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Council of Europe
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For debate in the Standing Committee
Pour débat à la Commission Permanente
See Rule 12 (4) - Voir article 12 (4) du Règlement

Congress of Local and Regional Authorities of Europe
Chamber of Local Authorities

Congrès des pouvoirs locaux et régionaux de l'Europe
Chambre des pouvoirs locaux

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Part II

THIRD SESSION

HEALTH AND CITIZENSHIP :
CARE FOR THE POOREST IN EUROPE

Rapporteur: Mrs K. Brodnianska (Slovak Republic)

EXPLANATORY MEMORANDUM

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* Objections to the Standing Committee procedure must reach the Head of the Congress Secretariat a clear week before the meeting of the Standing Committee; if 5 members object, the report will be submitted to the Plenary Session.
Les éventuelles objections à l'examen en Commission Permanente doivent parvenir au Chef du Secrétariat du Congrès une semaine avant la réunion de la Commission Permanente; si 5 membres du Congrès présentent des objections, le rapport sera soumis à la session plénière.

Foreword

In the last few years, the "social issue" has resurfaced in Europe in its new as well as its old guise. This is a matter of increasing concern to citizens, both individually and collectively, and it is therefore once more looming large on the agendas of governments and political authorities and institutions at all levels, including European organisations.

In the wealthy countries of western Europe which are almost all members of the European Union, it has been discovered with surprise that there still exist anachronistic situations of poverty, vulnerability and downright destitution which were not eliminated in the thirty years of almost constant economic growth from about 1945 to 1975. At the same time, it has been realised with dismay that the current trend is generating an increasing number of individuals threatened by economic and social exclusion.

In the countries of central and western Europe, political change has brought to light forms of poverty that were previously carefully concealed. The ensuing economic and social change has left previously protected groups or families out in the cold. The transition has been accompanied by a selection process.

As a guarantor of human rights, the Council of Europe initially tackled the new social issue from the point of view of the denial of rights. The ministerial conference held in Rome on 5 November 1990 emphasised the need, on the one hand, to maintain the indivisible nature of all human rights, be they civil, political, economic, social or cultural, and, on the other, to give the European Social Charter fresh impetus. Thus, a process was immediately launched to revise the Charter, a process which only reached its conclusion on 3 May 1996, when the Committee of Ministers opened the "Revised European Social Charter" for signature. The new Charter reinforces and expands the rights guaranteed: this is the case with regard to the "right to protection against poverty and social exclusion" (Article 30) and the "right to housing" (Article 31), which did not appear to in the first version of the Charter.

Secondly, at the end of 1991 a colloquy was held in Strasbourg under the title "Towards greater social justice in Europe: the challenge of marginalisation and poverty". A few years later, a project on "human dignity and social exclusion" was included in the Council of Europe's intergovernmental programme of activities. It is aimed at the drawing up of a report on poverty in Europe, based on national and thematic reports, and at the adoption of a summary report at a conference to be held in 1998.

The Conference of Local and Regional Authorities of Europe (CLRAE) and its successor, the Congress, soon perceived not only the social but also the political implications of the new situation. Its Resolution 236 of 1992, on a new municipal policy for multi-cultural integration in Europe and the Frankfurt Declaration, emphasised that "the existence of disadvantaged sectors of the indigenous populations in all European countries and in particular of groups, families and individuals living in a situation of extreme poverty and precarity requires the inclusion of the integration policy within a global approach and strategy covering all the different groups, families and individual, whether indigenous or of immigrant origin".

However, not until the conference that was held in Charleroi (Belgium), from 5 to 7 February 1992 on "European municipalities and democracy - the exclusion of poverty through citizenship", did the CLRAE indicate the full extent of the problem. The "Charleroi Declaration", which made a broad impact among local and regional authorities, citizens and their associations, is intended to provide a global, coherent and future-oriented framework for the planning and implementation of long-term policies for combating and eliminating extreme poverty as well as preventing the various forms of vulnerability which precede it. Resolution 243 (1993) on citizenship and extreme poverty reiterated the proposal already put forward in Charleroi for extending the Declaration to such sectors as housing, employment and health, where a group-based approach should not be precluded. Thus, the CLRAE adopted the following texts in turn:

- Resolution 237 (1992) on the Charter on the participation of young people in municipal and regional life (Llangollen Conference);

- Resolution 244 (1993) on the right to housing and its implementation by local and regional authorities (Nottingham Conference);

- Resolution 255 (1994) on HIV/AIDS - activities of local and regional authorities (Strasbourg hearing);

- Recommendation 5 (1994) on Europe and its elderly people: towards a pact between generations and conclusions of the Sienna Conference;

- Resolution 15 (1995) on local democracy: a civic project (Strasbourg hearing);

- Recommendation 11 and Resolution 16 (1995) on the contribution of Roma (Gypsies) towards a tolerant Europe;

- Recommendation 25 and Resolution 40 (1996) on unemployment/employment: new activities and occupations (Florence Conference).

The Conference on "Health and Citizenship - Access to Health Care for Europe's Poorest" was initiated and planned by a CLRAE working group confirming Ms Brodnianska (Slovak Republic) and Mr Winter (Germany), in which Mr Christofides (Cyprus) also participated in order to give the opinion of the Chamber of Regions. The conference was held at the Palais de l'Europe in Strasbourg on 8 and 9 February 1996.

An outline of different stages of the conference appears below. In this connection, I am particularly indebted to Professor Michel **Manciaux**, of the School of Public Health of the University of Nancy (France), a WHO consultant who drafted and presented the conclusions of the conference in his capacity as rapporteur.

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Opening of the conference

Opening the proceedings, Mr Peter **Leuprecht**, Deputy Secretary General of the Council of Europe, first stressed the choice of society facing the countries of Europe: either an "economically rational" society, entailing a risk of social indifference which would eventually spell its doom, or a society of solidarity, based on the tradition of many European countries and on respect for human rights. The place of health was crucial in that choice, and the official optimism, based on unprecedentedly positive health indicators, should not conceal the fact that national averages were in reality an amalgam of strongly contrasting situations. The gulf thus existing in the health field between the "haves" and the "have nots", who are virtually denied access to basic care, was to be found not only within each country but also between countries, to the detriment of those in eastern Europe. Illness prevention and health care promotion were everywhere the poor relations of medical and social policies. Quoting B Geremek, the Deputy Secretary General noted that "neglecting social policies might well endanger the whole democratisation process in Europe".

Concluding on the Council of Europe's role in this area, he referred to the plan of action proposed on the theme "human dignity and social exclusion" for the 1995-97 period and underscored the right of the poorest to freedom of speech, the essential role of local government at all levels and the challenge that we are all facing: what sort of Europe do we want?

After welcoming the participants of behalf of the Congress, Mr Karl Christian **Zahn**, Mayor of the town of Dorsten (Germany), emphasised the existing links between precarious living conditions and health. As a general rule, those with the financial resources and a good level of education have greater access to health care, while others must often make do with basic care or purely and simply be forced to reject medical treatment. The matter in hand was also a social problem, not merely a medical one.

It was essential to make everyone aware that health services were within everyone's reach without exception. It was the duty of the reception services to approach the people concerned. In conclusion, equality in terms of public health was a collective duty.

Mr **Valkeniers**, a Belgian senator representing the Parliamentary Assembly, mentioned that the Assembly was to discuss the future of social policy in Europe and that the Committee of Ministers planned to resume its regular debates on the draft Revised European Social Charter. He stressed that the protection of the social right of our fellow citizens called for political will at all levels. (Since then, on 24 September 1996, the Assembly has adopted Recommendation 1304 on the future of social policy, and the Committee of Ministers has approved the revised version of the Social Charter.)

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Introductory report: the poorest and obstacles to health care

The actual conference then began with the introductory report by Doctor François-Paul **Debionne**, a CLRAE consultant and a delegate of the ATD Quart Monde International Movement vis-à-vis the Council of Europe.

In all the countries of Europe, regardless of their level of wealth, profound economic changes were giving rise to an increase in the number of persons who had no work or even social utility and whose living conditions had come to resemble those of families that had lived in poverty for generations. Depending on the country, the proportion of persons in great difficulty varied between 5% and nearly 20%. The health of the poorest persons, families and groups was more greatly affected than that of others, and they faced obstacles in obtaining health care. For that reason, they were most directly concerned by the growing disparities in health in relation to the social status revealed by research on social inequality with regard to life-expectancy, illness and the utilisation of health care services.

Even when the administrative responsibility for health care provision did not place them in the front line for providing such care to the poorest, local and regional authorities had to contend with the complex realities of extreme poverty. All were disturbed and felt concerned. Sharing their experiences should help them all move forward.

"Living in poverty means living with worries. When there is not enough of anything, parents feel humiliated. Moreover, poverty is harmful to health: noise, pollution, poor housing, dampness, anxiety ... - as the years go by, it takes its toll on body and soul".

These few sentences, taken from the testimony of the father of a family living in extreme poverty, reflected the desire for well-being and the change in conditions. They also offered an insight into the everyday lives of those usually described on the basis of their needs, their wants and even the qualifications they lackd. The depiction of the poorest took the form of a list of "problem" groups, often conerminous with the following administrative categories: homeless, the long-term unemployed, former prison inmates, illegal aliens, nomadic populations, socially marginalised youth, drug addicts, single women with children and old people living alone. Extreme poverty also affected large families. Although precise criteria were a prerequisite to certain entitlements, there was a reason for concern about the possible side-effects of these categorisations, which might give rise to stigmatising or to a limiting of specific policies to duly recorded categories.

Health had not been taken into account in the debate on extreme poverty and social exclusion until recently. By and large, not until the mid-1980s had the attention given to the conditions of access to health care for the poorest made it possible to identify real barriers and numerous obstacles and limitations. The barriers were of a statutory, regulatory and administrative nature, such as the refusal by certain hospitals to admit persons unable to prove that the costs would be covered. One of the main obstacles to health care was the complexity of steps to be taken to secure recognition of entitlement to coverage once a person no longer fell within the registration procedure under a simple scheme, such as that applying to wage-earners. Owing to this complexity, these persons did not realise that they were eligible; nor, sometimes, did health care and social security personnel. This was exacerbated by the different scales applied by local and regional authorities for defraying the cost of health care for the poorest. In addition, there were often financial obstacles and difficulties in obtaining health care that were associated with geographical remoteness and the absence of nearby services; the scarcer and more expensive transport facilities were, the stronger this was felt.

Less well known and often underestimated were obstacles of an interpersonal or cultural nature. Owing to illiteracy, millions of people in Europe had problems coping and functioning independently. This difficulty in relying on the written word was often associated with temporal and spatial problems which greatly impeded access to health care structures: being on time for an appointment required outside support. In this context, misunderstandings between health care staff and the poorest occurred all too easily: each world had its own logic, points of reference, priorities and fears about the consequences of assistance. As long as the poorest did not understand that the primary concern of the professional staff was to help them, fears about the consequences of their visiting health care centres would prevail over the desire to receive health care. This being the case, the efforts by the administration and legislators to improve provisions on health care for the poorest remained fettered as long as they did not go hand in hand with the requisite supporting measures.

It would be too simplistic to address the relations of the poorest with the health care system solely from the point of view of medical treatment. It appeared self-evident to all observers that food health did not only depend on the availability of care, even if special training was provided for local staff. In actual fact, all aspects of health care policies (prevention, promotion, treatment, rehabilitation, reintegration) could be of benefit to the most underprivileged or, on the contrary, might not reach them. Peripheral factors, whether related to the physical, social or cultural environment or the influence of education, must also be taken into account. How effective could a health care system be if its efforts were reduced to nought by persistent insalubrity or even non-existent housing, malnutrition, unemployment or a lack of resources or know-how?

In point of fact, health care policies as a whole seemed limited in their ability to meet the needs of deprived populations. Merely introducing these policies was too narrow an approach to a multi-faceted process: health care strategies only made sense and were only appropriate when associated with all policies relating to the living conditions of the poorest, in particular housing, employment, resources, education, social cohesion, the urban environment etc.

But no policy was exempt from budgetary constraints and limitations on human resources. The choices for priority action must be based upon an in-depth knowledge of each situation and an active search for the bast way to prevent pauperisation and eradicate poverty.

Thus, like all policies, health care was of relevance to citizenship. How could policies really be appropriate if they were not based on the needs expressed, ie with the involvement of those concerned? How could they be effective without relying on a concept of the human being and human relations that was based on ethical values? How could they obtain the support of the better-off individuals, families and groups without a special effort on the part of local and regional authorities to promote the citizenship of all members of the community, regardless of their nationality or social status? Restoring the health and citizenship of the poorest went beyond the strictly professional aspects of assistance. It brought into play a humanist dynamic and an ethical dimension.

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Situations and policies: case studies

The participants (leading European and national political figures, mayors, local councillors from a number of cities, municipalities and regions of Europe, representatives of associations, European experts and ordinary citizens) then considered and discussed the policies pursued for providing health care to the poorest (assessment of needs, current schemes and future prospects) in the following cities and local authorities: **Strasbourg and Bas-Rhin** (France), **Göteborg** (Sweden), **London Borough of Newham** (United Kingdom), **Frankfurt am Main** (Germany), **Budapest** (Hungary), **Charleroi** (Belgium), **Vienna** (Austria), **Bratislava** (Slovakia) and **Tirana** (Albania).[1]

Three members of the Congress - Ms **Brodnianska** (Slovak Republic), Mr **Winter** (Germany) and Mr **Christofides** (Cyprus) - chaired the discussions in turn.

We will not summarise here one by one the different papers presented, even though they were all very interesting. Instead, we refer the reader to the Proceedings of the Conference which will be published shortly. However, the general **summary** made by Professor Manciaux following the presentation of papers and the discussions is reproduced herewith.

The discussions clearly highlighted a number of common concerns. Broadly speaking, cities and regions - which allocate a large part of their budgets for the health care and social security of their populations - encounter considerable financial difficulties in meeting those challenges. All too often, the state gives them a growing part of the responsibilities without making the appropriate financial resources available. This situation is partially offset by the commitment of many organisations which, in conjunction with the local and regional authorities, work to improve health care for the poorest individuals, families and groups.

The conference focused its attention on the Health Care Card introduced in various forms in many cities and regions. Should all health care be entirely free of charge, or should its beneficiaries be asked to meet part of the cost? Ideally, protection under the national social security system would be extended to the entire population, including the poorest. Before this goal is attained, social assistance measures could be introduced to compensate for insufficient coverage under the general social security scheme. Certain municipalities defray the share usually paid by persons insured under the national scheme, the basic cost being borne by the state. In most cases, the fear of an abuse of services has not been borne out: on the contrary, an early response to health care problems forestalls a deterioration in health which would require treatment entailing much higher costs, for example in hospital.

But what kind of health care is envisaged? Essentially, the most urgent form of primary health care, which does not exclude the hospitalisation that sometimes proves necessary because of inadequate basic care. Many of the cities represented provide their poorest inhabitants with basic care in collaboration with general practitioners. However, not all these front-line physicians

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[1] These cities and communities were represented by: Ms C Mieg-Schaller (Strasbourg), Mr Y Bur (Bas-Rhin), Mr B Mollstedt (Göteborg), Ms R Davies (London Borough of Newham), Mr A Glaser (Frankfurt am Main), Mr G Barath (Budapest), Mr J Van Gompel (Charleroi), Mr K Leitner (Vienna), Mr A Durkovsky (Bratislava) and Mr V Bozdo (Tirana).

have been trained to provide care suited to the poorest: the often lamentable state of health of these persons, the frequency of associated pathologies and the alarming increase in tuberculosis are not the sole reasons for this. The seriousness of the various social problems (resources, employment, housing) is such that a purely medical solution is doomed to failure. It is thus essential both to involve other sectors in covering the costs and to ensure the continuity of health care through long-term supporting action. The poorest cannot receive expensive health care, which in most cases is scarcely reimbursed (spectacles, dental care, hearing aids, etc), unless considerable additional financial assistance is available. In some programmes, the Health Care Card covers such treatment in full.

Any policy to combat extreme poverty must take into account the fact that this phenomenon is usually concentrated in certain neighbourhoods. Many of the cities represented have developed a neighbourhood policy emphasising better local health care services. But health care needs do not always generate demand: it is important to reach out to the poorest, to make facilities and visiting time available and to win their confidence so that applications for, and acceptance of, health care will develop. These persons, too often accustomed to a cold reception in the "conventional" services, are so afraid of the appointment having undesirable repercussions (labelling, placement, social control and the like) that they hesitate to appear.

Health care for the poorest will highlight a whole series of problems requiring action in other sectors. Combining health care with social, administrative and legal counselling services fosters the overall financing of costs. Urban policies and neighbourhood management schemes - which are in full expansion in Europe - are adopting this as one of their operating principles, there again in conjunction with specialised associations, NGOs and volunteers.

The following crucial question was posed at the conference: does not the introduction of policies, even if they are very carefully planned, tend to make the poorest citizens dependent upon assistance and to marginalise and stigmatise them all the more? The response is both political and ethical.

Politically speaking, such an approach is acceptable only if the individuals, families and groups concerned are treated as fully-fledged partners, not only as regards access to care but also as regards participation in the drawing up of health care policies. Professional staff and associations which convey the experience and views of the poor to political officials at all levels have an irreplaceable role to play in that connection as mediators. This partnership with the poorest sections of the community is an indispensable element of citizenship. It is also a step towards community solidarity. Lastly, it was noted that health care for the poorest also benefits the community as a whole: after all, the poor serve to reveal shortcomings in our societies that affect many others as well, albeit to a lesser degree.

Ethically speaking, it is not sufficient to do everything to prevent victims from being labelled, stigmatised or blamed. More positively, it is essential to promote confidentiality and respect for the privacy of individuals, their families and their lives. Although the training of health care and social workers is important, the whole of society should be made aware of these dimensions. Has it not been said that a society, a country or a municipality is judged by the way in which it treats its weakest members?

In contending with complex social ills, our societies do not always resist the temptation to seek remedies in medicine. The increasing use of medicine and, even more serious, of psychiatry to deal with the social problems facing the poorest was denounced by the participants, who called for a re-orientation of the role of health care and hospital staff. Health care workers must take account in their activities of the living conditions and needs of individuals, families and groups affected by extreme poverty, but they should not assume responsibility for these conditions, because they have neither the authority nor the means to do so. Solutions can come only from a carefully balanced, multi-sectoral approach where medicine has its role as well as its limitations. As for hospitals, often caught up in an inflationary technological spiral, they must bear in mind that medical responsibility must go hand in hand with the social role they used to enjoy when medicine did not have enormous resources.

There was a broad consensus on all these points, especially as they bore out the experience of the cities represented at the conference. It was striking to see the numerous areas of agreement in the various reports, even though there are considerable differences or even contrasts between such cities as Frankfurt and Tirana, for example. Although the pooling of experience is fundamental, the programmes introduced in one specific context cannot be applied in another without major modifications.

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Results of the Round Table

Following the presentation of the case studies, a round table was held under the chairmanship of Mr **Chénard** (France), Vice-President of the CLRAE, with two representatives of the Congress (Mr **Zahn**, Germany, and Mr **Gualandi**, Italy) as well as three representatives of European NGOs (Mr Claude **Marx** (France), Chairman of the "Health" Group of NGOs holding consultative status with the Council of Europe, Dr Cormic **Mac Namara** (Ireland), Chairman of the European Union of General Practitioners (UEMO) and Dr Myriam **De Spiegelaere** (Belgium), representing the ATD Quart Monde International Movement).

The round table dealt with three main issues: 1) how to improve access to health care; 2) how to respond more effectively to the health needs of the poorest; and 3) relations between health and citizenship. It gave rise to a broad exchange of views with the other participants in the conference. The **results** of the round table, which were also presented by Professor **Manciaux**, are reproduced below.

1. How to improve health care

This is a complex problem. To begin with, it is material and physical in nature, one might even say, as it is related to geographical proximity, an aspect that many stressed, as well as to the availability of convenient and inexpensive transport facilities and suitable working hours. Informal locations for an exchange of views and dialogue - including encounters in the street - can constitute, the antechamber to such services, as it were. It is essential to reach people where they live.

Financial accessibility depends on entitlement to health care. Fairly comprehensive arrangements, such as the Minimex in Belgium, the RMI in France and the Health Card in many regions and countries, encourage recourse to health care structures. Most cities are making great efforts in this area, by bearing the cost of social assistance.

Psychological accessibility is more difficult for interpersonal and cultural reasons. The social gap between health care providers and recipients is considerable. The language of poor individuals and groups is scarcely comprehensible to most professional staff, and vice-versa, so that community mediation often proves necessary. Health care personnel are discouraged by these problems and health care needs of the poor and have difficulty understanding that the failure of the latter, amidst a multitude of concerns, to give priority to health, make better use of the services available to them, continue a course of treatment once started or keep medical appointments. Ongoing assistance which respects the needs of each party is indispensable.

In our multi-ethnic societies, perceptions and ideas about health, illness and health care vary considerably from one community to the next. Poor neighbourhoods are often a mosaic of numerous ethnic groups, sometimes numbering several dozen. One type of community response consists in using women from these groups as mediators, who help health care personnel to understand the problems and reactions of these particular patients more fully. The development of ethno-psychiatry also helps to improve understanding of cultural differences with regard to physical, mental and social health.

More generally, we must recognise that, as Father Wresinski, founder of ATD Quart Monde, said, "*the poor are the sole experts on poverty*". Health care personnel must listen to them individually or, better still, collectively, through associations to which they belong or which temporarily act on their behalf. Empathy and humility are needed, and the staff who acquire those qualities become not only mediators but also the advocates of the poorest vis-à-vis their colleagues and public health officials.

It must, however, be recognised that the training of physicians and health care and social workers leaves them ill-prepared for such encounters. This situation must be remedied without delay.

2. How can the response to the health care needs of the poorest be improved?

First of all, as already pointed out, this can be done by helping to create demand, by developing a relationship of confidence and by avoiding disparaging judgments and humiliating decisions based on the assumption that the poorest are unable to care for themselves and raise their children.

Considerable stress has been placed on the importance of social ties, the social fabric and social support. Health care and social service staff must be able to rely on human resources in any community and on volunteers, associations and NGOs for help in creating a health care network.

But the multiplicity of initiatives and participants, as well as the various levels of service in the health care system, may pose a problem: co-ordination is indispensable if the intended beneficiaries of such efforts are not to be prejudiced by incoherent activism or dispersal of responsibilities.

Structures that are too cumbersome and centralised are also counterproductive, but urban and neighbourhood policies usually make it possible to take action that is closely in line with needs. However, a national administrative or even statutory framework might provide support, valuable guidance and the instruments needed for these local services.

At international level, incentives and instructions from intergovernmental organisations are equally desirable. This does not prevent - indeed, on the contrary - bilateral initiatives from being concluded, such as twinnings between cities or hospitals. That is particularly important for helping the countries of eastern Europe gradually to overcome situations in which they might otherwise remain indefinitely and inextricably caught.

Initiatives, innovation and ideas are needed, provided they are based on sound knowledge of the problems, have clear objectives, develop in partnership with those they are intended to assist and are amenable to assessment: otherwise, it would be impossible to evaluate their results, their positive or, as sometimes is the case, adverse. Knowledge of the situation, assessment of policies and activities, and anticipation of their impact and development constitute the indispensable goal of any serious programme.

It was emphasised that poor individuals and families, worn out by their everyday worries, place great expectations in a better future for their children. That is an important incentive for their participation. Such a perspective, which takes future generations into account, is also essential for professional staff and policies: the persistence and perpetuation of extreme poverty from one generation to the next would mean that they had failed.

3. Health and citizenship

Poor health is not in itself an obstacle to citizenship, although it may interfere with its exercise in various areas. But our most deprived citizens suffer both from a poor state of health and from a denial of rights, including the right to good health care, which robs them *de facto* of their citizenship. Restoring their health or at least improving it is the road back to citizenship.

This calls for a partnership not only with institutions but above all with other citizens. In this partnership, the poorest gradually play a role in improving their own and their family's health as well as participate in preparing health care policies. Community life furthers this partnership commitment and gives it a greater weight than the sum total of individual actions and achievements. The poorest become capable of participating when they are regarded as implementers and initiators of projects according to their experience (indeed, their "expertise") in a life of extreme poverty. Their refusal to resign themselves to their situation and their ambitions for the future of their children make them competent and valuable partners.

This active participation on the part of the poorest is in itself a factor that diminishes social exclusion and is a step towards reintegration and recognition - by them and by others - of their capacities, their dignity and, hence, their citizenship. Such an approach is demanding for those concerned with the rehabilitation - in the full sense of the term - of society's poorest citizens, but it is also beneficial for all partners, for the community and for society.

The round table also discussed the creation of a European fund for projects to assist local government in developing such approaches. Their might help to implement the conference's recommendations and intensify cross-border exchanges of experience and collaboration between cities and regions of Europe.

Conclusions: Final Declaration and the draft resolution and draft recommendation

Following the conference, under the chairmanship of Mr Bengt **Mollstedt** (Sweden), a former President of the CLRAE, the participants, after hearing a report by Mr Paul **Meyers** (Belgium), a former minister and the organiser of the CLRAE's "Extreme Poverty and Citizenship" Network of Towns, adopted a **Final Declaration**. This forms an appendix to the draft resolution and draft recommendation which are being submitted for adoption.

All these texts follow the basic structure of the proceedings of the Strasbourg conference. After reiterating the various obstacles to access to health care for the poorest, the shortcomings of health systems and other health-determining factors (nutrition, housing, illiteracy, isolation, unemployment), the Declaration emphasises that the improvement of the health of the poorest is destined to remain a mere hypothesis without the support of other public policies. The danger which threatens us is the medicalisation of social problems. However, several initiatives, at national and especially at local and regional level, reveal the conditions which enable the deterioration in the health of the poorest to be halted, remedied and even reversed: in particular, it is necessary to take account of the experience and views of those concerned, to help them to participate actively in the preparation, implementation and appraisal of all projects or programmes designed to improve their health, promote their social integration and provide them with long-term support.

In its second part, before setting out some specific recommendations, the Final Declaration attempts to define, in eight points, the role of public authorities, beginning with the state and with local and regional authorities in particular, with regard to health care availability, health policies and public policies in general.

Briefly, the problem is as follows:

Neither health care availability nor current health policies allow the health of the poorest groups, families and individuals to be improved to a satisfactory extent. Their health is conditioned by structural factors such as housing, nutrition, unemployment, lack of resources and sub-standard education. We cannot hope to improve their health in the long-term without at the same time taking account of these different dimensions and factors.

At local level, for instance, the health trend of all citizens may be monitored more closely. This is a highly suitable level for observation, information gathering, discussion and study. At the same level it is also possible to bring out a demand for health care which up to now has not been expressed clearly or sufficiently. This can be done in particular by improving consultation and contact with patients, in co-operation with the different voluntary associations. Furthermore, new activities can be implemented in partnership with the individuals concerned, and simultaneous support provided in conjunction with other public policies and the various forms of participation they provide for.

As needs are gradually identified, the shortcomings of the health care system become clear; firstly, those shortcomings at local level, but also those at regional and national level. There are some questions of organisation or co-ordination are important (for example, linkage between primary community health care and hospital treatment) which cannot be resolved, either partially or completely, at local level. However, they can be emphasised and clarified at this basic level, which can thus play a role as initiator. Furthermore, studies, proposals and practical measures are also dimensions inherent in public policies at the other territorial levels. In particular, the regional level provides a highly important framework for synthesis and co-ordination between the various policies, where, in particular, health policies acquire territorial and personal coherence. This aspect will no doubt be developed further in the Opinion to be formulated by the Chamber of Regions.

The texts to be adopted emphasise the need for policy planning, particularly in the health field. They envisage the dovetailing of the various public policies and their integration, both vertical and horizontal through the field networking of a series of activities which emerge from below in accordance with the grassroots principle and then spread out on a federal basis. They define the planning method to be used as a "partnership-based, pluralist, decentralised and interlinked approach".

The conference did not adopt a stance on the issue of the privatisation of medicine. However, it did emphasise the responsibility of states to ensure that all citizens have a right to health care. States cannot dispense with national health-care plans encompassing the knowledge and proposals that originate from below. However, they must not transfer their responsibilities to regional and local authorities "without sharing the financial burden ... on an appropriate basis and in accordance with the principles of territorial and personal fairness" (Final Declaration).

Other recommendations emphasise the desirability of providing suitable training for the professional and other sectors concerned so that they may work more effectively with poor individuals and families, as well as promoting an exchange of experience between cities, regions and hospitals, in particular with central and eastern European countries.

The Committee of Ministers is invited to instruct the European Health Committee "CDSP" to take the results of the Strasbourg conference on health and citizenship into consideration in the course of its work on access to health care. Gratifyingly, the 5th Conference of European Health Ministers, to be held in Warsaw on 7 and 8 November 1996, is to discuss the need to guarantee high-quality health care for all sections of the population. It is therefore to be hoped that the CDSP will take account of the CLRAE's work in a complementary manner, as requested in the Strasbourg Final Declaration.

Finally, in conclusion I cannot avoid referring to the decisions proposed to the Congress - firstly, a decision to pursue its campaign for the citizenship of the poorest by supporting the Council of Europe's "Human dignity and social exclusion" project; then a decision to build on the results of the Llangollen, Frankfurt, Charleroi, Nottingham, Sienna, Strasbourg and Florence conferences, by planning for the start of the third millennium, a major event on "**Europe and citizenship policies**".