

NewsMail 04 November, 2008  
**FORUM FOR PUBLIC HEALTH  
IN SOUTH EASTERN EUROPE**  
Collegiality, Professionalism, Amity

[www.snz.hr/fph-see](http://www.snz.hr/fph-see)

*On My Own*

Dear friends and colleagues,

This year 2008 was not easy for me as my mother died late in April in Berlin. On the other hand the election as incoming president of the World Federation of Public Health Associations ([www.wfpha.org](http://www.wfpha.org)) in May during the World Health Assembly in Geneva and the preparation of the World Congress in Istanbul April 27 – May 1, 2009 as chair of the Scientific Committee in addition to the honour, mean predominantly a lot of additional work. Therefore I discussed some necessary changes with my university in Bielefeld/Germany.

Our Forum for Public Health in the future will be under the responsibility of the principal investigators Prof. dr Jadranka Bozikov/Zagreb and Prof. Dr. Oliver Razum/Bielefeld. In addition there will be two main programmes: (I) Public Health Training resp. MetaNET Project; (II) Public Health Research Net (PHeRN). You find these buttons under the Managing Office. On the side of Bielefeld Prof. Dr. Doris Bardehle will be responsible for the first one and me for the second. With regard to the research section an office will be established in Maastricht, where Prof. Dr. Helmut Brand has taken a chair for European Public Health Policy. The executive position there will be taken by Assistant Professor Genc Burazeri PhD (formerly in Tirana). A number of additional changes also have been made during these days. Therefore have a look at the website ([www.snz.hr/fph-see](http://www.snz.hr/fph-see)).

As most of you will know there are two special issues on Public Health in Central and Southeastern Europe under preparation, the first one with our official journal, the CMJ coordinated by Prof. dr Sandra Grujicic ([sandragru65@yahoo.com](mailto:sandragru65@yahoo.com)) and the second one with the Italian Journal of Public Health coordinated by Prof. dr Vesna Bjegovic ([bjegov@eunet.rs](mailto:bjegov@eunet.rs)). Please contact them if you want to make a contribution.

Also recently the 5<sup>th</sup> volume of our teaching books has been published under the leadership of Prof. dr Luka Kovacic: Management in Health Care Practice (672 pages), see the project website.

Finally I placed at our website the minutes of our conference in Luxembourg on Professionalisation and Capacity Building for Public Health in South Eastern and Eastern Europe: The Legal and Educational Framework, February 20/21, 2008. The conclusions are an excellent starting point for our future work. I published them in the Journal of Public Health Policy No. 4/2008 (see below).

Handing over now most of my responsibilities to dear friends and colleagues I want to thank you all for the long years of extremely rewarding collegiality, professionalism and amity. I expressed this in my award speech in Lisbon, November 5, 2008 when I received the Andrija Stampar Medal from ASPHER. Thank you very much to all of you but not Good Bye!

Yours Ulrich

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Attachment 1

**Speech by the Andrija Stampar Medalist Prof. Ulrich Laaser in Lisbon,  
November 5, 2008**

Dear friends and colleagues,

In 1926 Andrija Stampar published the Ten Principles for the work of the medical profession, half a century ahead of their at least conceptual adoption by the global community. Today we are used to apply almost all of them not only to the medical profession but to all health professions. At this occasion I would like to mention only - very shortly - three of them (4, 6, 10):

1. *It is more important to enlighten the people than to impose laws; therefore the medical profession consists of only three short laws.*
2. *It is most important to prepare the ground in a certain sphere and to develop the right understanding for questions of hygiene.*
3. *The question of public health and its improvement must not be monopolized by medical authorities, but has to be cared for by everybody, for only by joint work can the progress of health be obtained.*
4. First of all the physician must be a social worker; by individual therapy he cannot attain much, social therapy is the means of success.
5. *Economically the physician must not be dependent on his patient, because it hinders him in the accomplishment of his principal tasks.*
6. In matters of national health no difference is to be made between the rich and the poor.
7. *It is necessary to form a health organisation, in which the physician will seek the patient, not the patient the physician; for this is the only way to gather an ever increasing number of those whose health we have to care for.*
8. *The physician has to be the teacher of the people.*
9. *The question of national health is of a greater economic than humanitarian importance.*
10. The principal fields of action of a physician are human settlements and not laboratories and consulting rooms.

Recently and still today our political leaders have to deal with a global financial crisis reminding us on the Black Friday in 1929. For one moment our Europe showed unprecedented unity. Unfortunately, this one-directional coordination cannot be observed for the vital problems of our time i.e. hunger, warming, and education. All of them impact on health and life-expectancy and therefore all of them are subject to our work in the field of Public Health. Inevitably the fantastic amounts readied to save

the banking system, will reduce our anyway narrow financial space to move. But that is not the main problem, except that we have to regard even more the cost-effectiveness of our work as efficiency has an ethical dimension: Sub-optimal use of scarce resources i.e. waste limits the allocation of money to alternate priorities.

The main problem across hunger, warming and education is global inequity between let's say Central Africa and Central Europe, more hunger, more environmental damage and less education there! Public Health has the instruments to analyse this and the experience to implement interventions. We have to take responsibility and not to restrict our profession to the classical fields of hygiene or the epidemiology of risk factors.

Isn't it that to what Andrija Stampar referred to, more than 80 years ago in his 4<sup>th</sup> principle, describing the physician or let's say the public health professional as a social worker? *Or as Salomon Neumann a Jewish physician in Berlin end of the 19<sup>th</sup> century and close colleague of Rudolf Virchow put it: Medicine is a social science.*

Isn't it that to what Andrija Stampar referred to in his 6<sup>th</sup> principle asking for "No Difference" between the rich and the poor in matters of national or let's say nowadays global health?

And, isn't it that to what he referred in the 10<sup>th</sup> principle, demanding from his colleagues to go out where the people are and not to wait in their offices?

The last two months I worked in Bulgaria in the framework of the Decade of Roma Inclusion 2005-2015, a programme of the European Commission. I was not aware before, that in the European Union there live up to 10 million Roma and Scinti, mostly at a very low socio-economic level, without adequate access to employment opportunities, to health care, to education and not acknowledged as national minorities in several countries i.e. without formal rights as a people. Injustice is right on our doorsteps! Since 1994 I have been almost every year in Palestine; I had the pleasure to see the Al Quds School of Public Health growing in East Jerusalem, Ramallah and Gaza and I had the depressing experience to see the anti-cyclic developments over the last years when bridges between the two people there were destroyed and walls built. Doesn't this pose challenges also for Public Health?

Shortly after the devastating nineties in South Eastern Europe we began to work together and have shown since that Public Health has the potential to overcome deep historical abysses. In the meantime our network of public health institutions is well established, now as the Forum for Public Health in South Eastern Europe ([www.snz.hr/fph-see](http://www.snz.hr/fph-see)). I remember the famous Skopje Conference on Public Health and Peace in December of 2001 and its Declaration (CMJ 43/2, 2002) which later has been adopted in full length by the World Federation of Public Health Associations ([www.wfpha.org](http://www.wfpha.org)). Also personally I was moved very deeply by the first visits of Croatian and Slovenian colleagues in Belgrade and of Serbian colleagues in Tirana. Later such visits became routine when our Albanian colleagues visited Belgrade or Skopje repeatedly and all of us met in Tirana or Skopje or Zagreb or Ljubljana or Podgorica or Belgrade or Bucharest or Sofia and many other places including Sarajevo, Chisinau, Plevna, Varna, Athens, Dresden or Luxembourg. Forgive me if I do not list all the names of my colleagues in South Eastern Europe whom I became

friend with, as such an evocation would take much more than the few minutes given to me. I receive the Andija Stampar Award not for myself but for all of them.

So far with support from the Stability Pact funded by Germany, our network published 5 teaching books in English of 500 to 800 pages each displaying between 25 and 50 modules authored by all of my colleagues in South Eastern Europe and in Germany, the latest book this year on Management in Health Care Practice. So you can see their names at the ASPHER booth here in Lisbon. In addition all books are accessible as full text at the network's website. The rationale was to provide to all the lecturers in the newly independent and post-communist states guidance to teach modern up to date Public Health. The network has also been involved in the establishment and functionality of many New Schools of Public Health and Master of Public Health programmes in South Eastern Europe.

I am very proud on our achievements but I am also very grateful to my colleagues and friends for their open minded cooperation with a German University, which after all what happened during the last century may not always have been self understandable. Last but not least I have to thank my Co-Principle Investigator Prof. Luka Kovacic, ASS in Zagreb for cooperation and friendship without any shadow throughout 8 years.

Nevertheless I want to take the opportunity to transmit also some critical observations on international networking, cooperation and coordination:

Networking at the national, European & global level is a fact and a must to solve problems of interdisciplinary, multi-professional and participative character. The still relatively weak status of Public Health work can only gain from internationalization. However, there are limitations and risks also. We can today observe a mushrooming of networks in the non-governmental as well as in the state sector but capacities are limited vis a vis a complicated and time consuming communication process, leading to impairment of implementation, to compromising and to postponement. I refer here to the proposal to create a Committee C at the WHA as a forum for the coordination of global initiatives and NGO's as well as multinational organizations. A similar attempt to improve coordination is the so-called basket funding as e.g. in Tanzania or in Bangladesh, a common basket of several donors.

Especially in the indispensable state sector knowledge and skills to secure coordination and collaboration in Public Health are limited. The temptation to accept international aid without conditions on the side of the beneficiary often disrupts national priorities as is the case if money comes too easy as in some EU funded programmes. With regard to loans especially of the World Bank - though at low interest rates - they often put an underestimated burden on later years. Loans especially have two sides: Money now - repay later (especially if by others, i.e. taxpayers in the next generation). In addition the money goes (via expert fees) mainly back to the crediting countries and the resulting question is (too rarely asked): Is the long-term outcome worth the (national) investment? The answer depends also on the structural sustainability of projects which in the majority of projects is impaired by the limited funding perspective of 2 or 3 years and disconnection of potential follow-up projects.

As I repeat the coordinative capacity at the national level (esp. in developing and

transitional societies) - as I repeat - is often very limited. Globally: 280 agencies, 242 multilateral funds, 24 Development Banks, 40 UN Organisations, and 1000s of NGO's can be identified, thus e.g. for East Timor (1 mio population) more than 1200 donor initiated studies (Spiegel 40/2008:42-44; 29.09.2008) or 1 study in average for less than 1000 inhabitants. That is a better coverage than the number of patients per doctor in many rural regions in the world. Is health the objective of international networking? Very often political and financial interests are dominant! So let us take responsibility for Global Public Health but be not naïve!

I am very grateful for receiving the Andrija Stampar Medal serving ASPHER since 1991 as member of the Executive Board and as president. I am moved as much as I have not been, since the first medal was awarded at the Annual ASPHER Conference in my professional home-town Bielefeld/Germany in 1993 in the presence of Andrija's grand-daughter, coming from Zagreb for this occasion. The Recipient at that time was Leo Kaprio from Finland and I am honoured to stand in his succession.

## Attachment 2:

### PUBLIC HEALTH AROUND THE WORLD

Public Health Executive Agency (PHEA) of the European Commission and Forum for Public Health in South Eastern Europe (FPH-SEE):

Conference on Professionalisation and Capacity Building in Public Health in South-Eastern and Eastern Europe: The Legal and Educational Framework

Luxembourg, 20/21 February 2008

#### Background

As a consequence of its inclusion in the EU Treaty (art.129 of the Maastricht Treaty and later art. 152 of the Amsterdam Treaty), public health is rapidly gaining prominence in European public policy domains. The increasing importance of preparedness for major health threats, the growing recognition of health as an important resource for economic growth and sustainability, and the rising awareness that important health inequalities in Europe are powerful driving forces.

Still many EU Member States and Candidate Countries have insufficient institutional and professional capacity for public health. Their process of reforming the relevant services is slow. Compared to the USA, other industrialized countries, and a few emerging economies such as Brazil, the relative lack of public health capacity in the EU is striking. The field of public health is at a crossroads, compounding the problems. Referred to as the “Third Public Health Revolution”, public health is undergoing profound changes: Goals: from the reduction of disease and mortality to the increase of healthy life years and reduction of health inequalities.

Approach: from a top-down prescriptive, administrative approach based on a knowledge transfer model to a participatory approach characterized by multi-component solutions addressing multiple causes at the socio-economic, environmental, and individual levels.

Actors: professional experts and decision makers are no longer the only relevant actors in dealing with population health, but are joined by a multi-disciplinary group including researchers, institutional decision-makers, professionals, civil society, and the private sector.

#### Recommendations

##### (1) Strategic Framework for capacity Building

1. Public Health capacities should be health oriented rather than disease oriented.

2. It is important to develop a strategic plan for capacity building for public health in Europe, starting from a SWOT analysis and defining specific capacity building objectives and targets.

3. Targets for a strategy to strengthen public health capacity should cover all five areas of current conceptual models of public health capacity building:

Organizational development,  
Resource allocation,  
Workforce development,  
Partnerships,  
Leadership.

4. Workforce development should be considered the highest priority, but other capacity areas/problems need to be developed/solved.

5. Perspectives and expectations of public health from other sectors and policy areas should enrich capacity building and lay out a basis for health in all policies.

6. A “Public Health Identity” needs to be constructed, reflecting the diversification of professional functions in public health while reconciling them as they are shared.

7. Develop an EU Framework of public health competencies.

8. The strategy for capacity building in public health needs to consider horizontal and vertical aspects: it must address all levels of government and administration (supranational to local), all domains (private, civil society, public, etc).

9. The pace of strategy development for capacity building must fit with the national context, proceeding in a measured way.

10. The EU needs clear leadership in public health.

(2) Legal and organizational framework

1. Common law can provide a general framework for public health, while specific laws can cover more specific and practical issues—public health functions to services. The decision on the necessity to have common laws, however, lies with the Member States.

2. There should be a division of responsibilities and roles in public health functions between higher and lower levels of authorities. The State, centrally, should deal with legal issues of public health, for example, quality improvement for health or health reporting to international organizations. Public health policy formulation, standard setting and the main regulatory tasks should also remain at the national level. Specific aspects, as in environmental protection should be at the local level. Budgeting for public health actions should be obligatory at all levels. Civil society and the community can support good governance for the

public health at the state level. If a Bismarckian model is the main model of health care financing, health insurance entities should bear responsibility for public health as well.

3. The connections between academic institutions and public health institutions, and between research and preventive interventions should be strengthened, for example, to decide on interventions on the basis of cost-effectiveness studies.

4. Individual health care is the responsibility of health care services (including different specialists in preventive programs such as immunizations, early detection of diseases, etc). Public health should be responsible for managing, monitoring, and reporting health services data on quality and efficiency focused on population-based approach.

5. There is a need to advocate more widely for population health, and particularly for ways to address social and economic determinants of health, and to bridge the gap between different sectors that are important for public health. Health information management and continuous quality improvement must be emphasized as core elements of the new public health.

6. There is a need for careful planning of human resources for public health at national and local level. Staffing and institutional policy in public health should become more integrated. Professional development of public health staff needs to be attended to, including incentives schemes for staff.

7. The EU policy framework provides an important incentive to build organizational, legal, and institutional capacity for public health. Unlike other countries or entities, the EU has declared that public health is important and has defined the common principles and values of universal access, solidarity, and equity. EU legislation is also an important consideration in the process of harmonization of the basis for public health actions, in the sense that the legal framework on public health is part of the *Acquis Communautaire*.

### (3) Educational Framework

1. Academic institutions providing training in public health face the challenge to integrate medicine and social sciences into public health studies.

2. The Bologna process provides a framework to reform the public health training curriculum. The majority of representatives of faculties from SEE countries have already started or are preparing programs fully compatible with the Bologna process (BMD-three layer system allowing mobility among fields).

3. Public health topics, views, and experiences should be included in medical studies and placed in the curriculum from the very beginning. A 10%–15% proportion of the overall teaching should become a target.
4. Public health curricula need continuous improvement according to needs, they should come in modular format, offering major/minor choices.
5. Research methodology should be taught from the first cycle (undergraduate or bachelor level) onwards, and further theory and practice be integrated in the curriculum. Requirements for faculty members should be of highest level of teaching and scientific/research competency.
6. Intra and interuniversity cooperation is crucial in organizing public health studies and should be facilitated within universities, at national and international level.
7. Public health programs should be organized as academic programs with all three Bologna cycles. They are not in competition with lifelong learning and professional training.