

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA



ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

*Health Educ. Methods
...
In for Services
on 20/11/83 - Lisbon*

INFORMATION AND HEALTH

Policy, pressures and the public

Report on a WHO Working Group (II)

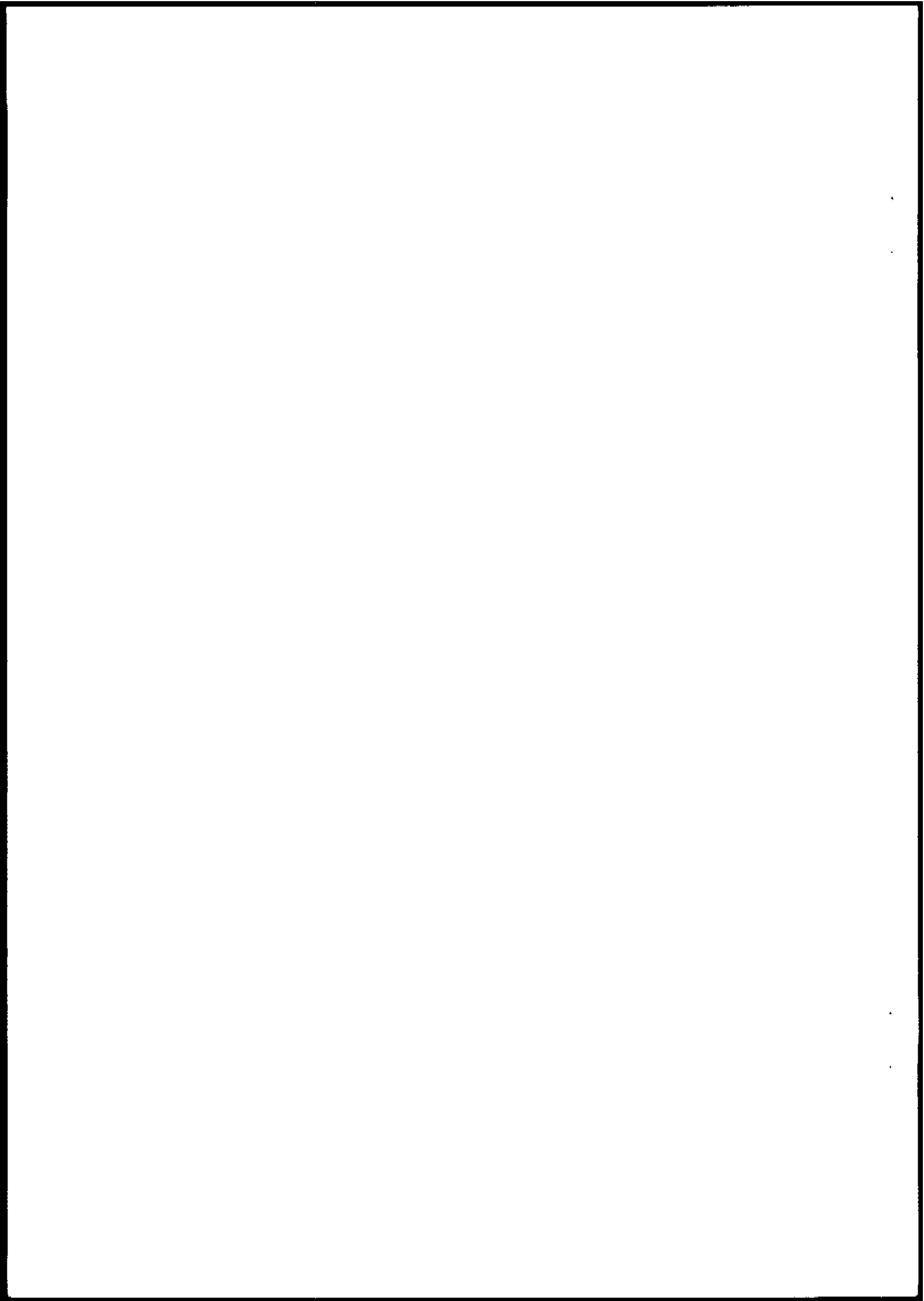
Lisbon
20-22 April 1983

Note

The issue of this document does not constitute formal publication. It should not be reviewed, abstracted, quoted or translated without the agreement of the World Health Organization. Authors alone are responsible for views expressed in signed articles.

CONTENTS

	<u>Page</u>
1. Background	1
2. Health themes of tomorrow	2
3. Explaining health policy in an international context	3
4. Pressure groups and their impact on information work	6
5. Explaining economic constraints to the public	9
6. Information policy of the Regional Office for Europe: its present programme and the outlook for the future	14
7. Conclusions and recommendations	15
Annex 1 List of participants	17



1. Background

The first Working Group on Information and Health, held in Luxembourg in November 1980, attempted to outline a framework of common interest for national health information officers in the European Region. It reviewed information approaches to the goal of health for all by the year 2000, taking into account such factors as the emergence of pressure groups, the impact of increasing costs on health structures, and the rights of patients to information and to a say in decisions affecting their health. It focused attention on new techniques that would make public information more effective in the health field.

The second Working Group was held in Lisbon, with the assistance of the Government of Portugal, from 20 to 22 April 1983. It had three main purposes:

- (1) to acquaint the 18 participants, who occupy key positions in the media, health ministries and international organizations, with the aims of WHO for health for all by the year 2000 at the European level;
- (2) to obtain the professional advice of the participants on the public information programme of the Regional Office at the national level;
- (3) to examine relevant issues in the field of health information, such as the emergence of pressure groups and the impact of economic constraints on national health information policy, in such a way that the participants themselves and the Regional Office can benefit from the experience.

The Lisbon meeting was also intended to suggest practical steps for the implementation of the recommendations adopted in Luxembourg. Five subjects were discussed by the second Working Group:

- health themes of tomorrow
- health information policy in an international context
- information policy and group pressure
- explaining health in times of economic constraint
- WHO regional information policy.

Participants were welcomed to the meeting by Dr Luis Magao, Director of the Office of Studies and Planning in the Secretariat of State for Health, Ministry of Social Affairs of Portugal. Dr Leo A. Kaprio, WHO Regional Director for Europe, sent a message to the Working Group.

Dr F. Cabrita Matias was elected Chairman, Mrs J. Hewlett-Davies and Mr C. van Hoewijk were elected Vice-Chairmen, and Mr A. Curnow acted as Rapporteur. A list of participants appears in Annex 1.

In his opening address, Dr Magao said that the purpose of the meeting was to ensure that all interested parties were properly informed about the objectives of WHO in its strategy for health for all by the year 2000, and to permit an exchange of ideas on the provision of health care, particularly in times of economic constraint. The steady increase in the costs of health in all countries had become a major problem for the managers of institutional health systems. For this reason, adequate information both for the public in general and for the users of health services had become essential to the success of the WHO strategy. Care had to be taken, however, to see that the information given was not tendentious and that the media were not subject to manipulation, whether by economic, governmental or "benevolent" agents.

As independent experts, the members of the Working Group had standards of professional ethics to guide them in analysing the growing influence exercised by pressure groups, and in suggesting ways in which the media could avoid being misled by information that was not scrupulously objective or realistic.

The Working Group could also point to ways of improving the information offered to those who received health care on both the limits and the possibilities of medicine, and could certainly create a better understanding among the providers of health services of the economic and social aspects of these services.

In his message to the Working Group, Dr Kaprio said that WHO would pursue the goal of health for all by the year 2000 in a climate sympathetic to the world's media; the Organization's doors were open to those who sought to report on its activities. The media influenced both policy-makers and the public. They could be both directly and indirectly instrumental in changing health conditions in Europe for the better by the turn of the century.

WHO saw the main functions of the media as:

- to create awareness and political good will;
- to help set social norms involving good health behaviour;
- to inform decision-makers of the latest developments and the potential limitations of health services;
- to help deliver health messages (for example, through entertainment programmes); and
- to stimulate community involvement in health issues.

Lifestyles and the environment in the year 2000 would be determined by the way in which Europe tackled the issues of health and related economic and social problems. He commended to the study of the Working Group the publication Health crisis 2000^a which the WHO Regional Office for Europe offered to the media and the public as a dramatic way of considering the issues.

2. Health themes of tomorrow

The media should debate the realism or otherwise of the goals in various health fields outlined in the document Targets in support of the regional strategy for health for all by the year 2000,^b issued by the WHO Regional Office for Europe. This document seeks to give the media information of a kind they understand and can use, in terms of targets for life expectancy, the prevention of chronic diseases, special care for high-risk groups, to name but a few. The document may help commentators on health questions to take a less pessimistic view of the issues involved and of the health outlook in general.

While it is desirable to discuss in Europe the responsibility for dealing with the health problems of other continents and related information activities, this is quite different from discussing European health problems and information work. The Working Group therefore agreed to discuss health problems that principally concerned Europe and corresponding information activities.

The discussion revealed that the importance attributed to immunization varies among European countries, and its relevance as a central issue of a debate on health themes of tomorrow in the regional context was questioned. Immunization could nevertheless be critically important to the realization of health for all by the year 2000.

Vaccination programmes are very important in Spain where considerable effort in immunization is still needed to eradicate or control certain diseases. In the United Kingdom, it is not true to say that journalists are not interested in immunization; they are very interested in what has gone wrong. Concern about vaccine damage has had the effect of reducing public support for vaccination programmes, as in the case of pertussis. It is a problem for health information specialists to combat apathy about vaccination as the idea spreads that a particular disease is no longer a daily threat.

Health information specialists could have a considerable role to play in shaping the health policies of tomorrow and in communicating their significance to the media, but they should by no means be put in a situation where they replace policy-makers.

Other major issues that will occupy health information specialists in the years to come are the lifestyle problems that lead to cardiovascular diseases and cancer and those that affect mental health. A major challenge will be the containment of problems in three areas: tobacco, alcohol and drugs. It is more realistic to speak of containment than eradication. None of the health problems arising from tobacco, alcohol or drugs will be wiped out in the lifetime of today's adults or of their children.

One of the major problems will be the treatment of casualties of current lifestyles, and within the concept of containment there must be policies for their treatment. There has, for example, been no improvement in the treatment of lung cancer over the past 20 years and the lung cancer death rate will increase. Before 2000 in the European Region, there will be more than one million deaths from this disease alone. All the victims will expect treatment. This is a challenge that must be recognized and to which responses must be found.

^a O'Neill, P. Health crisis 2000. London, William Heinemann Medical Books, 1983.

^b EUR/RC33/9 Rev.1.

In spite of all the discussions about the rising costs of health, the problem of expenditure obstinately remains. In the debate on the containment of the consumption of health services, and therefore of costs, it must be recognized that some of the demands are not justified. This requires a change of attitude that is not easy to achieve but vitally important.

Health policy provides the starting point. In all European countries there is an awareness that a great deal of money is spent on official health systems and doubt that value is being obtained. It was suggested that journalists have no way of measuring progress in relation to goals in health programmes or of judging whether huge sums of money are being wisely spent. Consequently, they write about questions such as the use and misuse of drugs, but do not concern themselves with health policy. Real health information would be interesting to the public, but without clear health policies there can be none.

Journalism as a means of transferring new ideas or of questioning existing courses of action has a role to play in influencing health policy, but it is difficult to discern any pressures from the media for change and improvement in health policy.

On the whole, however, health issues are generously treated by the media; there should be no complaint about the amount of material published on health. The problem lies in knowing what international organizations and governments want from the media.

Journalists are not social workers. They would lose their independence and credibility if governments and international organizations so regarded them. The press reacts to, comments on and evaluates ongoing activities. Journalists, nevertheless, could help governments and agencies to find the right subjects to "sell".

"Saleability" may not be the proper criterion for themes that deserve to be incorporated in health information and education programmes. It has been said that the important question is not that of selling some kind of information, but on generating information that someone will want to "buy".

There are major problems in persuading people to accept personal responsibility for their health and wellbeing, but it is the key to creating an interest in reducing the incidence of disease and in health for all.

Journalists could help to mobilize the public in favour of better lifestyles, and the prevention and early detection of disease. They could improve public awareness of addiction, accidents (road, industrial and domestic) and modern diseases (cancer, cardiovascular, sexually transmitted) in particular. Although the press has a behavioural influence, health information officers must take it as it is, and not as they would like it to be.

The questions of wellbeing and self-improvement - the development of leisure, health at work and issues related to unemployment - are also themes that deserve attention in health information. In preventive medicine, interest in the issues related to wellbeing will be very important in the coming years, and it would be impractical not to discuss them under health themes of tomorrow.

3. Explaining health policy in an international context

Social policy, of which health policy is a part, covers the whole range of advantages and disadvantages dealt out by government to each segment of the population. Setting policy entails weighing these advantages and disadvantages and trying to strike a positive balance. A policy aimed at economic or political benefits may have social costs. Even an apparently benevolent social policy may have unintended consequences leading to increased social costs in a segment of the population.

Policy-making is not merely the introduction of new forms of service or benefit to provide a basic solution to a problem. Rather it is a process leading to continuing evolution. The essential catalyst is evidence of effectiveness. Thus, it is in large part a process controlled by the experience of those who have the power to mould policy. Scientific evidence is an increasingly important output and is now central to any discussion of the evolution of policy. Therefore, the communication of scientific knowledge to policy-makers (and consumers) is of paramount importance.

Decisions are taken by politicians, and anyone who tries to influence the making of policy has to recognize that the politician, as a policy-maker, has motives. These motives have to be taken into account in evaluating whether a course of action is good or bad. Those who see their role as influencing policy-makers have to exercise courage: they have to be able to tell policy-makers things they do not want to hear.

In dealing with the media, both courage and circumspection are required. The objective is not to try to control information, but to present it accurately. Journalists want more than facts. They want to understand the philosophy, environment and motivation behind the facts, to help them to a sure interpretation of the reasons for action. Press officers and journalists are links in the same chain between the government and the public. They serve as part of a two-way channel of communication between policy-makers and the people for whom policy is made.

The dilemma of those who try to translate research into health information was mentioned. Presentation requires clarity, simplification and precision, but simplification must not entail the polarizing of issues.

The question was raised, "Why is there no independent critical journalism on health issues?" There is a need for it because WHO speaks of alternative health policies in a very general way and national governments are under so many constraints - financial, pressure groups, etc. - that alternative ways must be found to put the issues before the public. One view of the official position was that WHO could not impose objectives on its Member States and could not go further than to lay down fairly general precepts. The job of health information services is to enable media representatives to do their work in the way the latter see fit. Confidence in the expertise of journalists, as presenters of facts, is essential. No organization should try to manipulate journalists or tell them what they should do. Information should be presented modestly and correctly. The less abstract the subject matter, the more pleased the representatives of the media will be.

To what extent is health policy deliberately and objectively created? In countries where governments are responsive to pressure groups, it can be postulated that there are no policy-makers. Health policy has a "weather-vane" quality, related to capricious consumer requirements, and consumers want health presented in an entertaining way. Health goals are nonspecific and subject to fashion, which gives health journalism a quality of high-level gossip without serious discussion. As very few people in health education can describe the circumstances in which they achieve their goals, can journalists be expected to analyse aims or policy? There is nothing external to measure them by. In these circumstances, analytical reporting is hardly possible, and the public is treated to simplified, dramatized and ultimately trivial reporting. This is due to a consumerist approach at the political level. The future of health is not being planned on the basis of research or even on the basis of what people want. Journalists cannot be "recruited" to help carry health policy to the public or to be involved in more than a popularization of health information because they do not know what the aims are. Health for all creates a frame of reference, but the problems are not defined in sufficiently concrete terms.

National experience was cited to show that journalists are interested in the evolution of health care systems. If they are interested in health, they must be interested in the context, and if journalists continue to put questions to WHO, the organization will finally produce the information they want to use. They are interested in international comparisons that make a major contribution to the understanding of health issues. When a journalist does not bother to put good questions, it is because he senses a lack of transparency. Either he does not expect a reply or he does not care to receive one that is dressed up.

Information officers cannot be expected to act as agents of change in systems, establishments and policies, but journalists are not forbidden to think in alternatives. The press has freedom, but is not using it in the health field. Critical journalism has helped to change education and transport policies, but critical journalism does not seem to exist in the health field. WHO needs critical journalism on primary health care issues, yet journalists are not looking for answers to the questions about what must be changed.

The problems, for health information officers and for journalists, of handling alternative medicine were mentioned. Alternative medicine and alternative therapy have become fashionable. This makes good copy for the press, but there are pitfalls. Some practices are harmful and can kill people and should be exposed. On the other hand, giving objective information on alternative medicine is difficult. In France, however, a consultation was arranged recently between all partners to the discussion on alternative cancer treatment. They were forced to face each other and arrive at a re-evaluation. Given political courage, results of this kind can be achieved.

There is a tendency for official agencies to think of the press as a whole rather than to consider the requirements of individual journalists. There are many different specialists, but are the agencies cooperating enough with the various departments of the media and thereby reaching more people?

The qualifications and imperatives are the same in health journalism as in some other fields. In France, for example, there is cooperation between the medical pages and others dealing with cookery and beauty. There is a three-week training course offered by the National Association of Medical Journalists for colleagues outside the health field who want to learn about health journalism. It was suggested that WHO could prepare information material for columns other than those dealing with health. Other interdisciplinary approaches are possible. In popularizing seat belts, for example, or in campaigns against smoking, an effort should be made to influence light entertainment and television plays to show good practices.

In 1977, the Organisation for Economic Co-operation and Development (OECD) published Public expenditure on health in a series of studies on resource allocation. The report deals essentially with the major economic implications of increasing health expenditure. It begins with an overview of the levels of spending on medical care in different OECD countries, distinguishing the requirements of hospital care, medical services and pharmaceuticals. It examines some of the factors underlying the rising trend in health expenditure and seeks to assess the effectiveness of the expenditure in relation to public policy objectives in health. Publicly financed health in the OECD as a whole accounted for about 4.5% of GNP in 1977. This has risen to about 6% today, and strains visible six years ago have greatly increased.

The resource constraints being experienced by so many governments must lead to greater precision in the choice and fixing of objectives and in the cost-benefit equation. An updated and expanded OECD health study, provisionally entitled Expenditure on health under economic constraints in the OECD area, should be issued sometime in 1984. The new study, covering the period 1960-1981, will be a comprehensive source of information on health in the OECD's 24 member countries. It will include comparisons of mean lengths of stay in hospital by illness, average numbers of patients per bed per year and doctors' earnings.

Such cross-country analyses of policies, as well as cost and resource data, are one of the major information contributions that can be made on the international level. They also show how the less developed can learn from others further ahead in the field. Such studies inform and help the media as well as policy-makers, for whom they are originally compiled, to look at the resource allocation dilemma of today. All informational inputs that heighten public awareness of the issues and choices facing governments and policy-makers are to be welcomed if they help gradually to remove inefficiencies, waste and misallocations.

Policy-making is an evolutionary process that requires a model. Although it is possible to influence attitudes that in turn influence behaviour, and in so doing identify objectives, the changing of attitudes does not necessarily change behaviour. It is useful to inquire into the relationship of research to policy-making. The policy-maker who says, "Don't bother me with statistics or information; just give me conclusions," is a familiar figure, but what is the relationship of research, and the information gained from it, to policy-making? Is it direct or indirect? If direct - and this is seldom the case - the timescale and research has to be compatible. The influence of research on policy is usually a long-term affair. If an activity is identified as beneficial, political pressures may grow behind it. In such cases, a decision may have to be taken irrespective of the rate of advance of the relevant research because opinion has moved more rapidly. Furthermore, resources are sometimes greater for research than for the application of its results, and the quality of research is sometimes judged by the degree of satisfaction brought by the answer.

There is, in fact, no straightforward link between research and policy-making. Rather, there is an indirect relationship between a body of research and a body of policy-making. This implies a need for greater freedom of design for research and for research workers, with fewer time constraints. It is necessary to maintain a level of capability in research activity generally rather than in finite projects. In considering the effectiveness of research in terms of policy, the increasing importance of unintended consequences has to be taken into account. Health policies reflect the sum of knowledge, attitudes and behaviour that is sufficient to bear on an activity and change it for the good of the community.

Health professionals cannot tell the medical profession what to do. The situation is collaborative and not conflictual. The aim of discussion is to create the knowledge and attitudes necessary to bring about change.

There may be problems that call for courage on the part of information professionals in discussing alternatives to the established medical system as well as in the field of health policy. The established medical system has brought remarkable progress in the last three decades in dealing with the diseases of civilization. There have been enormous growth rates in health

systems, but no corresponding increase in value for money. This creates the need to discuss alternative systems, but the discussion generally does not take place in relation to concrete goals.

It was suggested that intergovernmental organizations interested in health were well placed to recommend that their member states modify their health and health information policies. These organizations often have privileged access to information and research results and could draw attention to experience and stimulate initiatives. Leadership and courage are to be expected of such organizations. Many of those for whom health policies are formulated are not capable of exercising personal responsibility or expressing views on health policy as it applies to them: the elderly, the mentally ill, the handicapped, babies, etc.

4. Pressure groups and their impact on information work

It is popularly supposed that pressure groups are a comparatively recent phenomenon, beginning perhaps with the environmental and consumer movements of the late 1960s and early 1970s. Although that was the era of the creation of large, well organized bodies whose sole purpose was to lobby for specific ends, no one concerned with public information can doubt that there have long been groups bringing pressure to bear, in various ways, on official bodies in an attempt to influence policy decisions, expenditure and the setting of priorities.

Those who work for governments have long expected pressure from politicians opposed to the government of the day and have become accustomed to the pressures of industry, commerce and the professions. Every policy welcomed by one group will be criticized by another that feels it has been less generously treated.

The change lies in the fact that these groups have learned to exploit the media much more cleverly. Some do so with subtlety alone as their weapon, others with the backing of large financial resources.

The pressure group is likely to have a narrow field of interest on which it can concentrate, while information services cover a wider field and have to reconcile conflicting interests. The pressure group exists to be articulate and forceful. This is also true of public information officers, but the latter's efforts are often dissipated by their wider range of interests. When a group is fighting for the retention of a single hospital, it can cite the possibility of the death of a few identifiable babies or sick people. The official response can only describe the needs of an entire population, which may be sound and sensible, but it cannot touch the heart.

The pressure group can weigh its evidence. It does not have to distort facts, only to present them in a way that aids its single cause. Information officials cannot present facts selectively because this would damage the credibility that is their chief asset. It is not credible to present facts in different ways to serve different ends.

Most information officers deal with press and other media who are anxious to assert their independence. It should not be otherwise; a free press is important to democracy, and information officers exist because of the need for democratic accountability. The job is certainly made more difficult by the knowledge that the media tend to favour the views of the pressure groups because they seem to be less tainted by bureaucratic or political considerations.

There is a constantly increasing need for advocacy to accompany straight, factual information, and pressure groups increase the tendency of the media to force information services into an adversary position. This affects both what information services say and the way they say it. It makes credibility more difficult to sustain.

It is fashionable to promote "open government" and "freedom of information", but the resulting difficulties must be accepted. The more plans, policies and philosophies are revealed, the more ammunition is given to opponents. Consultation is rarely a dialogue of like minds. It is more frequently a babble of conflicting needs and aspirations. To make a contribution to the search for solutions requires the exposure of conflicts.

The journalist, like anybody engaged in dispensing information, is in daily contact with pressure groups that endeavour to sway him in the same way as they try to sway others. It is all too often forgotten, however, that the journalist is himself a fully fledged member of a socio-professional group engaged in constant pressurization. The basic question is thus not how the professional journalist can be made independent of pressure groups, but how to maintain equilibrium among the various forces exerted, so as to arrive at a sort of isotonic stability. Pressures on journalists cannot be qualified as being either good or bad. The universe is governed by the laws of action or interaction and pressures are essential to all progress.

Moreover, the present social, economic and political setting is bound to intensify pressures, regardless of their origin or intended point of impact. The greatest danger is not, in fact, having too many pressure groups but having too few. Such groups are an integral part of any democracy. At the same time, their plurality must be protected, because the moment there is only one kind of pressure, the phenomenon will begin to be disquieting or dangerous.

It is important to distinguish two types of pressure: positive (or challenging) and negative (e.g. the withholding of information). Both forms of pressure are all the more insidious for being less obvious, but they must be all the more determinedly resisted. The journalist must have the right of access to sources and must be guaranteed the right to check facts and to follow up leads. Where professional bodies exist and are strong enough to fight back, they must do so or else this must be done by legislation. Within the journalistic profession, however, there is general agreement that pressures exerted on journalists are part of their daily round and that it is up to each journalist to fight for his independence and professional integrity. For the rest, the countervailing pressures cancel one another out; this is the balance that has to be maintained.

When pressure groups active in the health field are discussed, a subtle terminological distinction is sometimes drawn between those that the speaker regards as forming part of the "establishment" and those that he does not. The former are described as constituting a "lobby", representing a valid interest, even if their case is sometimes pressed too hard or in an unreasonable manner, while the latter, described as "protest movements" or "agitation", are regarded as potentially suspect in their motives. There are, indeed, cases where a line can be drawn between the two, but the distinction could be dangerous.

The pharmaceutical industry, like the tobacco and alcohol industries, is a typical large pressure group within the establishment. As with other industries, its lobbying activities raise some major problems of principle. The industry is heterogeneous in its standards and its ethics, but its lobbying is monolithic, i.e. it acts inter alia on behalf of companies that do not sufficiently respect scientific or ethical norms. The sheer size of the lobby can result in a serious distortion of the picture that society forms of the industry and the way it functions. An adequate counterbalance to its activities is needed. While emphatic presentation of correct information is the technique most usually involved, rather than distortion of information, the data provided can be so misleading in their selectivity that objective proof of their misleading character is possible and correction can be demanded. Investigations sponsored to obtain specific data are usually designed to illuminate only questions of concern to the industry. Suppression of unwelcome information can often be documented. Lobbying via third parties (such as cover organizations or individual physicians) is increasingly common, while economic pressure is used on a large scale to direct the information flow in a manner favourable to the drug industry, such as by selectively supporting with advertising and page subsidies those journals that present an uncritical view of the industry.

Of course, the drug industry is necessary and has a serious purpose to fulfil, but its lobbying creates problems. It has created the image that those who are not for it are in opposition. Since the drug industry is necessary, both from the research and production points of view, anyone who questions its activities tends to be labelled as an enemy of society.

On the other hand, lobbyists against the drug industry sometimes try to reap the benefit of unfortunate incidents or to exaggerate their claims. They are sometimes motivated by political considerations. The documentation produced by these groups is sometimes inaccurate and may be no less selective than that provided by the drug industry to support its case. The accusation of political motivation can, indeed, be documented.

It is hardly possible to envisage the creation of any mechanism by which pressure groups can be called to account for the correctness and balance of their information, but there are certain practices that can objectively be documented as inadmissible. Something would be done to counter them if society were made more aware of the fact that these practices exist and that official agencies scrupulously refrain from employing them. Would a published code of behaviour for official information officers and pressure groups not emphasize the point? One difficulty, however, would be the definition of "pressure groups".

Governments have in certain cases created pressure groups and spent money on them, although such organizations do not always support the government. The Health Education Council and Royal Commissions in the United Kingdom are examples. Governments sometimes use pressure groups to promote the adoption of ideas that are unpopular among their supporters. In a very broad sense, the provision of objective, factual information is a means of exercising pressure.

If the definition is made wide enough, however, to include official or semi-official agencies, a civil servant's own department could be considered as a pressure group. It could be inferred that there is no such thing as objectivity if government agencies and government-sponsored activities are included among pressure groups. They could be better described as interest groups seeking to influence the direction of affairs controlled by government.

A pressure group was described as "any group whose action is felt as pressure at the point of reception of its information". By this definition, WHO and some government agencies are pressure groups. Another definition suggested was "a group of people that tries to influence policy but that does not constitute an institution".

International nongovernmental organizations are sometimes influential pressure groups and a means of two-way transmission of information with intergovernmental organizations through both formal and informal relationships. Their publications can be useful channels of dissemination.

In fact, the defined limit of the pressure group can be set anywhere beyond those that are easily recognizable.

Pressure groups are a fundamental element of social action and therefore necessary. It is important, however, to have in the health field, as already exists in such areas as housing, transport and education, a balance of countervailing pressures.

It makes sense for information officers and journalists to be concerned with organizations that seek to do more than offer objective factual evidence. The problem is recognizing objectivity in the information presented by pressure groups. It is necessary to go back to the motivation behind factual, objective information. Objectivity is open to question when a spokesman is seen as representing a pressure group with a motive.

Pressure groups perform valuable services for journalists if the latter decide to take advantage of them. The media should challenge and test statements from governments and compare them with information from other sources, including pressure groups. In this sense, pressure groups represent an important dimension in the work of an official information officer.

It is necessary to recognize the good and bad aspects of pressure groups. Efforts should be made to combat action on their part that has a destabilizing effect. The risk of destabilization and manipulation always arises when the parties involved are observing different rules. An ethical code could be drawn up for the dealings of the media with pressure groups.

Double-checking information is sometimes difficult for journalists. If pressure groups were forced to disclose their sources of finance and statutes, it could help journalists to distinguish between pressures and establish the facts.

The key issue in the recognition of pressure groups is not their origin; some started as pressure groups, some have learnt pressure group techniques, and some are subject to pressure. What is crucial is to recognize the extent to which a group has open aims or hidden plans. Policy-makers and governments should ask themselves what is hidden.

A journalist can arrive at an objective balance of information through exposure to the views of various pressure groups. The risk, however, is that the information, boiled down to a consensus, will be called truth. Journalism would then amount to no more than a distillation of everyone's gossip. Investigative journalism should analyse the origins of pressure groups, their status and aims and, above all, their hidden aims where they exist.

Journalists are well advised to seek opinions on their own terms rather than on those of pressure groups. It is questionable whether truth and enlightenment emerge from the adversary techniques now employed. For example, it is very difficult at conferences to get balanced delegations, because industry can pay their way and the humanitarian groups cannot. This can lead to fuzzy or meaningless conclusions or recommendations that cancel one another out. There are also conferences that appear to attract considerable press interest, which turns out to come mostly from secondary journals, financed by industry.

From the journalist's point of view, the professional solidarity of drug companies ends when they begin to talk about individual products or groups of products. Their competition is a guarantee of the independence of the press. The subscribers are the address book of a journal, its support committee and its guarantee of freedom. There are independent and dependent persons in all professions, a fact that emphasizes the importance of ethics. One way for a journal getting most

of its revenue from advertising to resist pressures is to tell advertisers who complain about the editorial content that, if they withdraw support, their competitors will be happy to take their place.

Journalists are habitually critical, but continue to be invited regularly on all sides. The weight is not all on the side of industry and government in the health sector. Some countries have organizations of health "consumers", e.g. patients with diabetes and cancer. They reduce the impression of one-way lobbying.

5. Explaining economic constraints to the public

The aims of a country's health care policy must determine its information policy on health economics. Information policy should serve these aims as effectively as possible. Information on health economics should make the public fully aware of the consequences of their actions for the health service, and therefore have a potentially important impact on the efforts to keep costs down.

An information policy on health economics should be based on the answers to the following questions.

- Which sector of the public is to be the target of information on health economics?
- What subject matter should the information deal with?
- What relevant items of information should be passed on?
- How is the relevant information to be passed on?

The answers to these questions depend quite considerably on the national character of the health service and the overall economic frame of reference. The structure of decision-making with regard to the health care policy of the country or region concerned is just as important as the economic situation and state of development, the attitude of the population, tradition and the societal functions connected with health.

The target public for information on health economics can be divided, generally speaking, into three groups:

- the consumers (actual and potential) of health services, distinguishing between payers of premiums, taxpayers and people paying directly;
- the suppliers of services concerned with health (not only the suppliers of curative products and services but also of preventive services, such as insurance, accident prevention, fitness clubs, etc.) plus suppliers of goods that are detrimental to health;
- the political decision-makers (governments, authorities, hospital directors, trade unions, voters, etc.) and the public who in reality are a heterogeneous group with very different interests.

The subject matter of information on health policy has aspects of macro-economics and micro-economics, as well as highly individual economic aspects concerning the people involved. The relevance of information depends on the target public and the subject matter. Information of a macro-scale is often presented to the public without any attention being paid to the way in which such information may be translated into reality for the individual in terms of health economics. Information regarding health economics should serve as an early warning system and as an aid to decision-making for various groups of the public.

The information manager seeking to promote the development of the public health system should try to orient information policy in the first place towards the decision-maker. The spectrum of decision-makers consists of:

- active voters
- political parties
- organized interest groups
- associations
- members of parliament active in health politics
- members of the executive authority in public health.

As decisions concerning health and health policy are taken not only at the formal level of politics, a national and international information policy has to include many other decision-making groups, such as physicians, hospital managers and hospital staff, pharmacists, members of other

medical professions, the pharmaceutical industry, insurance companies, other professional institutions in health care, scientists, planners and, of course, consumers.

All these groups meet in the market place for health care goods and services. Some essential characteristics of this market are:

- unclear origins, motives or funding;
- the strong position of the providers of goods and services;
- the weak position of the consumer;
- an almost unlimited demand for health services, often determined by the provider and dependent on chance; and
- coverage of costs by third parties and administrations that give consumers no incentive for economical (cost-conscious) behaviour.

Freedom of choice rests to a great extent with the supplier and only to a small extent with the consumer. The consumer has an element of choice at only two moments: when he decides whether or not he wants to see a doctor and when he decides which doctor (or institution) he wants to go to. After that, demand is determined in many cases by the providers (e.g. physicians). The so-called "over-consumption" by patients can often more correctly be described as "over-supply" by the providers. The latter would, however, point out that this "over-supply" is induced by an "over-demand" from patients!

Influencing the consumers first through information activities aimed at cost-containment and at strengthening health-related cost-consciousness is not a very promising strategy and could foster the attitude of "blaming the victim".

As health care systems become more and more of a general refuge for social problems, society will continue to try to solve nonmedical problems in a medical way. The more effective activities of all kinds, however - including those in information - could be made outside the purely medical "health care system". Medical care - and this is important to health information - should resume its proper place.

Since expensive additional capacity offered in the health care field is creating additional demand, and since there is more effectiveness in terms of better health investment outside the medical area, it is the supply side and political decision-makers that are to be aimed at in the first place with intensive information activities. The political decision-makers have to play their role in redirecting resources into sectors such as nutrition, education, traffic, housing, urban planning and culture, where better health and higher cost-effectiveness can be realized, rather than into super-specialized medical care systems. Promoting these necessities and giving information about the evaluation and results of investments could be important tasks in the health information sector.

To improve health and to find cost-effective ways of doing so calls for information about priorities, options and alternative methods. It also calls for information about cost-reducing measures, such as limiting subsidies or increasing the share of costs paid by patients, about promoting primary health care instead of increasing specialization or about promoting day hospitals, ambulant services, domestic help and better manpower effectiveness. Such information is needed by every group in the health care system with different emphases. Every group needs background information and common knowledge in order to judge facts and situations, as well as its own behaviour, as far as health is concerned.

Better understanding by the public, based on better information on financing procedures, could contribute to cost-containment. A system in which most of the costs are covered by an anonymous third party and where at the same time the suppliers dictate the market is financially weighted in favour of the zealous user of health services and the productive provider; on the other hand, it punishes those who take care of themselves or prevent illness, as well as the fair-minded physician who does not abuse his strong market position or who resists over-demand despite the risk of losing a patient in an unfavourable "market".

Some examples of necessary background information are:

- socioeconomic and demographic facts related to health care
- types and characteristics of service needs
- services and capacities available
- resources needed to produce each type of service
- costs evoked by the services
- the cost-benefit relationship of services
- ways of financing these costs
- new trends and developments.

In general terms and in terms of economic constraints, information should provide decision-makers in all areas with ideas and initiatives for better health and higher cost-effectiveness and should help them to determine and evaluate the consequences of their activity.

From the information receiver's point of view, an effective health information policy has to allow for the fact that the readiness to receive information is limited, and that the ability to digest it has been considerably strained. The quantity of information to be handled is increasing, and so is its velocity and frequency. This situation influences the filtering capacity of the information receiver. It obliges the information officer to:

- create motivation for the acceptance of information
- measure out and concentrate his information
- help in evaluation and in the transfer of the information into daily life
- inform selectively and in as timely a fashion as possible.

Much attention and effort are required to establish the framework of a particular information need. The need varies according to the scope and purpose of the decisions to be taken by the addressees. At the Swiss Hospital Institute, three tools have been developed to determine information needs on a continuous basis:

- the periodic organization of small group seminars to discuss information and documentation needs as well as internal information needs;
- a continuous evaluation of the daily press, periodicals and records of parliamentary debates and the compilation of the results;
- the organization of inquiries.

From these activities, a profile of each target group can be established as a working basis for the collection, selection, processing and transmission of information.

There are obstacles to short-term health improvements and cost-containment campaigns. There is the difficulty of delineating a valid cost-benefit relationship in most cases involving the individual behaviour of the consumer of health services; behaviour is often based on (bad) habits that take a long time to change; furthermore, "knowing" something and putting the knowledge into practice are different things. The obstacles to short-term cost-containment today are particularly evident in issues such as accident prevention, health education (e.g. antismoking campaigns) and fighting pollution.

Since short-term results are hardly achievable through information activity (however efficient), a long-term strategy is needed to strengthen cost-effective ways of thinking and methods leading to well planned and well organized decision and action in health care. This is why information on economics in public health is not only of concern to the mass media or to individuals or particular groups. It is also very much the concern of specialized and competent documentation centres that are able to collect, select, compile, evaluate and transmit information on a professional basis.

It is also absolutely crucial to integrate knowledge about health economics into general education. In this way, it may be possible to make knowledge and consciousness of health economics effective at all levels.

In focusing on economic constraints, projections are necessary. A national information centre (such as the Swiss Hospital Institute) has an important role in this respect: to monitor, and thus to act as an early warning system. As in political economy, it is appropriate to develop advance economic indicators in health politics and to provide information about them, so enabling decision-makers to act instead of just reacting.

Information activities aimed at coordination are also becoming increasingly important. For example, widely distributed and readable accounts of current research projects and decentralized statistics are important tools of coordination.

Data should nevertheless be treated with care. Quantitative data may easily impress, but sometimes they tell only half the truth. Qualitative criteria are often of equal importance in the sphere of health economics, as elsewhere.

Public opinion polls in the Federal Republic of Germany have shown since their inception that health is regarded as the most important aspect of life. There is evidence to show that other industrialized societies take the same view.

The interest in information on health is marked and increasing. The mass media acknowledge this fact and are doing their best to satisfy it. Practical health advice is given quite remarkable space in the press and on radio and television in the Federal Republic of Germany. On television, there are regular programmes on the new frontiers of high technology in medicine. Programmes of this sort tend to give weight to spectacular and unique medical achievements or totally new breakthroughs, and in terms of popularity they compete successfully with popular programmes shown at peak viewing times. Serious scientifically based medical journalism has high standards and is well accepted by the serious German press. Practical, everyday health problems and health advice, with special emphasis on self-medication, on natural drugs and psychosomatic questions, are a major traditional feature of Sunday newspapers, family magazines and the weekly press.

Thus, health is by no means an under-represented issue in general public information. At the same time, the detailed attention given to health cost-containment has not significantly affected the amount, shape or quality of this type of general health-related journalism.

In addition to more general health journalism, the number of specialized information campaigns or activities on individual topics conducted by health ministries, large health institutions and the wide range of health promotion agencies and groups has expanded considerably. The health information components of health education campaigns against smoking, alcohol, drugs and overeating have also increased enormously. In the Federal Republic of Germany, there is no lack of scientific research, political will or practical activity in educative health information. A wave of scepticism is mounting, however, as to the effectiveness and efficiency of such information campaigns (most of them lifestyle-oriented and centred on the individual). They are becoming a growing target for fundamental criticism, and with growing budgetary constraints, the willingness to spend still more money on these doubtful pursuits is diminishing fast. Qualified assessment of the usefulness of such campaigns or publicity efforts is needed.

The explosion of costs and their containment have attracted most of the political energy in the health field over the last few years and will go on doing so. Health policy information, if it exists at all, has concentrated almost exclusively on this aspect, especially in the Federal Republic of Germany where, by tradition, health policy is not generally centred on concrete health problems or well defined health programmes. As in many other countries, policy concentrates on providing an institutional framework for the complex interactions of doctors, hospitals, other health delivery agencies, health insurance bodies and others. The main issues of the resultant approach to policy are, for example, doctors' payment regulations and licensing criteria, hospital financing procedures, health insurance contributions or health budget growth rates.

Health policy information therefore seems to be heavily biased, and the emergence of cost-containment as the dominant policy issue has increased the already existing bias. Official statistically based health information systems seem to follow the same lines. Health policy information is basically not aimed at the broad public. It is aimed at a very restricted elite group of experts, policy-makers and administrators within and around the institutionalized health system. It fails to reach or touch the public in any meaningful fashion. It therefore does not help in creating the atmosphere, pressure or arguments for broad political discussions on health matters. Thus, although there may not be a general lack of health information, there is a remarkable lack of widely understandable and interesting information on health policy.

WHO's strategy of health for all by the year 2000, if properly adapted to the special circumstances of large parts of the European Region, could be a stimulus for substantial changes in this type of health policy and information on health policy on the basis of two assumptions.

(1) The strategy could and should reveal far-reaching health policy options, and thus significantly challenge the parochial, national traditions and day-to-day pragmatism that seems to dominate health policy thinking in even the most developed European countries.

(2) The strategy will achieve this only if it helps to establish concrete and publicly understandable goals for solving specific health problems (such as reductions in morbidity and mortality for the most prominent disease groups) or if it is able to combine these understandable and attractive goals with political instruments from the budgeting, planning and controlling sectors. Perhaps a new type of attractive and broadly understandable health policy could and should be supported by an appropriate health information policy that people would be interested in and journalists could reasonably be expected to have an interest in publicizing.

A reorientation of health policy, as envisaged in the strategy, requires a significant mobilization of the community, but people will not be very interested in proposals on new delivery systems and budget growth rates for their own sake. Unless campaigns show that primary health care is the key to practical improvements for the chronically ill, to better health services for children, to progress in preventive medicine or to solving other problems, information campaigns on the structural necessity and advantages of this concept will, in large parts of Europe, be of interest only for the ivory tower health services researchers or for major pressure groups with a biased interest of their own.

The question of cost-containment is taking up a large part of the political energy given to health, and this is likely to continue. There are three ways to face up to the situation:

- by introducing co-sharing systems, as a way of raising more money from the public;
- by having a proportional reduction in services; or
- by discussing, deciding on and implementing deliberate, substantive priorities.

The third alternative is one that few countries have tried. In a democratic society, such an option would be taken on the basis of broad public discussion and information-giving processes. This mechanism is wanting because there is a lack of true health policy without which health policy information is largely lacking.

Health policy may have one of the lowest rankings in government consideration in terms of the people chosen to create it and their relative power. There is a contrast between the high degree of interest in health and the low degree of interest in health policy. Policy currently has little to do with how people think when they are considering their health. This wide gap between health interests and policies could be bridged if policy were made more interesting, more political, more controversial and less the subject of compromise. A good press would follow automatically.

Journalists will only market information that is acceptable and interesting. They will not cast serious doubt on existing systems because the current pressure group constellation does not question such systems; a serious challenge cannot be expected from them. An ambitious engaged journalism, however, could sense the existing gap. Journalists have a social role to fulfil and the press is one of the few fields with enough freedom, engagement and intellectual capacity to bridge the gap between health interests and policy.

There are controversial matters in health policy that could become pegs for public debate and that are therefore of interest to the media, whose role is very important. Journalists have a duty to be sceptical and cynical and to engage in investigative and analytical reporting.

Economic constraints can be divisive. They can be used by governments and others as pretexts for withholding the best possible medical care. Is it not possible to take a more positive approach, to use a situation of shortage as the only means of driving policy into more logical paths? If governments choose to take this course, they can be certain of the hostility of certain groups - such as doctors and drug industries - but they can seek allies among the international organizations and in the conscious and responsive participation of the enlightened consumer or patient. Greater participation by the public is needed in the organization of health services.

Governments, however, are not yet so short of money that they are making comparative evaluations of high technology medicine on the one hand and community health projects on the other. The allies for change lie in two directions; international bodies with the necessary intellectual/conceptual background can be extremely weak. What are needed are critically engaged administrative bodies, scientific research bodies and transformation agents, among the foremost of which are the press. A combination of all represents a good strategy, but they must be related to various elements of power. One rests in community participation. Where there is strong community participation, as in Finland, a decentralized approach gives a better opening for new developments than in highly centralized countries. A second element in the power situation are insurance companies and similar bodies with large financial resources. A third element consists of powerful organizations, such as the trade unions that organize the interests of ordinary people. A combination of those interests in the Federal Republic of Germany has in the past produced slight

changes in health policies, but this is no longer true. The trade unions are not oriented towards change, realizing that it is not congruent with their members' interests, but there is an urgent need for change and the problems are growing. People need concrete evidence that it is in their interests that there should be user/consumer-oriented health and not provider-oriented health. Cost-benefit relationships must be understood by the public. Journalists could develop public opinion on health questions.

There are risks involved, however, for those concerned with information on health-related matters, stemming from the factors governing the generation of information and the consequences of producing it. To a great extent, it is public demand that governs the work of the media professional. The public taste for what is spectacular, conflictual, scandalous or forbidden or for news items offering even the remotest hope of overcoming its most serious problems is one factor. Another is the urgency of news production, with its demanding deadlines. The enormous coverage achieved by the media is also a potential problem. If an item of information sparks off a polemic on a controversial subject, much of the audience will receive only part of the information, and the very heat of the argument can lead them to wrong conclusions. The extent of coverage also prevents the message from being tailored to the characteristics of the audience, with the consequent risk of misinterpretation and reactions springing from subjective involvement.

Among the consequences are an excessive public reliance on the resources of medical technology and a demand for high technology in the form of large hospitals and super-sophisticated facilities, which could have an impact on the planning of services and the degree of satisfaction with their results. Both of these consequences run counter to conscious and responsible participation in health affairs.

It is therefore essential to have a continuous dialogue between information media and health professionals to counterbalance the tendency to sensationalism that can result from technological progress and is the reverse of clear, simple, dispassionate and properly tested information as a basis for health promotion.

There is support for the view that high technology impresses the media, which in turn creates a public demand for it. One consequence is that it becomes difficult for governments to balance the real needs of primary health care with public demand.

Patients consider they are not being well cared for if they are not given the latest high technology treatment. This tends to alter relationships between patients and doctors. Thus, it is difficult for the patient to be satisfied, even when he is getting the best treatment available. An emphasis on health - and not disease - would help to counterbalance this trend, but the promotion of health does not create sensational news.

It is possible that advanced technology is being badly used in health services. It is a question of interests and pressure groups. There is the interest of the makers in selling equipment, the interest of the administrators in buying it, and the interest of doctors in using it, because it enables them to raise their fees and seem more important. The press is under the influence of pressure groups to support more technology, whether it is properly used or not. No one has a really personal interest in preventive action, and here there is a role for consumers and governments to play.

Nevertheless, there is a danger in thinking that primary health care does not involve technology. The alternatives should be examined in terms of opportunity in relation to cost. The concept of primary health care is too nebulous and has about it an air of nostalgia which is easily debunked if it does not take into account the use of modern resources.

6. Information policy of the Regional Office for Europe: its present programme and the outlook for the future

The basic desire of journalists is for their functions to be recognized for what they are and for their independence to be guaranteed.

Journalists do not claim to be educators or social workers. They are not part of yet another pressure group. On the other hand, they do expect to have guaranteed independence of access to sources and freedom of analysis.

These self-evident facts do not mean that journalists seek isolation, for this would obviously conflict with their functions. Following contacts with representatives of WHO in April 1981, the French National Association of Medical Journalists (ANJIM) conducted a survey of all its members to determine their expectations of the Organization. There were numerous replies, and this

established that it was a "sensitive" subject for members of the profession. The answers applied, moreover, as much to national authorities and their administrative bodies as they did to international organizations such as WHO. In the first place, and unsurprisingly, all members of the profession stated their interest in a continuing system of exchanges. In addition, almost 90% of them said that they were interested enough to visualize the establishment of standing consultative bodies. Despite this, only 62.5% thought that participation by journalists in such groups would be "useful", and only 31.25% were ready to devote free time to this matter. There is no doubt that there is a favourable attitude to such types of exchange. How can they be developed?

In practice, 25% of all members of the profession in France said they never made use of information coming from international organizations, 12.5% claimed to do so sporadically, and 56.25% said they did so with some degree of regularity. In all this, the main problem appears to be the time-lag between an event, even an administrative event, and the moment the organizations concerned communicate it to those working in the media. It was felt, for instance, that many WHO reports never reach journalists at all, even though there are very few reports that are specifically restricted to governments.

Less administrative and more specific information should be presented, with more of an attempt to maintain a degree of professional "appeal". There are clearly many areas journalists would like more information on:

- health and socio-health intervention techniques, such as nutrition
- computerization of health
- epidemiology
- comparative statistical studies on the health status of communities
- women's and children's health problems.

These are typically European subjects, in contrast to the third world themes for which international bodies often (and rightly) try to create interest among journalists. It is obviously worthwhile to take this fact into account, without losing sight of the corollary that information must never be provided to a professional on any other basis than the reciprocal one of "goodwill". In this matter, there is never anything more than an obligation to provide the material, without any corresponding obligation to produce results.

In technical matters, standardization is taking place among countries, but the degree of international comparison and adaptation in non-technical areas including health policy is low. International organizations should take the lead in creating a greater international exchange and actively disseminating health policy information. A service to journalists is largely a matter of defining relationships, establishing contacts, being available and making clear the goals of the organizations.

As a result of the recommendations made in Luxembourg in November 1980 by the first Working Group on Information and Health, WHO has decided to multiply the occasions when journalists are included in WHO technical working groups as fully fledged temporary advisers. This offers WHO a chance of explaining its policy in a direct way to the journalists participating in its meetings, resulting in in-depth coverage by the media they work for, but perhaps more importantly it exposes medical and other public health participants to the views of the press - and through it to those of the public - and also to the technical requirements of the media if they are to play a role. Straightforwardness is an obvious sine qua non when dealing with the press, and so is the necessity to express oneself clearly, in accessible terms rather than in impenetrable jargon or fancy sociological concepts.

In the months ahead, there will be more and more instances of the direct involvement of selected journalists in major meetings organized by the Regional Office for Europe. An evaluation of this innovative approach could perhaps be made at the next meeting of the Working Group on Information and Health.

WHO should produce concrete goals for itself and for others from time to time. WHO has an immense advantage in terms of popular sympathy and respect, but it is less admired for its lack of courage on certain topical issues. WHO would earn respect to the extent that it was prepared to take a stand on these issues and speak out on them.

7. Conclusions and recommendations

(1) A reorientation of health policies as envisaged by the strategy for health for all by the year 2000 requires an effective mobilization of the community. The public will involve itself in health policy matters only if the issues are made clear and are felt to be of personal concern. Health

for all by the year 2000 should take fully into account the present health challenges in the European Region. Certain health problems, although unquestionably important in a worldwide context, are not of practical concern to the general public in the this Region. While organizational, technical and financial problems may be of the greatest relevance for a small élite in the health field, they will not mobilize interest among the general population or help significantly to enhance the current status of health policy. Policy-makers should present policy issues in a way that will encourage enlightened public debate of the choices that have to be made.

(2) Issues concerning the lifestyles of individuals, the enrichment of their leisure time, employment and unemployment, all of which affect their wellbeing, will assume increasing importance in the coming years and will lead to new developments in health policies and health information.

(3) Health information should emerge from, and serve as a commentary on, previously established, sound health policy concepts and not be a substitute for them. Information officers should try to ensure that the media give the same attention to health policy as, for example, to education and environment policies; information activities should be directed to stimulating discussion of the thrust, coherence, relevance and objectives of health policies, with the aim of raising public interest in health questions, as the WHO-sponsored publication Health crisis 2000 seeks to do, and should help the media to engage in debate on the costs and benefits of health services.

(4) WHO should provide the media with more factual information on cancer and cardiovascular and other diseases related to contemporary lifestyles. Communicable disease remains an important health problem in many parts of Europe and health information programmes should combat the danger of complacency towards immunization arising from the belief that certain diseases are no longer a threat.

(5) Popular entertainment is a powerful medium for health messages. Efforts should be made to enlist the support of the creators of entertainment in presenting positive health behaviour as the norm.

(6) Health issues are open to manipulation for purposes other than health promotion. Policy-makers and journalists in the health field should investigate and evaluate the origins, motivation and methods of operation of pressure and other interest groups. To encourage more openness and frankness, a code of conduct should be formulated for these groups.

Annex 1

LIST OF PARTICIPANTS

TEMPORARY ADVISERS

- Mr D. Affeld
Health Economics and Health Planning, Federal Ministry of Labour and Social Affairs, Bonn,
Federal Republic of Germany
- Mr H. Beesley
Director, Press and Information, Council of Europe, Strasbourg, France
- Dr A.E. Bennett
Director, Health and Safety Directorate, Commission of the European Communities, Luxembourg,
Grand Duchy of Luxembourg
- Professor A. Brenna
President, SAGO, Milan, Italy
- Dr F. Cabrita Matias
International Relations Department, Ministry of Social Affairs, Lisbon, Portugal (Chairman)
- Dr A. Coelho
Sub-Director of the National Institute of Health, National School of Public Health, Lisbon,
Portugal
- Dr H.D. Crawley
Director, Health Education Bureau, Dublin, Ireland
- Mr A. Curnow
Director, Information Service, United Nations Office, Geneva, Switzerland (Rapporteur)
- Mr D. van Daele
First Counsellor, Ministry of Public Health and Family Affairs, Brussels, Belgium
- Dr E. Duhr
Director of Health, Department of Health, Luxembourg, Grand Duchy of Luxembourg
- Mr P. Gaskell
Press Officer, Press Division, Information Service, Organisation for Economic Co-operation and
Development, Paris, France
- Mr M. Gombeaud
Le Quotidien du Médecin, Neuilly s/Seine, France
- Mrs J. Hewlett-Davies
Director of Information, Department of Health and Social Security, London, United Kingdom
(Vice-Chairman)
- Mr C. van Hoewijk
Director, Health Information Division, Ministry of Welfare, Health and Cultural Affairs,
Leidschendam, Netherlands (Vice-Chairman)
- Dr L. Magao
Director, Office of Studies and Planning, Secretariat of State for Health, Department of
International Relations, Ministry of Social Affairs, Lisbon, Portugal
- Mrs C. Maza Aymat
Director of Information Services, Ministry of Health and Consumer Affairs, Madrid, Spain

ICP/INF 003
3532L
page 18

Dr P. Najera
Chief, Service of Health Education, Ministry of Health and Consumer Affairs, Madrid, Spain

Dr H.-C. Reinhardt
Swiss Hospital Institute, Aarau, Switzerland

WORLD HEALTH ORGANIZATION

Regional Office for Europe

Dr G. Dukes
Regional Officer for Pharmaceuticals and Drug Utilization

Mr J.-M. van Gindertael
Public Information Officer (Secretary)

Headquarters

Mr J.C.S. Ling
Director, Public Information and Health Education