mid-1990s in Afghanistan, for example, Meddings found a decline in the rate of weapons related injury, before and after a particular region came under uncontested control, of only 20-40% when weapons remained in circulation.[12]

Supply side strategies such as buyback and amnesty schemes have been tried in countries such as the United Kingdom and Australia. In response to massacres at Dunblane and Port Arthur, those countries tightened regulations, the former banning handguns and the latter semiautomatic rifles. British citizens voluntarily turned in 250 000 weapons, while the Australian buyout programme netted 750 000. Law enforcement officials in both countries affirm the effectiveness of these measures in reducing damage by these weapons.

Many argue that a supply side approach alone is inadequate, and various demand side measures have been proposed. Awareness building and educational programmes to promote cultures of peace; international norms that stigmatise the possession of guns; and programmes to reintegrate former combatants into society and to provide real economic opportunities have all been postulated to reduce harm from small arms, but are more difficult subjects of study. In Mozambique a unique project, Tools for Arms, combines supply and demand side approaches. The buyback of weapons, the metal of which is turned into art, provides compensation for gun owners, giving them new economic opportunities.

International humanitarian law may be applied to restrict weapons that cause damage disproportionate to war aims. Whole classes of weapons could be banned from civilian possession, just as landmines and other indiscriminately harmful weapons have been banned from military and civilian use. Although it seems clear that restrictions on the possession of weapons are necessary to prevent harm due to small arms, such restrictions are fiercely opposed by highly organised, wealthy, and influential groups such as America's National Rifle Association. The failure to reach meaningful agreement to control illegal manufacture and trafficking in small arms at the recent United Nations conference on the illicit trade in small arms and light weapons was partly the result of the lobbying of these groups.

Public health models could be used to evaluate the effectiveness of each preventive approach. International Physicians for the Prevention of Nuclear War (IPPNW) has used the public health paradigm to call for the abolition of nuclear weapons and to support the global ban on landmines. With the convening of an international medical conference on small arms last autumn in Helsinki, IPPNW announced its intent to campaign for policies that can reduce firearms related injuries. The conference drew more than 200 participants—physicians, researchers, social scientists, peace activists, representatives of governments and international agencies, and students—from six continents to address gaps in our knowledge, propose areas for research, and ponder educational and advocacy strategies.

The next steps will be to determine data on which to base recommendations for policy change and community action; standardise databases and collection methods across the world; heighten awareness about the public health and social consequences of small arms among local, national, and international policy makers; and inform professional colleagues, students, and the public about the multiple causes and the devastating consequences of small arms violence.

Neil Arya *family doctor and president of Physicians for Global Survival*

99 Northfield Drive, Waterloo, Ontario, Canada N2K 3P9
(neilarya@hotmail.com)

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Health care and the European Union

Profound but uncertain consequences for national health systems

Education and debate p 1027

Slowly, in health and social affairs ministries across Europe, the realisation is dawning that European Union law has profound consequences for the organisation of national healthcare systems. Even in the United Kingdom, which for many years was in a state of active denial about the influence of Europe, ministers are looking at how to exploit the opportunities offered by provisions on free movement of patients (to France) and professionals (bringing teams of German surgeons to operate at weekends in NHS hospitals).

Yet the scope for action is often uncertain. A failure to address health care explicitly at a European level means that the evolving legal situation is based largely on policies designed to address broad principles, in particular the free movement of goods, services, people, and capital. These are then applied to the health sector in rulings on specific cases brought before the European Court of Justice, but leaving uncertainty as to how they should be interpreted in similar but slightly different circumstances. The

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situation is complicated further by the changing nature of healthcare delivery, such as public and private partnerships within publicly funded systems, potentially bringing new areas within the scope of competition law.

As Duncan notes in his article this week (p 1027),[1] the consequences for the United Kingdom of the changing European environment are likely to be considerable. Some are obvious. Directives on doctors and on working time have already had important implications for patterns of medical staffing and, potentially, for the viability of many district hospitals. But others are less clear. Recent rulings that citizens can obtain health services abroad without obtaining prior authorisation from funders raises important and as yet largely unexplored issues.[2] When is a decision to deny treatment abroad justified on grounds of clinical effectiveness and when is it an unwarranted block on provision of services? How long is what the court terms "undue delay," which is sufficient reason for patients to demand that their treatment be paid for in another country where it can be offered sooner? It is almost certainly much less than the time most people wait for definitive treatment in the United Kingdom. But how much less, and what are the consequences for primary care trusts with limited budgets?

Further questions relate to the implications of the new British system of revalidation. Will it apply to German surgical teams visiting at weekends? The European Court of Justice has consistently held that the right of establishment allows professionals to work in more than one member state,[3] a view confirmed by two recent rulings by the European Free Trade Area Court,[4 5] but they must adhere to established professional standards. How will this work in practice?

It is increasingly clear that it is necessary to consider possible implications of European law whenever change of any sort is contemplated. What might the European Court of Justice say about the recommendation in the Kennedy report[6] into heart surgery at Bristol Royal Infirmary that the National Institute for Clinical Excellence, established to advise the NHS on what interventions it should provide, should be at arm's length from government? As the institute plays an important role in reimbursement decisions, will European law permit this role to be fulfilled by a non-state body?

And it is easy to forget that the NHS does more than just provide health care. NHS trusts are involved in training and research, and here too current arrangements could be open to challenge by private research teams on grounds of competition. The application of competition law to trusts is also likely to change if they are permitted to keep their surpluses and engage in more entrepreneurial activities. This is likely to require creation of new legal and financial structures to avoid legal challenges.

Yet some bodies are already taking full account of European Union law. In two recent rulings, the Office of Fair Trading and the Competition Commission both referred extensively to European case law in decisions on pharmaceutical pricing.[7]

It is increasingly clear that the present uncertain situation cannot continue. A recent report by the high level committee on health of the European Commission[8] suggested that internal market rules should take full account of the interests of patients and health services and not just purely economic interests. It also recommended reformulation of the European Union competencies in health with the objective of moving all related health powers into one treaty article that would clarify roles and responsibilities.

However, this may not be sufficient. The next treaty revision must consider explicitly how the European Union can ensure that the social nature of health care in Europe is not unintentionally undermined. But this will take time. In the short term, three things are possible.[9] Firstly, much greater coordination within the European Commission among those responsible for the many issues that have implications for health care is needed.

Secondly, there must be a greater use of the newly established system of open coordination of national social policies.[10] This system, which has formally established mechanisms to learn from the experience of others while taking account of national circumstances, provides an opportunity to promote best practice by increasing exchange of information on what works and what does not, and in what circumstances. In many cases it will be possible to develop shared approaches to common problems, but this mechanism respects historical, political, and cultural diversity. It does not force the harmonisation of processes that, while pursuing the same goal, are organised in ways that are incompatible with each other.

Finally, the European Union must establish, as soon as possible, a system that can monitor the evolving impact that European Union law has on healthcare systems and propose remedies when unintended effects arise.

Elias Mossialos *research director*

European Observatory on Health Care Systems, London School of Economics, London WC2A 2AE

Martin McKee *research director*

European Observatory on Health Care Systems, London School of Hygiene and Tropical Medicine, London WC1E 7HT

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