistically, with the Pan American Health Organization also playing a key role. In this context, in 1974 the Latin American and Caribbean Association of Education in Public Health (ALAESP) was created. With a current membership of 65 academic institutions, the purpose of ALAESP is to foster training, research and innovation in public health in the region.

The evolution in the development of the field of human resources for health (HRH) during the second half of the 20th century is critical to understanding how best to face future challenges in this field.

Below, I briefly summarize the following historical periods:

1950-1970:

Problems: scarcity of professional staff and teachers, and insufficient health infrastructure,

Solutions: acceptance of need for changes both in management and training of HRH, improved access to modern medical literature and international experience.

1970-1980:

Problems: Lack of secure employment, emphasis on medical specialization and hospital care.

Solutions: Creation of integrated teaching-service models, improvement in labor regulations, prioritization of graduate training and continuous education

1980- to date:

Problems: Neo-liberal policies related to widespread poverty, unemployment and inequity; emergence of market-driven models

Solutions: Increasing focus on health determinants, emphasis of training of nurses and technicians to work at the primary care level, promote broader population health coverage by multi-disciplinary teams; and greater focus on evaluation and monitoring, including the development of HRH observatories

At the beginning of the 21st century, Latin America is characterized by societies of increasing complexity and greater uncertainty; accelerated industrialization, economic globalization and significant and rapid urbanization, with its accompanying ecologic problems. The region is also witnessing a greater degree of democratic participation, In addition, the region is experiencing explosive advances in scientific knowledge and new technologies, and greater access to higher education and global communications. Finally, many countries in the region are seeing an expansion of their aging population, and a dramatic epidemiologic shift to chronic diseases.

To effectively address these challenges, it is necessary to mobilize and strengthen Human Resources in Health, providing them with competencies and skills to effectively address current and emerging health problems in the context of changing societies and evolving health systems. This can only be achieved through the development of and collaboration between modern health systems and academic institutions that are able to respond in a thoughtful, yet opportunistic, manner.

More specifically, it is necessary to improve knowledge management at undergraduate and graduate level, enhance in-service training for health personnel, strengthen leadership capabilities of academic and health care decision-makers, and commit to effective community mobilization and social action. Furthermore, university and health authorities must allocate sufficient resources to implement required reforms.

Recently, under the leadership of ALAESP, an Action Plan to foster HRH in the Latin American region has been defined. Among others, this plan includes the following objectives:

1. Setting up the perspective and view of human resources for health as a strategic area at the country and regional level.
2. Promoting a country-specific human resources agenda designed to strengthen HR-related public policies and foster strategic work through inter sectoral and trans-sectoral alliances.
3. Facilitating collaborative action and strengthening leadership in the field of human resources among various sectors, institutions, and HR organizations (e.g. health, education, labour, worker unions, professional societies, student organizations, etc.)
4. Developing inter-country collaborative projects on priority problems, supported by funding agencies and national governments, and mindful of lessons learned from recent health and education reforms.
5. Defining an information system to identify common information needs and enable more extensive and reliable planning.
6. Establishing a strategy of HRH Observatories as an instrument to enable policy analysis and promote ongoing qualitative and quantitative monitoring of human health resources in each country of the region.
7. Creating instruments and mechanisms to monitor commitments made and implemented.

To implement this plan and to ensure regional coordination, we propose the establishment of an organization based on a supranational network composed of peer-recognized individuals. The network format would be flexible enough to include existing institutions committed to the area of human resources, such as concerned ministry departments, academic institutions, civil society organizations active in the health area, national commissions on human resources, and expert commissions on human resources committed to sub regional integration.

The role of the Network would be to ensure coordination among various players, utilizing necessary and/or available technological instruments and meetings, as we move forward on the Action Plan. Technological support would need to include more than one technology and make use of various tools, e.g. conference calls, electronic mail, websites, etc. This initiative should be intimately coordinated with existing country and regional programs.

This paper would be incomplete without calling attention to the fact that research in Public Health remains a largely neglected area, with a lack of prioritization and funding to build sustainable health research systems in most developing countries. Consequently, we agree with recent comments by COHRED in response to the 2006 WHO World Health Report on this matter when: " `Health research should be mainstreamed as an explicit political priority, alongside HRH, in the strategic national workforce plan, and in investments in workforce training and education". In the Latin American region, this approach must take a high priority in upcoming years and be strengthened through alliances and collaborations between academic, government and international institutions.

In summary, Latin America has an extensive and rich experience in the field of Human Resources for Health that is closely related to the development of public health services. This experience can be shared both with underdeveloped and developed countries through collaborative work, and should be harnessed to develop alliances to address the dramatically changing political, economic, and public health realities in the region, to the benefit of all.

Changing health challenges in Europe: Building public health capacities for the 21st century

Horst Noack

The two professional organisations in European public health, EUPHA and ASPHER, are facing formidable (significant, considerable) challenges. They are challenged to guide and support the development of public health capacities. In order to do so they need to clarify their visions of the future public health and the envisaged directions of public health policy and practice. Whereas EUPHA's remit is the enhancement of public health research, ASPHER is committed to enhancing education and training of the professional workforce in public health. The two organisations ought to join to strengthen two of the most basic public health capacities.

A country's public health capacities are based on the *public health concept* shared by the community of public health actors and scientists. This concept tends to vary between two distinct perspectives, an exclusive disease-oriented perspective (referred to as *public health medicine*) and an inclusive health-oriented perspective (referred to as *comprehensive public health*) (1). The dominant public health perspective defines the *key values, principles and rules* guiding the formation of *health policy and practice* and the development of the *knowledge base. These are the tools* professional actors have at their disposal to achieve what health policy or practice are seen to demand. In philosophical terms the basic concepts, the key values, principles and rules and the knowledge base of the field define the ontological, ethical and epistemological foundations of the *multi-discipline* of public health.

The health sector is one of the fastest growing sectors in modern society. It comprises a complex and dynamic array of organisations and networks active in many broad fields: the management and practice of health care, health promotion and disease prevention; the production and marketing of health products; the generation and dissemination of health-related information and knowledge; the education and training of the professional workforce; and the governance and financing of health services. These organisations and networks represent a huge (enormous) system both of private and public health capacities. In many countries there is a serious imbalance between the manpower resources of the private and the public sectors, and within the public sector between the resources for individual disease care and the promotion of public health.

In many countries the public health sector lacks an appropriate research infrastructure, an adequate scientific knowledge base and a sufficiently qualified workforce. In several European countries formal education and training programmes were established only recently. Life-long "learning by doing" and specialised work-accompanying training programmes are considered to be essential components of

professional development and qualification. In many countries public health policy and practice are not sufficiently based on existing scientific knowledge or evidence. They are simply not adequately prepared to respond to the complex challenges of future public health.

Many health reforms since the 1980s have been aimed at slowing down rising health care expenditures. Their impact on population health would still be hard to judge. Today expert opinion about the directions of the future public health differs widely. The spectrum ranges from the cautious prediction of a well-governed *healthcare system* optimising existing resources (2) to the idea of a post-modern *health society* seeing health as a high value and a human right and as an overarching goal in all policies (3).

The large majority of current European healthcare reforms seek to improve the quality and the outcomes of health/disease care. Based on the perspective and the principles of *public health medicine* they may implement policies and instruments to integrate fragmented services, to base the financing of services on diagnosis-related groups (DRGs), to manage health care quality at regional or organisational levels by adhering to the principles of evidence-based medicine, disease management and case management. Intended developments tend to be strengthened by the continuous monitoring of changes, training of staff and financial incentives.[50] The scenario of public health medicine challenges governments to invest into researching the determinants of good healthcare, professional management and evaluation as well as problem-oriented scientific education and training programmes focussing especially on clinical epidemiology and intervention and evaluation methods. Despite its positive effect on the professional capacity and on the quality of healthcare the health impact of this reform strategy will be quite small because it does not address the determinants of health.

Very few countries are planning or implementing a health care reform aiming at sustained health improvement of the entire population. So far only Sweden has fully adopted a health policy based on the perspective and principles of *comprehensive public health.* Applying a similar logic Finland is preparing a *Health in All Policy* soon to be discussed with the health ministers of the 25 EU member countries. The Swedish health policy addresses a wide range of economic, environmental, settings-related, literacy-oriented and medical determinants of health such as economic and social security, the conditions of working life, the social and cultural contexts of physical activity, eating habits, consumption of tobacco and alcohol, or disease prevention (4).

The scenario of comprehensive public health challenges governments to support capacity building on a very broad scale. It calls for research on the processes and outcomes of health development, healthy ageing and their complex determinants, for long-term health promotion, primary prevention and integrated health care. It also calls for long-term practice-oriented scientific education and training efforts for public health

[50] Noack R H (2005): Scope, Purpose and Major Topics of the 13th European Conference on Public health in Graz. http://public-health.meduni-graz.at/

professionals working in regional or local communities, schools, workplaces and other social settings, covering relevant content from the health sciences, general and social epidemiology, health management and evaluation methods. If successful this policy can be expected to have a significant impact on the health capacity of a society, the reduction of health inequalities and the improvement of the health of the entire population. It is in line with WHO's *Eleventh General Programme Work 2006 – 2015* (5) and with EUPHA's *10 Statements of the Future of Public Health in Europe*[51].

In both scenarios the public health community has to face yet another big challenge. Public health professionals are challenged to cope creatively and efficiently with an ever-increasing amount of health-related information and established knowledge. Future capacity building for public health will have to focus on the entire knowledge cycle: the processes of knowledge generation, knowledge dissemination and transfer, knowledge utilisation in research and evaluation, education and training, policy making and organisational or social practice, and the evaluation of new information/knowledge.

A systematic effort to analyse and manage the information/knowledge process in public health opens up a challenging new field within the larger context of capacity building. This is most likely a field where the two professional organisations in European public health, ASPHER and EUPHA, can benefit from each other if they continue to deepen their communication and cooperation.

EUPHA wishes her older sister ASPHER a happy birthday and much success for the next 40 years!

References

1. Noack RH. Building the Modern Public Health: Perspectives, Theory and Practice. In Tellnes G (Ed.). Urbanisation and Health. Oslo: Academic Press, 2005.123-39.

2. McKee M. The future. In: Marinker M (Ed.). Constructive Conversations About Health Policy and Values. Oxford: Radcliffe, 2006.215-29.

3. Kickbusch I. Health and wellbeing. In Marinker M (Ed.). Constructive Conversations About Health Policy and Values. Oxford: Radcliffe, 2006.31-40.

4. Hogstedt C, Lundgren H, Moberg H, Pettersson B, Agren G (Eds.). The Swedish Public Health Policy and the National Institute of Public Health. Scandinavian J Public Health 2004; 12: Supplement 64.

5. Noack RH. President's Column: the future of public health in Europe: towards a more active partnership with WHO/EURO. Eur J Public Health 2006; 16: 226.

[51] European Public Health Association – EUPHA: 10 Statements on the Future of Public Health in Europe. EUPHA report 2004-1.

Health reform and health systems in Europe: future demands for professionalisation

Martin McKee

Health reform and health systems in Europe: the challenges for public health professionals
One advantage of increasing age is the opportunity it provides to observe changing political fashions. These fashions affect all aspects of our life but they seem particularly to impact on our health systems. To some extent this is understandable; the delivery of health care is extremely complex and no-one ever feels they have got it just right. What is more, the challenges that health systems must face are constantly changing so that, even if the perfect system was ever to be designed, it would soon be out of date.

These fashions have profound implications for the public health workforce. In many countries, public health professionals are employed within the health system and, even where they are not, their work depends crucially on their ability to work effectively with the organisational structures that exist within the system, such as health authorities or provider organisations. The effectiveness of their work depends of the development of long term, sustainable relationships with the various parts of the health system, relationships that are frequently based on close personal relationships with people who share the goal of making the world a better place. Yet in some countries, the system acts to undermine the stability that is necessary for these relationships to flourish. This may be because senior appointments are in the gift of political parties so that when the governing party leaves power, so do the top officials, taking with them the institutional memory that is all too important in preventing the same mistakes being made again and again. An example is Spain, where the careers of many excellent public health professionals have moved in parallel with the changing political cycle over the past decade. This loss of institutional memory and disruption to social networks can also arise where there is rapid organisational change. The most extreme example is England, where a succession of health ministers has engaged in a dizzying array of damaging “reform”, each hoping to advance their career by “doing something”, regardless of whether their constant organisational restructuring has any rationale. This extremely damaging process, which at least provides the rest of the world with a catalogue of examples of how things should not be done, has seen the loss, through early retirement, of many highly skilled and motivated professionals.

Yet while public health professionals can be victims of reform, they can also contribute much to it. Underlying the seemingly endless debate about how to configure health systems there are two simple questions. The first is how to pay for health care. If health care was a simple commodity, like bread or newspapers, this could be left to the market. Of course it is not. Those who can most easily afford to pay for care need it least while those in most need are least able to afford it. Consequently, any civilised state must engage in a process of redistribution. This is where it becomes difficult, as those in the first

category seek to justify policies that will allow them to keep as much of their money as possible while those in the latter category seek to redistribute sufficient to meet the needs of those who require health care. There is, however, a second consideration. If money is to be collected, redistributed, and transferred to health providers, how can this be done at least cost? The enormous transaction costs in the American health care system serve as a warning of how badly this can go wrong. Public health professionals have a crucial role in contributing where there are debates on different approaches of health care financing, bringing an equity perspective to bear and emphasising the need for simplicity, especially as there will be many people advocating for complexity, largely because they hope to benefit from it by ensuring that the high transaction costs flow to them.

The second question relates to how to deliver health care. Here too public health professionals have an increasingly important role. The demands on health systems are changing. Populations are aging, and advances in medicine have increased the possibilities for treatment of many disorders. As a consequence, there are many more individuals with multiple, complex, chronic diseases. The traditional model of a single episode of care involving a patient and a physician is obsolete (1). What is now needed is a means of ensuring that the many diverse resources, including different, and sometimes interacting, drugs, therapies, and health professionals are brought together at the right time and in the right place to meet the needs of the patient. This demands new models of care, such as stroke units or cancer networks. These models do not appear spontaneously. Public health professional have much to offer from their expertise in assessing and synthesising evidence, the understanding of organisational theory, and their ability to implement change.

There is, however, a third area where public health professionals can make a difference. The growing demands on health systems everywhere are creating upward pressure on costs. The usual political response is to seek ways to reduce the supply of health care provision. Yet there is another side to the equation, reduction in demand. If everyone was healthy there would be little need for health care. A few countries are now recognising the scope for constraining the growth in health care expenditure through policies that promote health, exemplified by the Wanless Report prepared for the British Treasury (Finance Ministry) (2). At the same time, there is also some recognition that poor health is a brake on the economic development that is needed to sustain future growth (3), so that health care spending, like spending on education and transport infrastructure, should be seen as an investment and not as a revenue loss. Public health professionals have played a key role in developing these arguments but there is enormous scope for them to engage in them further, and to bring these messages to a wider audience.

Public health professionals in Europe have much to offer to the process of health care reform, in debates about financing, delivery, and the contribution of public health to

the economy. The arguments are there. All that is needed is for public health professionals to voice them with confidence.

References

1. McKee M, Nolte E. Responding to the challenge of chronic disease: ideas from Europe. Clin Med 2004; 4: 336-42.

2. Wanless D. Securing the future of health: taking a long term view. Final report of health care trends review team. London: HM Treasury, 2002.

3. Suhrcke M, McKee M, Sauto Arce R, Tsolova S, Mortensen J. The contribution of health to the economy in the European Union. Brussels: European Commission, 2005.

APPENDICES

List of ASPHER Members as of July 2006

Albania

- Institute of Public Health, Tirana
- Department of Public Health, Faculty of Health Medicine, Tirana University

Armenia

- College of Health Science, American University of Armenia, Yerevan, www.aua.am/

Austria

- Medical University of Graz, public-health.meduni-graz.at
- Health Science Department, University for Health Informatics and Technology, Tyrol, Hall, www.umit.at
- School of Public Health, Faculty of Hygiene and Social Medicine, Innsbrück, www.uibk.ac.at/c/c5/c543/pubhealth

Belgium

- Ecole de Santé Publique, Université de Liège, www.facmed.ulg.ac.be/recherche/uer/santepubl.php#1

Bulgaria

- Department of Public Health, Medical University of Varna, muvar.acad.bg/En/
- Faculty of Public Health, Medical University, Sofia

Croatia

- Andrija Stampar School of Public Health, Zagreb, www.snz.hr

Czech Republic

- School of Public Health, Institute for postgraduate medical education, Prague, www.ipvz.cz

Denmark

- Master of Public Health, Institute of Public Health, Faculty of Health Sciences, University of Aarhus, www.mph.au.dk
- Institute of Public Health, University of Copenhagen, pubhealth.ku.dk/ifsv

Estonia

- Department of Public Health, (ARTH), Faculty of Medicine, University of Tartu, biomedicum.ut.ee/arth/english

Finland

- Department of Public Health and General Practice, University of Kuopio, www.uku.fi/laitokset/kansy/english
- School of Public Health, Tampere, www.uta.fi/laitokset/tsph

France

- Ecole Nationale de la Santé Publique, (ENSP), Rennes, www.ensp.fr

Germany

- School of Public Health, Faculty of Health Sciences, University of Bielefeld, www.uni-bielefeld.de/gesundhw/index.html
- Institute for Public Health/Health Science, Technische Universität Berlin, www.ifg-gs.tu-berlin.de
- Technische Universität Dresden, www.public-health.tu-dresden.de/dotnetnuke2
- Akademie für öffentliches Gesundheitswesen, Düsseldorf, www.afoeg-nrw.de
- Medical School Heinrich-Heine-University, Düsseldorf, www.uni-duesseldorf.de/WWW/MedFak/PublicHealth
- Department of Nutrition and Home Economics, Hamburg University of Applied Sciences, Hamburg, www.haw-hamburg.de/Department.636.0.html
- Department of Tropical Hygiene and Public Health, University of Heidelberg, www.hyg.uni-heidelberg.de/ithoeg/index.htm
- Zentrum für Angewandte Gesundheitswissenschaften, (ZAG), Universität Lüneburg und der Fachhochschule Nordostniedersachsen, Lüneburg, www.fh-lueneburg.de/zag
- Hochschule Magdeburg – Stendal, www.hs-magdeburg.de
- Department of Medical Informatics, Biometry and Epidemiology, (IBE), München, www.public-health-muenchen.de

Greece

- National School of Public Health, Athens, www.nsph.gr/esdy_basic2/index.htm

Hungary

- School of Public Health, University of Debrecen,www.sph.dote.hu

Ireland

- Department of Public Health Medicine and Epidemiology, University College, Dublin, www.ucd.ie

Israel

- Hadassah, School of Public Health and Community Medicine, The Joseph and Belle Braun, Hebrew University, Jerusalem, www.md.huji.ac.il/publichealth

Italy

- Centro per la Formazione Permanente e l'Aggiornamento del personale del Servizio sanitario, (CEFPAS), Caltanissetta, www.cefpas.it
- Istituto di Igiene e Medicina Preventiva, Milano, users.unimi.it/~igimepre/anglo.html
- Scuola di Specializzazione in Igiene e Medicina Preventiva, Universita degli Studi, Perugia, www.unipg.it/~dipigmed
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- Kazakhstan School of Public Health, Almaty, www.ksph.kz

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- School of Public Health, Latvian Medical Academy, Riga, www.svs.lv

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- Centre of Public Health, Medical Faculty, University "St. Cyril and Methodius", Skopje, www.cjz.ukim.edu.mk

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- Netherlands School of Public and Occupational Health, (NSPOH), Amsterdam, www.nspoh.nl

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- National School of Public Health and Health Services Management, Bucharest, www.incds.ro/english.htm

Serbia

- Centre - School of Public Health, School of Medicine, Belgrade University, www.sph.med.bg.ac.yu
- Institute of Public Health, Novi Sad, www.izzzns.org.yu

Slovakia

- School of Public Health, Postgraduate Medical School, Bratislava, www.spamba.sk

Spain

- Escuela de Estudios de Ciencias de la Salud, Badajoz, www.juntaex.es/consejerias/syc/ecs/escuela_salud.htm
- Escuela Andaluza de Salud Publica (EASP), Granada, www.easp.es
- Escuela Nacional de Sanidad Publica, Madrid, www.isciii.es/ens
- Escuela Valenciana de Estudios para la Salud (EVES), Valencia, www.san.gva.es

Sweden

- Nordic School of Public Health, (NHV), Göteborg, www.nhv.se
- Department of Science and Health, Blekinge Institute of Technology, Karlskrona, www.bth.se/ihn
- Centre for Public Health, Faculty of Health Sciences, Linköping, infoweb.unit.liu.se/hu/main_page
- Unit of Public Health Sciences, Malärdalen, www.mdh.se

Switzerland

- Swiss School of Public Health (SSPH+), Zürich, www.ssphplus.ch

Ukraine

- School of Public Health, Kyiv Medical Academy of Post-Graduate Education (KMAPE) and National University of "Kyiv-Mohyla Academy" (NaUKMA), Kiev, www.ukma.kiev.ua

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- Welsh Combined Centres for Public Health, University of Wales, Cardiff, www.cardiff.ac.uk/medicine/epidemiology_statistics
- Department of Public Health, University of Liverpool, Liverpool, www.liv.ac.uk/PublicHealth/index.html
- London School of Hygiene and Tropical Medicine (LSHTM), London, www.lshtm.ac.uk
- Evidence for Population Health Unit, School of Epidemiology and Health Sciences, Medical School, University of Manchester, www.ephu.man.ac.uk
- School of Health and Related Research, University of Sheffield, www.shef.ac.uk/scharr

Uzbekistan

- Second Tashkent State Medical Institute, Tashkent

Associate Member

- European Public Health Association, (EUPHA), Utrecht, The Netherlands, www.eupha.org

Honorary Member

- Gudjon Magnusson, World Health Organization, Copenhagen, Denmark,

List of all Presidents and EB Members and their terms

Current President:

Professor Anders Foldspang, since 2005, Executive Board Member since 2000

List of ASPHER Past Presidents:

Professor Charles Normand, 2003 - 2005, Executive Board Member: 1994 - 2006
Professor Roza Adany, 2001 - 2003, Executive Board Member: 2000 - 2004
Professor Jose Maria Martin Moreno, 1999 - 2001, Executive Board Member: 1998 - 2002
Professor Richard Madeley, 1997 - 1999, Executive Board Member: 1996 - 2000
Professor Franco Cavallo, 1995 - 1997, Executive Board Member: 1994 - 2000
Professor Ulrich Laaser, 1993 - 1995, Executive Board Member: 1991 - 1996
Professor Jeffrey Levett, 1992 - 1993, Executive Board Member: 1991 - 1994
Professor Francisco Bolumar, 1991 - 1992, Executive Board Member: 1990 - 1993
Professor Christian Rollet, 1990 - 1991, Executive Board Member: 1989 - 1992
Professor Ivan Forgacs, 1989 - 1990, Executive Board Member: 1988 - 1990
Professor Lennart Köhler, 1987 - 1989, Executive Board Member: 1991 - 1997
Professor Michael Davies, 1985 - 1987, Executive Board Member: 1990 - 1992
Professor Aloïsio Moreira Coelho, 1983 - 1985
Professor Frans Doeleman, 1981 - 1983
Professor Charles Edward Gordon Smith, 1979 - 1981 († 1991)
Professor Alfred C. Eberwein, 1977 - 1979
Professor Marcel Graffar, 1975 - 1977. († 2000)
Dr. Bo Holma, 1973 - 1975
Professor Christine Lucasse, 1970 - 1973
Dr. Jean-Simon Cayla, 1968 - 1970 († 2005)

List of ASPHER Executive Board Members in post:

Professor Theodore Tulchinsky, since 2005
Mr. André Meijer, since 2005
Dr. Pina Frazzica, since 2004
Dr. Lidia Georgevia, since 2003
Professor Ramune Kalediene, since 2004
Dr. Stojgniew Sitko, since 2001

List of ASPHER Past Executive Board Members: (since 1986)

Ms Aislinn O'Dwyer, 2002 - 2005
Professor Stipe Oreskovic, 2002 - 2005
Professor Joanna Meulmeester, 2000 - 2003
Professor Andreas Geiger, 1998 - 2004
Dr. Pascal Chevit, 1998 - 2003
Professor Arja Rimpela, 1997 - 1999
Professor Alena Petrakova, 1996 - 1999
Professor Philippe Chastonay, 1995 - 1998
Professor Serge Gottot, 1995 - 1998
Professor Bernard Junod, 1991 - 1992, 1995 - 1998
Professor Evelyne de Leeuw, 1992 - 1998
Professor Ferenc Bojan, 1993 - 1996 († 1997)
Professor Andre Rys, 1992 - 1995
Professor Alain Jourdain, 1992 - 1995
Dr. Paul Rasch, 1992
Professor Patrick Vaughan, 1991 - 1994
Dr. Carmen Martinez Garcia, 1991 - 1992
Dr. Henk Leliefeld, 1990 - 1992
Professor Felix Vartanian, 1990
Dr. Saturno, 1990
Dr. Tom Landheer, 1990 - 1991
Dr. Maurice Beaver, 1988 - 1991
Dr. Tom Fryers, 1988 - 1990
Professor Erik Kroger, 1987 - 1991
Dr. Frada Eskin, 1986 - 1990
Dr. Alexander Macara, 1986 - 1989

List of Projects/Programs with involvement of ASPHER

Since 1993: Public Health Education European Review – PEER

One of the core concerns of ASPHER is the development of a quality assessment mechanism of public health education programmes. The PEER Review is a supportive and developmental tool based on improving the quality of Public Health Education throughout the European Region. Since 1993, ASPHER has completed 21 PEER reviews. A list can be found on the ASPHER website.

1991 - 1996: PHARE Evaluation Policy Programme

Under the EU PHARE programme, ASPHER took part in the elaboration of a policy process. This involved a mission in Romania in 1996 in order to evaluate the Romanian Health PHARE Programmes. And in 1997, ASPHER contributed with other partners to a manual for the evaluation of the country programmes 1991-1995 in the Health PHARE Sector (Guidelines, process and tools).

1996 - 1998: European Degrees in Public Health

The objective of this project was to create a flexible modular system that might be based on independent specific modules (e.g. EU Health policies), and also on:

- Integration of an EU dimension into existing modules (e.g. comparison of Health care systems),
- Field practice and thesis work in another EU country focused on a European or other subject,
- Combination of these, attaining a critical mass, which would justify the label of MPH with EU mention or option within the existing legal framework of national MPH,
- Conception by some European institutions of a joint programme in order to create an « EMPH ». European Master in Public Health.

1996 - 1998: Inventory of training programmes, courses in public health and in health promotion in the European Union

This project funded by DGV of the European Commission was created to determine the extent and content of Public Health and Health Promotion training offered across Member States of the European Union. It involved a survey of institutions in EU Member States providing education and training in Health Promotion and Public Health. The objective was to provide a description of courses with a view to facilitate students' decisions.

After completion of this survey an online database was created which was closed in 2001.

1997 and 1998: Summer School Seminars on Health promotion and Public Health policies in the European Union

With support from DGV, ASPHER organised two week-long seminars on the various programmes supported by the European Commission in the public health sector. The aim of these summer schools was to create a forum for discussion and exchange in an informal environment that would be of mutual benefit to all participants free of the conflicting interests of policy makers and academics.

1998: Evaluation of the EU "Second Action plan for the Fight Against Cancer" 1990-1995

The aim of this evaluation carried out by ASPHER for DGV of the European Commission was to examine the effectiveness of the second action programme against cancer in order to improve subsequent measures. It involved identifying the value added by this Community programme.

1998 – 1999: First phase of the evaluation of the EU Public Health Programme Cancer, Drugs, AIDS and other communicable diseases (EVAL 1)

ASPHER carried out for DGV of the European Commission the evaluation of these three separate EU programmes. This entailed participation in the elaboration of the methodological framework of evaluation, realisation of evaluation of projects and actions in those three programmes and contribution to the preparation of the interim reports.

1998 - 1999: Interim evaluation of the « Programmes régionaux de Santé (PRS) »

This evaluation was carried out by ASPHER for the French Ministry of Health. It was concerned with the organisation of the regional health programmes in France and their evolution as well as designing performing tools for monitoring and final evaluation of these programmes.

Since 2000: **Accreditation of public health training programmes**

Approaches to quality assessment of public health education and entry into the labour markets for PH professionals varies in different countries of Europe. Presently only different national organisations (if these exist in a given country) provide licensing, certification or/and accreditation of educational programs, which is not comparable across European countries. Moreover, those national-level procedures do not properly cater for discipline specific assessment, especially for public health educational programs. The project aims at launching and enforcing the continuous quality improvement process by the development of European Accreditation standards in public health education, elaborating the criteria related to these standards, the procedures to check them and a policy of helping the educational establishments to improve.

2001-2005: OSI-ASPHER Programme: Quality Development of Public Health Teaching Programmes in Central and Eastern Europe

This program funded by the Open Society Institute (OSI) aimed at developing quality in public health teaching programmes, within educational entities across thirteen countries throughout the CEE region, by drawing upon the experience, expertise and networks of the Association of Schools of Public Health in the European Region (ASPHER).

To achieve the aims involved in quality development, ASPHER and OSI designed a two tiered approach. This approach took into account the differing levels of development among educational entities. The programme consisted of two parts, stream 1 for the more advanced schools and programs and Stream 2 for the emerging and developing schools and programs.

2003-2005: European Master of Public Health (EMPH)

This pilot project co-funded by DG Sanco built upon previous projects such as the European degrees in public health. Its objectives were to:

- establish a more permanent corporate structure (management and governance) for the EMPH
- help ensure acquisition of a European competence in public health through Peer validation of training modules offered by the partners in the EMPH network
- discuss and develop the real content areas of a European public health approach with a view to gain an understanding of the basis for the elaboration of new modules by the partners in the future
- contribute to the development of accreditation of public health training programmes.

Since 2005: Public Health Training in the Context of an Enlarging Europe (PHETICE)

PHETICE is financed by DG Sanco and coordinated by the Karolinska Institutet in Stockholm. It involves four other partners including ASPHER. The overall aim of this project is to make a contribution to the health of European citizens through combining the different efforts made by varying professional public health training groups and European programmes.

Within PHETICE, ASPHER is responsible for Work Package 6 (Web-based questionnaires and databases and support to effective dissemination of resources produced).

2006: Development of lists of core competencies

Schools of Public health train their students to be able to develop, organise, manage, evaluate and adjust cost-effective interventions aiming at the promotion of health and at the reduction of present and forecasted PH problems.

This project is concerned with the development of lists of core competences necessary for the PH master graduate to fulfil this mission. Such lists will supply SPHs with a quality development tool besides the already existing tool of peer evaluation. Competencies will be categorised within the five PH main fields:

- Methods (epidemiology and biostatistics; qualitative methods)
- Social environment and health
- Physical, chemical and biological environment and health
- Health policy, organisation, management and economics
- Health promotion and prevention

The project will integrate PH expertise from SPHs as well as PH employers, international organisations (EU; WHO) and other PH stakeholders and will result in an annual publication.

List of ASPHER and ASPHER-related publications

Foldspang A, Louvet T, Normand C, Sitko SJ (Eds.). ASPHER 40th Anniversary. 1966-2006. Anniversary Book. ASPHER Series N°1. Saint- Maurice: ASPHER, 2006.

Foldspang A, Louvet T et al (Eds.). Vademecum, The European Master of Public Health (EMPH). Saint-Maurice: ASPHER, 2005.

La mejora de la Calidad y la Acreditatión de programas de Formación en Salud Pública, Un proyecto conjunto, Fundación Merieux –ASPHER 2000-2001. Valencia: Escuela Valenciana de Estudios de la Salud: Artes Graficas, 2004.

Bury J, Gliber M. Quality Improvement and Accreditation of training programmes in Public Health, Fondation Mérieux-ASPHER Joint project 2000-2001. Lyon: Edition Fondation Mérieux, 2001.

Laaser U. The Internet Journal of Public Health Education, (http://www.aspher.org/D_services/I-JPHE/I-JPHE_Home_Page.htm). 1999; 1

Ministry of Health Kazakhstan, WHO, ASPHER. Kazakhstan School of Public Health, Project Document. Copenhagen: Regional Office World Health Organisation, 1997.

ASPHER-European Commission. Inventory of Public Health and Health Promotion Training in the European Union, Database and Background materials, Maastricht: Primavideo, 1997.

ASPHER. Rapid Survey of National Institutes of Public Health in the European Union. St Maurice: ASPHER, 1996.

Laaser U, Leeuw de E, Stock C. Scientific Foundations for a Public Health Policy in Europe. Weinheim und München: Juventa Verlag, 1995.

ASPHER. The Athens Memorandum: Training and Research in Public health. ASPHER's support for article 129 and the European Commission's Communication on the Framework for Action in the Field of Public Health. Maastricht: University of Maastricht: Uniprint, 1994.

Köhler L, Bury J, Leeuw de E, Vaughan P. Collaboration in European Public Health Training: Position paper ASPHER. Maastricht: University of Maastricht: Uniprint, 1994.

Association of Schools of Public Health in the European Region (ASPHER)

The Association of Schools of Public Health in the European Region (ASPHER) is the key independent organisation in Europe dedicated to strengthening the role of public health through the training of public health professionals for both practice and research.

Founded in 1966, ASPHER has over 70 institutional members, located in the Member States of the European Union (EU), in the Council of Europe (CE) and in the European Region of the World Health Organisation (WHO).

As University Departments and National and Regional Schools in Europe are *the* primary training institutions for public health professionals in their countries, they provide the critical link between the science and practice of public health in Europe. ASPHER members are closely linked to national health administrations, academia, professional organisations and public health programmes and services.

Our goal is to champion the interdisciplinary nature of public health, as the public health field draws on various academic disciplines, theories and research methods related to the behavioural, cultural, social and economic influences affecting health and health care systems; to promote the European dimension in public health training programmes; and to develop and strengthen a unique network of training institutions to advocate their views for a new public health strategy in Europe.

ASPHER's General Assembly elects the Association's President for two years and an Executive Board. The Executive Board appoints the Executive Director and the Secretariat Staff. Together they develop the Association's projects, member services and committees.

ASPHER provides a formalised system of Public Health Education European Review (PEER Review) designed to improve the quality of training programmes for public health professionals. Along with the publication of the Internet Journal of Public Health Education (I-JPHE), ASPHER holds an Annual Conference, disseminates a monthly Newsletter, and shares information about current projects and services on its web site.

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