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The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves. The European Region embraces some 850 million people living in an area stretching from Greenland in the north and the Mediterranean in the south to the Pacific shores of Russia. The European programme of WHO therefore concentrates both on the problems associated with industrial and post-industrial society and on those faced by the emerging democracies of central and eastern Europe and the former Soviet Union. In its strategy for attaining the goal of health for all the Regional Office is arranging its activities in three main areas: lifestyles conducive to health, a healthy environment, and appropriate services for prevention, treatment and care.

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HEALTH IN EUROPE
The 1993/1994 health for all monitoring report

World Health Organization
Regional Office for Europe
Copenhagen
A limited number of computer diskettes with the graphics from this publication and the data used to draw them are available on request from the WHO Regional Office for Europe, Epidemiology, Statistics and Health Information Unit and Distribution Unit.

WHO Library Cataloguing in Publication Data

Health in Europe: The 1993/1994 health for all monitoring report

(WHO regional publications. European series ; No. 56)


ISBN 92 890 1320 6 (NLM Classification: WA 900)
ISSN 0378-2255

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Design/Layout Grethe Lystrup
Printed in Denmark
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Acknowledgements

Gratitude is due to the many staff of the WHO Regional Office for Europe and external experts who contributed their judgement and advice to this report. Particular acknowledgement is owed to: Professor J. Ashton, Professor J. Catford, Professor V. Grabauskas, Professor M. Marmot, Professor H. Van Oyen, Professor M. Rosén, Professor F.W. Schwartz, Dr V. Shkolnikov, Dr Anne Staehr-Johansen, Dr J. Steensberg and Dr W. Weiss.
Regular monitoring and evaluation of countries' progress towards health for all are an important part of the policy adopted by the WHO European Region in 1984. This book presents the results of the 1993/1994 round of monitoring. Since the large-scale evaluation of 1990/1991, the Region has changed in many ways. This report gives a concise account of the new situation.

The Member States of central and eastern Europe and the former USSR, with hundreds of millions of people, have continued to undergo a dizzying array of political, economic and social changes. These have had profound effects on daily life, health and the stability of society. Some countries are in the throes of armed conflict, which have taken a terrible toll on their health, societies and economies. In addition, the transition to market economies and more liberal social arrangements has continued to create enormous difficulties in health development.

A widening gap in health separates the eastern and western halves of the Region. Health problems in the eastern countries include stagnating life expectancy, more premature deaths from chronic disease, outbreaks of communicable disease (particularly diphtheria) and increasing numbers of accidents. Finally, the standards of living are declining for a large part of the population, particularly elderly people in urban areas. Substandard housing and nutrition and now decreasing health care create conditions threatening the health of many millions of people.

The western countries of the Region have seen a much more encouraging health situation. Most have continued to make progress against both communicable and noncommunicable diseases. Here, the consolidation of the European Union is creating a more stable environment for health development in many countries.

Thus, the underlying structure of national and international interrelations in the Region has changed profoundly, with important implications for health. All countries are searching for new or more effective forms of integration, although the obstacles to, speed of and expected outcomes of this pursuit differ.

The obvious challenge for health authorities is to find an adequate response to this major shift. Policies for health for all provide the overall strategy for future health development. Implementing them, however, requires public health knowledge and techniques to manage change in society. The aim is to achieve optimal health gains through sensible action that targets the determinants of health and that continuously measures the outcomes of intervention in terms of their health impact. This requirement applies to the full range of actions to improve health, from multisectoral efforts to improve health and prevent disease and accidents to the daily work of physicians and other health care providers at the clinical level.
A number of aspects, however, need further emphasis in the years ahead. Health care financing and infrastructures, and public health action should be adapted to sustain minimal economic growth and ease the pressures of social disruption. This requires continuous emphasis on efficiency, effectiveness and quality of care. In addition, building networks and partnerships needs a higher place on the health and social policy agenda. Health policies should become more tangible to citizens, not only providing strong leadership by health professionals but also creating broader understanding and support of health targets in sectors other than health, nongovernmental organizations, communities and the people themselves.

As societies in the Region give increasing importance to information and knowledge as tools for health development, more resources should be devoted to reaching good standards in education, training, research and information systems for health. Investing in these areas is vital for future health development, and Member States and the Regional Office will work together in this direction, as part of their progress towards health for all.

J.E. Asvall
WHO Regional Director for Europe
Introduction

This is a report on health in Europe. It describes the health status of the people of the WHO European Region, outlines the most relevant determinants of their health and identifies the main public health actions that influence it. The report therefore highlights the progress achieved and the different experiences of countries of the Region in pursuing their policy for health for all.

At the thirtieth session of the WHO Regional Committee for Europe, in September 1980, the Member States of the European Region approved their first common health policy: the European strategy for attaining health for all. The Regional Committee adopted 38 specific regional targets to implement this strategy at its thirty-fourth session, in September 1984. In addition, 65 essential regional indicators or groups of indicators, incorporating the 12 global indicators, were proposed to be used as a means of assessing progress towards the attainment of the targets. a The forty-first session of the Regional Committee, in 1991, approved an updated version of the 38 regional targets and a list of indicators. b

By asking the Regional Office to carry out a full evaluation of progress every six years and to monitor the situation between these evaluations, the Member States also made a commitment to report and compare their achievements, as they cooperated in a Region-wide public health movement. Several countries have gradually developed capacities for monitoring and evaluating public health policies and action, and produced highly comprehensive and relevant reports. Countries such as Sweden, Switzerland and the United Kingdom often facilitate and reinforce this work by the publication of public health reports.

Many Member States in the eastern part of the Region are “new countries”. For them, this exercise comes closer to “baseline” reporting than to monitoring of progress towards health for all. This report uses country groupings – such as the countries of central and eastern Europe (CCEE) or the newly independent states (NIS) of the former USSR – to analyse health status in the Region. These terms retain considerable usefulness in describing established socioeconomic and health patterns in the Region, particularly the very significant “east-west gap”.

The feasibility of monitoring and evaluation and the precision and validity of the assessments vary extensively, according to the more quantitative or qualitative nature of the issues, targets and indicators concerned, the existence of standardized definitions and rules of procedure for information collection, and the way these are applied in different countries. Ten years of experience in monitoring and evaluation at the regional level has shown that some form of health intelligence system in the

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a Targets for health for all. Copenhagen, WHO Regional Office for Europe, 1985 (European Health for All Series, No. 1).

b Health for all targets. The health policy for Europe. Copenhagen, WHO Regional Office for Europe, 1993 (European Health for All Series, No. 4).
Regional Office is vital for assessing and reporting on health in the spirit of health for all. This includes the extensive and systematic use of expert advice and consultation to evaluate, analyse and complement the reporting by countries. In this process, the Regional Office gradually developed an extensive information infrastructure to support an increasingly sharper Regional Office public health knowledge base (Annex 1).

This report summarizes current public health knowledge about Europe. It has been designed to become widely available and accessible, as will the information infrastructure that underpins it. In addition, the Regional Office will issue regular updates. The aim is to increase awareness for public health action in the Region, so that health for all can become a more meaningful goal for all the people of the European Region.
THE PREREQUISITES FOR HEALTH

Health and wellbeing are inextricably linked to the overall conditions of life. The prerequisites for both health and healthy living include feeling free from life's threats, and having meaningful roles and functions in society, proper education, a decent home, and the necessary earnings to meet basic needs. These factors have increased their influence on the health of the population in the European Region more strongly than ever since the launching of the strategy for health for all.

The 50 countries of the European Region

When the WHO Regional Committee for Europe met for its forty-fourth annual session in Copenhagen in September 1994, the Region embraced 50 Member States. The 12 CCEE and the 15 NIS can be viewed as having economies in transition from central planning to a market economy. The Region also contains 21 countries situated in northern, southern and western Europe. They are highly industrialized and mostly densely populated, and have developed market economies. Turkey and Israel, although differing in many respects, are also Member States of the Region.

The countries in the Region vary widely in their level of economic development (Annex 2). With the gross national product (GNP) per head as a main criterion, 24 countries could be found in the middle-income group (with a GNP per head of US$ 635–7909) and 18 could be found in the high-income group in 1991. These differences are likely to continue to shape how people live and work.

Aging in Europe: implications for health

The demographic background is important for understanding the present and future health situation in the European Region. Long-term trends in population growth tend to converge. According to earlier United Nations projections, future increases in the population of the Region will take place mainly in some NIS and Turkey.

Recent figures show some divergence, however, with growth rates decreasing for the CCEE and NIS, and increasing elsewhere in the Region. Falling birth rates contributed to very low or negative growth rates in most of the CCEE and NIS (Fig. 1.1). Age-specific fertility rates also tend to converge and decline (Fig. 1.2) except in the central Asian republics of the NIS, Albania and Turkey. If the central Asian republics are not considered, the NIS show fertility patterns like those of the CCEE.

A most important development throughout the Region appears to be the further aging of the population. The proportion of people over 65 years of age, especially the very old, will continue to rise (Fig. 1.3). The extraordinary reduction in birth rate in most of the NIS, comparable to the effect of war, has accelerated population aging. The combined effects of aging and declining fertility influence the conditions under which children are growing up, raise questions about the claims and social role of elderly people and pose major economic and health challenges for the future.

In addition to the continuing demographic transformation of the Region, lasting migration from south to north and east to west continued to create a critical situation with respect to the prerequisites for health. Migration defies the capacities of social systems to integrate different ethnic groups and can create imbalances in the availability of appropriately qualified human resources in the countries that gain people as well as those that lose them.

On the positive side, the feared massive emigration from east to west did not materialize, according to the reporting system on migration of the Organisation for Economic Co-operation and Development. Rather, the trends point towards organized temporary migration, which showed little growth or even falling numbers after 1989–1991. Germa-
Fig. 1.1. Birth rates in selected countries of the European Region, 1980–1992

Source: data from the WHO Regional Office for Europe.

Fig. 1.2. Estimated age-specific fertility rates in the European Region, 1990–1995

ny was the main destination of migration from east to west. In addition, the lack of rapid population increase could be seen as a positive effect, avoiding burdens inflicted on other regions in the world.

### War affecting eight countries of the Region

In 1992 alone, wars affected at least eight countries in the Region: Armenia, Azerbaijan, Bosnia and Herzegovina, Croatia, Georgia, the Republic of Moldova, Tajikistan and the Federal Republic of Yugoslavia (Serbia and Montenegro). Each conflict involved one or more governments and caused the death of 1000 or more people per year.

During the past two years, armed conflict in the former Yugoslavia killed more than 150,000 people, wounded hundreds of thousands, and displaced close to 4 million. In other countries, too, fighting continued to take its toll of suffering and damage. In addition to these obvious and immediate effects, war and conflict cause the deterioration of the social environment, with a long-lasting negative impact on people's health and wellbeing.

In most other countries in the Region, including Israel, however, the threat of military confrontation has decreased, bringing a significant peace dividend. As noted in a recent report from the United Nations Development Programme (UNDP), this dividend is the resources saved by reducing military spending. European nations realized very considerable savings from reducing military expenditure between 1960 and 1990. The percentage of gross domestic product (GDP) devoted to military expenditure fell from 4.7% to 2.9% in the countries of the European Union (EU), from 2.7% to 2.3% in the Nordic countries, and from 11% to 10% in the former USSR. In addition to reducing
direct military expenditure, the ratio of this expenditure to combined expenditure on education and health largely fell, except in the former USSR.

Unfortunately, there was no easy way to account for the use of these savings. An effective way should therefore be found fully to harness these funds. This will be an important item on the agenda of the World Summit on Social Development, to be held in Copenhagen in 1995.

In particular, health authorities in all countries should take a lead in mobilizing the social sector to develop and discuss, in appropriate fora, coherent and realistic policies for devoting the peace dividend to national human and health development, and to international assistance needs. It seems strange that work on social development and health problems in many countries appears to be more difficult to finance when military budgets are falling than when they were rising.

Social tension from economic recession and unemployment

In general, eastern countries have seen five successive years of falling activity. The aggregate decline of output since 1989 was over 30% by the end of 1992, and possibly around 40% by 1993 (Fig. 1.4).

For most western European countries, the economic situation has been marked by a long recession. Hopes for prompt recovery at the start of the decade proved to be little more than wishful thinking. Unemployment rates rose from about 8% in 1991 to over 11% in early 1994, with several countries facing much sharper increases. For example, unemployment grew from 7.5% to 17.7% in Finland and from 16.0% to 22.4% in Spain. In 1993, standardized unemployment rates over 10% were observed in France (11.6%), Ireland (15.8%), Italy (10.2%) and the United Kingdom (10.3%). Registered unemployment was 12.3% in Denmark.

Fig. 1.4. Percentage change in GDP over the preceding year, 1990–1994

Source: Adapted from Economic survey of Europe.
Among the almost 35 million unemployed people in the western part of the European Region, particular concern must be given to the increasing number of long-term unemployed, who risk gradual loss of skills as well as marginalization: being ostracized as inferior to others, not only in the labour market but also in society. Long-term unemployment is a particular problem for the Region. Many people of working age were discouraged from seeking work or had to become part-time workers, as was often the case for women. Most important, unemployment rates are usually highest among young people; youth unemployment is around 30% in France, Italy and Spain. This may have serious implications for wellbeing in the Region.

**Signs of recovery in the west in 1994**

Nevertheless, recent data indicate that the most difficult phase of the economic recession in the west, and the transition to market economies in the east, is probably over.

Economic growth in the western countries was expected to rise to some 1.5% in 1994. Most recently, the GDP forecast for Germany was higher than expected, a distinct improvement in an economy that is very important for the CCEE. In eastern Europe, Poland was first to show a 1.5% increase in GDP in 1992, and 4.0% in 1993. Signs of recovery could also be detected in the Czech Republic, Estonia, Hungary, Romania, Slovenia, Turkmenistan and Uzbekistan. The situation remains critical, however, in the countries at war and in several NIS.

The situation with respect to the prerequisites for health has worsened in many respects since the end of the 1980s. In general, however, promising signs of recovery and the initiation of more favourable conditions for investment in health can be seen. If GDP in 1985 is taken as 100%, some analysts predict that it will be about 160% in western Europe, about 135% in the CCEE and about 115% in the NIS in 2005.

**Increased social exclusion, poverty and homelessness**

Inevitably, the severe consequences of political and economic problems spread across the Region. Migrants and refugees continued to concentrate in urban areas, where they frequently joined other socially marginalized people. This situation has resulted in critical sanitary and living conditions, particularly substandard housing and homelessness. More people in several underprivileged groups lived below the poverty level. In different eastern European countries, such people comprised from 11% to almost 40% of the population; in the EU, the average was close to 15%.

In addition, inequities in income increased in almost all countries of the Region. Related to this is an increased uncertainty about social and economic prospects. The mechanisms through which these trends affect health and wellbeing are very complex and difficult to disentangle, but there is little doubt that they are related to various kinds of health risks and damage: rapidly eroding social support structures, declining birth rates (particularly in the east) and a high incidence of psychosocial and mental health problems.

**Apparent surge in violence**

With economic pressures and social tension, threats against personal security also surfaced rapidly throughout the Region. Apart from the open fighting mentioned above, violent behaviour on the streets, and against women, children and the elderly showed disturbing trends.

In almost all countries risk to life was greater than ever before. While this was particularly true for the CCEE and NIS, the homicide rates also increased rapidly in the Federal Republic of Germany, Italy and Portugal in the late 1980s. Drug trafficking was widely believed to be connected to the increase in crime. UNDP reported that drug-related crimes in Denmark and Norway, for example, were estimated roughly to have doubled in the second half of the 1980s.
Although grossly underreported, violence against women was recognized to show alarming proportions in all countries. Domestic violence and rape cause morbidity and mortality in women. In industrialized countries, domestic assaults have been reported to cause more injuries to women than motor vehicle accidents, rapes and muggings combined.

In addition, accidents on the road and at work continued to pose major risks to life and health, particularly in the NIS.

More democracy and better prospects for investing in social welfare?

The fundamental improvement of the overall social and political climate should be considered if balanced conclusions are to be reached. Four rather encouraging general conditions need to be better understood and translated into action to improve the living conditions of those in need.

East-west confrontation having ceased, democracy is being restored in many of the CCEE and NIS, and political dialogue has been strengthened. Intensified cooperation within the EU may stimulate improvements to the prerequisites for health.

While the process of transition in the CCEE and NIS brought about new problems, it also offered opportunities to consider health needs in a much more consistent and determined way, under the new legislative, political and managerial arrangements.

Reducing military expenditure resulted in substantial savings. Health authorities have an important role to play in discussing the use of the “peace dividend”.

Investing in health by meeting urgent health needs can create jobs, even if not in the traditional form of employment for health professionals. Here, health authorities can actively stimulate and promote innovative approaches.

From prerequisites to health development

The links between the main prerequisites for health and development in lifestyles and health are complex and cannot always be charted. Nevertheless, the practical and scientific evidence is more than sufficient to show their decisive role in shaping the health experience of different populations, social groups and individuals. This understanding and perspective form the basis for the further examination of the trends in health in the Region.

Key sources


Health for all statistical database. Epidemiology, Statistics and Health Information Unit, WHO Regional Office for Europe, 1994.


HEALTH OF PEOPLE IN EUROPE

Constraints of data and methods

The health of people and populations has to be assessed with a wide range of measures, ranging from “hard” data on mortality, through disability and morbidity data, to the subjective perception of health and various aspects of the quality of life.

Although the chances for sufficiently accurate measurement vary widely, the data on mortality and the incidence of infectious diseases, and, to some extent, hospital statistics are still the best available. Mortality data for international analysis are at present available from almost all countries of the Region, except Monaco, San Marino, Turkey and some countries that emerged from the former Yugoslavia. The insufficient availability and comparability of data on noncommunicable diseases or disability, not to mention measures of the quality of life, are major obstacles to the complete assessment of health status. For these reasons, composite indicators, such as disability-adjusted life years (DALYs), disability-free life expectancy or health expectancy, could not be used for comparisons in the Region, because the non-mortality components of these indicators are lacking.

Life expectancy at birth is therefore the main global indicator used to assess health, as it summarizes mortality patterns in the population. Available data on morbidity, disability and quality of life are taken into account to cast some light on other aspects of health in the European Region.

Since the last health for all evaluation, in 1990/1991, the European Region has become more heterogeneous, with countries ranging from world-leading market economies, with correspondingly high levels of health, to countries with health indicators that show a pattern close to that of developing countries. In this situation, assessing the health status of the Region as a whole is not always meaningful. Assessments were mostly made of groups of countries with similar health status patterns or trends. The groups were constructed according to purely technical criteria related to the availability and comparability of historical data series.

In general, the following groupings were used: the 15 NIS, the CCEE (6 countries: Bulgaria, the former Czechoslovakia, Hungary, Poland, Romania and the former Yugoslavia), the 12 EU countries and the 5 Nordic countries (Denmark, Finland, Iceland, Norway and Sweden). Certain countries are therefore not covered by these group comparisons. The main focus of the analysis is the east-west gap in health and the impact of the current socioeconomic difficulties in the CCEE and NIS.

Greater inequities in health: the widening east-west gap in life expectancy

The increase in the east-west gap in life expectancy and mortality started in the 1960s and 1970s. The gap widened further in recent years, mainly because of the rather sharp deterioration of health in most of the NIS and some CCEE (Fig. 2.1). All countries in southern, northern and western Europe show a further steady increase in life expectancy, although with some variations in growth rate. The average for the CCEE increased very slowly and has been stable since 1990, although the patterns vary within this group.

Further to the east, the situation is more complicated and dramatic. According to the preliminary 1993 data available for several NIS, life expectancy dropped to the lowest levels seen for decades.

Considering the long-term increase in the east-west gap in life expectancy, the question is: which diseases contribute most? The answer could point to the possible strategies needed to narrow the gap. In 1992, the average life expectancy for the CCEE and NIS was about 7.3 years less for males, 4.9 years less for females and about 6 years less for
both sexes combined; life expectancy for both sexes was 75.6 years in the west and 69.6 in the east.

About half of the gap is due to mortality differentials in cardiovascular diseases in people over the age of 35 years (Table 2.1). External causes of death, particularly in the middle-aged population, are the second largest contributor. Respiratory diseases are a more common cause of infant death in the CCEE. In total, cardiovascular diseases are responsible for more than 50% of the present gap, and external causes and respiratory diseases, for 23%

### Table 2.1. Contribution to the gap in life expectancy between the CCEE and NIS and the rest of the European Region, by age and cause of death

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>&lt;1 year</th>
<th>1–34 years</th>
<th>35–64 years</th>
<th>≥65 years</th>
<th>All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious and parasitic diseases</td>
<td>0.3</td>
<td>0.1</td>
<td>0.08</td>
<td>−0.01</td>
<td>0.47</td>
</tr>
<tr>
<td>Cancer</td>
<td>0</td>
<td>0.05</td>
<td>0.25</td>
<td>−0.35</td>
<td>−0.05</td>
</tr>
<tr>
<td>Cardiovascular diseases</td>
<td>0</td>
<td>0.07</td>
<td>1.36</td>
<td>1.85</td>
<td>3.28</td>
</tr>
<tr>
<td>Respiratory diseases</td>
<td>0.68</td>
<td>0.2</td>
<td>0.15</td>
<td>−0.5</td>
<td>0.97</td>
</tr>
<tr>
<td>Digestive diseases</td>
<td>0.02</td>
<td>0.03</td>
<td>0.08</td>
<td>−0.04</td>
<td>0.09</td>
</tr>
<tr>
<td>External causes</td>
<td>0.04</td>
<td>0.64</td>
<td>0.71</td>
<td>0.03</td>
<td>1.41</td>
</tr>
<tr>
<td>Illdefined conditions</td>
<td>−0.1</td>
<td>0.01</td>
<td>0.04</td>
<td>0.18</td>
<td>0.12</td>
</tr>
<tr>
<td>Other diseases</td>
<td>0</td>
<td>0</td>
<td>−0.02</td>
<td>−0.2</td>
<td>−0.22</td>
</tr>
<tr>
<td>All causes</td>
<td>0.93</td>
<td>1.09</td>
<td>2.63</td>
<td>1.4</td>
<td>6.06</td>
</tr>
</tbody>
</table>
and 16%, respectively. Infectious and parasitic diseases contribute about 7%.

From the point of view of age, the main contribution to the gap comes from the group aged 35–64 years (43%), followed by older people (23%) and infants (15%).

When measuring the east-west health gap in relative terms, virtually all causes of death that are used as health for all indicators show a particularly dramatic widening (Fig. 2.2). Even the “positive” balance in mortality from breast cancer in women aged under 65 years is gradually shrinking.

The significant improvements in Romania were the main cause of the decrease in the east-west ratio of maternal mortality between 1985 and 1992. Mortality from homicide in the east reached a level more than 10 times higher than that in the rest of the Region. Infant mortality and premature mortality from cardiovascular diseases are about three times higher in the east, and premature total mortality is about two times higher.

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**Health decline in the NIS**

Detailed mortality data for the former USSR and its constituent republics became available for international analysis in the late 1980s. Historical mortality and life expectancy trends in the NIS are complicated and need special in-depth analysis. The current trends in life expectancy have three components: a long-term secular trend, the effect of the anti-alcohol campaign in the former USSR in the mid-1980s, and the current difficulties of transition. Since the 1960s, life expectancy has stagnated in most NIS. The 1970s saw a continuous slight decline, with some temporary improvement in the first half of the 1980s. In 1985–1987, most probably owing to the anti-alcohol campaign, life expectancy rose sharply. In terms of mortality, the average annual health gain in the former USSR was about 100 lives saved per 100 000 population. For example, life expectancy in the Russian Federation increased by 3.2 years for males and 1.3 years for females between 1984 and 1987. The highest point was reached in 1986/1987 and a subsequent gradual decline start-
Fig. 2.3. Trends in life expectancy at birth for males in selected NIS and the EU, 1970-1993

The main difficulty in assessing the net impact on NIS mortality of the present economic crisis is the distortion of secular trends in life expectancy by the anti-alcohol campaign. The simplest assumption is that all gains above the 1984 or 1985 level (the campaign started on 1 June 1985) are due to the campaign and that the decline below this level is attributable to the current economic difficulties. Using 1985 as a baseline, life expectancy in 1992 was 0.4 years below this point in the Russian Federation (for both sexes), and 0.9 years in Ukraine and 0.1 years in Lithuania. Preliminary data for 1993, however, indicate a further, particularly sharp decline, pushing life expectancy below the levels observed in the 1960s or even the 1950s.

In summary, the restoration of the previous alcohol-related mortality patterns probably accounts for the decline in life expectancy until about 1991/1992. From 1992, the economic crisis and other problems related to the transition to a market economy are most probably responsible for the further deterioration. Trends in alcohol consumption (including that of unregistered alcohol) support this view; consumption in the Russian Federation in 1992, for example, reached the level of 1984 (Fig. 2.4).

The analysis of the components of the 1984–1987 gains and the 1987–1992 losses in life expectancy indicates that both were largely attributable to the same causes and the same population group: external causes (accidents, homicide, suicide) followed by cardiovascular diseases, particularly for middle-aged men. The mechanisms of such an impact are not clear and need further investigation.

Preliminary 1993 mortality data for Estonia, Kazakhstan, Latvia, Lithuania and the Russian Federation unanimously show unfavourable trends, pushing life expectancy back to levels observed decades ago. This fall affected males most. For example, life expectancy for males in the Russian Federation...
was estimated to be 59 years, which is below retirement age. The component analysis confirmed that the same causes of death continue to play a leading role. During 1993, out of the total loss of 3 years of life expectancy for Russian males, 1.14 years (38%) were lost to the increase in accidents, homicide and suicide, 0.97 years (32%) to cardiovascular diseases and 0.9 years to all other diseases.

Only a relatively small proportion of the mortality increase in the NIS can be attributed to problems in the health services (such as some of the increase in deaths from infectious and parasitic or respiratory diseases), although shortcomings in these services significantly affected the provision and quality of care. Most of the increased mortality is attributable to socioeconomic and living conditions, combined with lifestyle-related behavioural factors, such as accidents, violence and homicide, suicide, stress and alcohol-related cardiovascular deaths.

Taking account of the current extremely low levels of life expectancy in the NIS, some recovery in the near future is more likely than a further deterioration. The main difficulties of the first years of transition to a market economy also seem to be more or less over, as indicated above.

### The CCEE: a mid-point between east and west

Health status in the CCEE could be placed between the deteriorating trends in the east and the improvements in the west. Countries within this group vary, however, both in current levels of life expectancy and recent trends. For example, life expectancy in Hungary began to fall in 1989, after a rather significant improvement in 1986–1988. It dropped slightly in the former Czechoslovakia and Poland around 1989/1990, but increased again in 1992. Life expectancy improved in Romania between 1987 and 1991, with some drop in 1992. (The most recent drop in Bulgaria, Hungary and Romania may be attributed in part to the noticeably lower post-census population figures provided by these countries.)
The data for 1992 show a rise in life expectancy in Albania and the Czech Republic. For Albania, however, detailed mortality data, on which life expectancy is based, were received for the first time very recently and their completeness still needs to be checked.

In general, the data available on the CCEE point more towards a further slow increase or stagnation than to a significant decline in life expectancy, except perhaps in Hungary. If the economic difficulties of the transition are reflected in life expectancy, this effect is still no bigger than several temporary fluctuations in the past. A more definite answer can only be given in a historical perspective.

Western Europe’s life expectancy: approaching limits for improvement

Twenty Member States from the north, west and south of Europe, for which mortality data are available, lead the Region in life expectancy. In this group, life expectancy ranges from 78.8 years in Iceland to 74.4 in Portugal. It has constantly improved for the whole group for at least the last two decades, although countries differ in the rate of growth.

Comparing the relative position of countries between 1980 and 1991/1992, Denmark shows the most unfavourable change (falling from tenth to eighteenth place), followed by Norway and the Netherlands (Fig. 2.5). The Danish Ministry of
Health launched a special investigation into the reasons for this change. It found that one of the largest contributors to the excess mortality in Denmark was cancer mortality in women. The high rates of smoking (particularly among women), alcohol consumption and unemployment, and the early entry of women into the labour market were reported as the main causes of the relatively unfavourable development in life expectancy in Denmark.

Portugal showed the opposite trend. Life expectancy was rather low in the 1970s but rose rapidly, significantly reducing the gap between Portugal and other western countries.

Since almost all western countries have passed the health for all target of 75 years’ life expectancy, what is the potential for further improvement? To answer this question, the current feasible life expectancy was calculated from a life-table that was constructed using the lowest age-specific mortality rates observed in any country of the Region. At present, feasible life expectancy is 77.2 years for males, 83.3 years for females and 79.8 for both sexes combined. Another way of estimating the upper limit to life expectancy is to set premature mortality at zero. Assuming the total elimination of mortality before 65 years and unchanged present mortality at older ages, life expectancy would increase by only 4–5 years in countries such as Iceland, Sweden or Switzerland. This means that a slowing of the rise in life expectancy may be expected. Actually, signs of a reduction in increase can be seen in the above countries when the average annual slopes in the periods 1980–1985 and 1985–1991 are compared.

Cardiovascular diseases: potential for health gain through prevention

Cardiovascular diseases (CVD) are the leading cause of death in the Region. They cause about half of all deaths and about one third of permanent disability, and are responsible for a large proportion of health care costs. CVD are also the main component in the east-west mortality gap. This means that even a small relative reduction in CVD mortality would yield a noticeable gain in absolute terms.

Many epidemiological studies have shown that risk factors related to lifestyle play a key role in the development of CVD. Smoking, unhealthy nutrition and low physical activity, for example, lead to high blood pressure, high cholesterol and overweight. Observation and intervention studies suggest a wide variation in risk factor levels between countries, which is likely to be related to variation in CVD rates. This indicates a large potential for preventive action in the Region (Fig. 2.6).
Although differences in risk factors can largely explain the differences in premature death from CVD, other factors could have contributed to the mortality decline in western countries. These include socioeconomic differences, advances in medical technology and changes in the availability, accessibility and use of hospital and ambulatory care.

The experience of community control programmes, initiated in the 1970s by the Regional Office, for Europe shows that planned, coordinated intersectoral effort can lower risk factors in the community. Further, more and more countries are developing and implementing national strategies to prevent CVD by reducing the levels of these factors.

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**Cancer: some progress in the west**

Cancer is the second leading cause of mortality, and is responsible for about 20% of deaths in the Region. Here, too, the CCEE and NIS show trends diverging from those in other Member States (Fig. 2.7). Although past trends in the western countries were unfavourable, the most recent data show a slight improvement for 1991/1992. Since the last evaluation of progress towards health for all, more western countries are experiencing declining trends or steeper declines.

The diverging trends in cancer mortality between eastern and western countries are largely due to mortality from cancer of the lung, the digestive
organs and the cervix. Higher rates of smoking can explain the higher rates of lung cancer in the eastern countries. Cancer of the digestive organs is decreasing in the western European countries; this can be related to changes in nutritional patterns. Eastern countries show no clear trend.

Cervical cancer in women is a rather special case; it is decreasing in all countries, although much more in western Europe than in the east.

In most countries, deaths from cancer in people under 65 are about twice as high in men as in women. Some north-western countries, however, such as Denmark, Iceland, Ireland, Norway and the United Kingdom, are exceptions to this rule. They show a high female cancer mortality, comparable to or even exceeding male mortality. As mentioned with regard to life expectancy in Denmark, the most probable reason for this is the adoption by women of some aspects of lifestyle that had previously been considered the province of men, particularly smoking.

The International Agency for Research on Cancer (IARC) regularly analyses the recent trends in cancer mortality and incidence. The latest IARC report indicates that tobacco-related cancer is on the increase, particularly among females. All other types of cancer are showing either stable or slightly decreasing trends.

Injury and poisoning: an epidemic in eastern Europe

External causes are the third leading cause of death in industrialized countries, and make a special contribution to the east-west health gap. Mortality from external causes is increasing in almost all the NIS and CCEE, and declining in most other countries of the Region.

Accidents are the biggest single cause of death and disability among young people. The transition to a market economy in the NIS and CCEE is associated with increasing social violence, weakening
Fig. 2.8. Incidence of poliomyelitis in the European Region, 1981–1993

Note: Incidence figures not divided according to source until 1984.
Source: data from the WHO Regional Office for Europe.

Fig. 2.9. Incidence of diphtheria in the European Region, 1980–1993

Source: data from the WHO Regional Office for Europe.
occupational safety measures and growing psychological stress related to uncertainties about and an inability to cope with the new social and economic conditions. All this, combined with the effect of excessive alcohol consumption in some NIS, is reflected in the increase in mortality from external causes of death, particularly from homicide.

According to the latest available data, standardized mortality from external causes ranges from over 200 deaths per 100,000 population in some NIS to about 30 per 100,000 in the United Kingdom. A relatively high mortality rate is also observed in Finland, mainly because of high numbers of suicides.

**Communicable diseases: no room for complacency**

The latest reports from a number of countries prove that communicable diseases unfortunately remain major health problems in the Region. Without considering the AIDS epidemic, the resurgence of highly contagious diseases such as poliomyelitis, diphtheria and cholera alarms health authorities in many Member States.

Dying from diphtheria or cholera in Europe in the 1990s seems very improbable. It is a fact, however, and disease could easily spread to the areas with armed conflict, large numbers of refugees or grave economic problems, if public health authorities remain complacent.

In general, immunization coverage remains high and stable in the Region. Recent experience has shown that this is not sufficient to eliminate measles, for example. Protection against pertussis has been insufficient in a number of countries, particularly the NIS. In addition, low coverage of immunization with DPT/DT vaccines in many regions of Belarus, the Russian Federation and Ukraine is one of the main causes of the diphtheria epidemic in these countries.

The global goal of a 95% reduction in measles mortality was achieved, although the eradication of the disease is no longer considered a realistic goal. The reduction in morbidity is estimated to be 81–98%. Owing to a shortage of vaccines in some NIS, the pace of progress towards eradicating poliomyelitis has slowed, but reasonable prospects remain for reaching the goal by the year 2000. Although poliomyelitis occurred in fewer countries in 1993, the actual number of cases rose (Fig. 2.8). The diphtheria situation deteriorated in 1990 and worsened dramatically in 1992 and 1993. Almost all cases were reported from the NIS. The Russian Federation and Ukraine saw most of the sharp rise in incidence in the early 1990s (Fig. 2.9). National action plans for diphtheria control, based on Regional Office recommendations, have been carried out in Belarus, the Russian Federation and Ukraine.

In some countries, tuberculosis morbidity has stopped declining in recent years or even increased; this is partly attributable to immigration in western countries. During the 1980s, notified tuberculosis cases declined almost everywhere in the Region. Since 1988, 13 countries have stopped vaccination with BCG vaccine. Tuberculosis notification has levelled off or increased in recent years in many CCEE and NIS. It has also increased in western countries: Austria, Denmark, Ireland, Italy, the Netherlands, Norway and Switzerland. With the present trend of mass migration, an increasing number of refugees, and the critical socioeconomic situation in many countries, transmission is very likely to increase.

The resurgence of cholera has become another concern. For example, 165 cholera cases were registered in Tajikistan in 1993, and a large outbreak occurred in Dagestan, Russian Federation in 1994. Imported cases from endemic areas outside the Region endangers countries in which sewage and sanitation are still poor.

By August 1994, a cumulative total of 116,000 AIDS cases had been reported in the countries of the European Region. The annual incidence shows signs of slowing down, reflecting the effect of the tremendous preventive efforts undertaken by Member States since the epidemic began. Fig. 2.10
shows increases in cases transmitted by injecting drug use and heterosexual contact.

Mortality from infectious and parasitic diseases varies from 40–50 per 100 000 population in the central Asian republics to 5–10 in western countries, but continues to decrease in most countries of the Region. A slight increase was observed in the NIS in 1990–1993. For example, mortality in 1992/1993 in Lithuania, the Russian Federation and Ukraine has reached the levels observed in the first half of the 1980s. Some increase since the early and mid-1980s has taken place in Denmark, the Netherlands, Romania and Switzerland.

An assessment of women’s health in the European Region, based on selected regional health for all indicators, confirms that women live longer than men: on average, 5–7 years more in western Europe and about 7–13 years more in eastern countries. The higher mortality rates of men often draw attention away from the health problems that women face. Women’s health has a strong influence on the health of the children they bear and raise. Although women care for the young and often the old, their health and social status are usually worse than those of men. Improving women’s health will therefore affect family health in general.

Women have more years of unhealthy life (higher rates of chronic illness and disability), associated to a great extent with their longer survival.

In total, 10 NIS and 1 of the CCEE have maternal mortality rates above 30 per 100 000 live births.
Abortion-related mortality, on average, is responsible for about 20–25% of maternal deaths in the CCEE and NIS. This must be regarded as an unacceptably high family and social loss that needs emergency attention.

Abortion remains the principal means of contraception in the CCEE and NIS; countries may have two or three times as many abortions as births. In the western part of the Region, most teenage pregnancies are unwanted, and about one third end in abortion in some countries. In many countries, lack of sex education for the whole population denies people an informed choice; in women, such ignorance endangers their security and causes them bodily harm.

In addition to health problems related to maternity, women have other unique health problems related mainly to reproductive functions and the menopause. The rates of cervical cancer mortality in CCEE are double the average for the Region, and about three times the EU average. The highest mortality rates from cancer of the breast, however, are found in the western part of the Region.

It is feared that the concerted targeting of young people, particularly young women, in tobacco advertising will lead to more smoking among women. Increases in female lung cancer mortality in a number of countries illustrates the danger (Fig. 2.11). Some western European countries are trying to ban cigarette advertising in magazines for young women.

The numbers of prostitutes and other sex workers are increasing rapidly in the Region, and the proportion of AIDS cases in females continues to increase.

Western countries have identified mental and emotional health as a priority issue. Women are
more likely than men to suffer from depression and anxiety, and to be prescribed tranquillizers. Addiction to tranquillizers is becoming a problem.

Finally, women’s economic situation is in general less favourable than that of men, which has important implications for health.

### Elderly people: the most vulnerable population group

Western countries reported some signs of improvement in the health of elderly people. Some countries calculate disability-free life expectancy, based on data from health interview surveys; France, for example, reported a marked increase in disability-free life, both in absolute terms and in relation to overall life expectancy.

The health and quality of life of the elderly tend to be low priorities in the government policies of most countries of the Region. The situation is particularly bad in the CCEE and NIS, where elderly people, especially those living alone, were the first to suffer from the consequences of the economic crisis. The huge inflation rates of recent years in the NIS have virtually wiped out all the savings the elderly had accumulated. State pensions are too low to pay the increasing prices of housing, heating and food. In addition, the economic crisis affected the institutions for the elderly funded by the state. International aid was important in helping to meet the basic needs of residents of homes for the elderly.

### Successful use of quality indicators improves health care outcomes

Many chronic conditions, and particularly their complications, create a major burden of disability and reduced quality of life. Two examples are diabetes and oral health.

The prevalence of diabetes varies between 1% and 4% of the general population in different countries.
of the Region. The prevalence of complications also varies, but still tends to be high in most countries. For example, a WHO study of vascular disease in diabetic patients in various European study centres indicates that the true prevalence of this severe complication may vary from about 15% to over 40% in males and from about 20% to some 50% in females. More recent studies showed that the prevalence of retinopathy in patients treated with insulin is probably in the range of 40–60%. In Lithuania, for example, more than 90% of all insulin-dependent diabetes patients eventually develop retinopathy and about half of these develop proliferative changes threatening their vision. The complication rates are probably slightly higher in Lithuania than in Sweden or Denmark, at least with respect to retinopathy, but are likely to reflect the situation in many countries of the Region. The important fact, however, is that some areas and countries, such as Iceland, have been able to demonstrate very low complication rates.

For this reason, several initiatives were recently launched to reduce the burden of such conditions in the Region. These initiatives are based on the simple principle of sharing information on performance and the best care practices between care providers, hospitals or countries, to encourage and motivate action for improvement. As a result of these initiatives, there is already clear evidence that diabetic complications have fallen in a number of countries, including Croatia and Norway (Fig. 2.12).

In addition, standardized quality indicators in use at the clinical, regional, national and international levels are increasingly accepted as the basis for further quality development in oral health. Sharing information on these indicators as well as on the best technical solutions or practices has already helped significantly to improve oral health in a number of countries, particularly Denmark.

### Are Europeans feeling worse?

Mental health and wellbeing could be considered a continuum ranging from severe psychiatric conditions to complete satisfaction with the perceived state of health and quality of life, with disorders, distress and psychological problems of varying severity lying in between. At least 5% of the population of the Region is estimated to suffer from serious, diagnosable mental disorders (neuroses and functional psychoses), although prevalence estimates vary widely from study to study. At least an additional 15% of the population is estimated to suffer less severe, but potentially incapacitating, forms of mental distress.

As to perceived health, this indicator is closely related to objective health and living conditions, and is a strong predictor of health problems and mortality. Data collected for this report show large and striking differences between countries that need to be better understood (Fig. 2.13). It is known that the absence of diagnosed disease is not a guarantee of good perceived health, and that many people with chronic conditions nevertheless feel healthy, if they are appropriately treated. This discrepancy, and probably many of the differences between otherwise comparable countries, reflect different cultural attitudes towards health and giving personal judgements.

Mental health and wellbeing became an increasing problem in the Region, mainly as a result of war-related trauma, economic crisis, social deprivation and migration. The unusually rapid and extensive change in social, political and economic structures contributed to the increase in the number of people affected by depression, anxiety and personality adjustment problems. Such conditions always affect the quality of life, but their impact was most likely to increase where adequate care and support structures were missing.

Further, rates of suicides among young people are on the increase in many Member States and the consumption of tranquillisers and antidepressants is large and growing, as shown by recent studies in countries such as Finland and Spain. Rates of homicide and purposeful injury are on the increase in almost all Member States. The Regional Office study on parasuicide provided the first estimates of
such behaviour in 13 countries. Although trends are not yet clear, the study shows a higher risk of parasuicide among the unemployed, for example.

Another increasingly used measure is healthy life expectancy. This is a generic term for indicators of the average duration of different states of health within the life-span, which is calculated by life-table methods. Several calculations have been made for dementia-free life expectancy, for example. Calculations for France showed a difference of just under a year between life expectancy and dementia-free life expectancy, which remains constant at all ages after 65 years. Dementia-free life expectancy is predicted to continue to increase in absolute terms, although it will fall slightly as a proportion of the overall life expectancy. This assessment is likely to be applicable to other countries with comparable mortality patterns.

In addition, a large proportion of people with severe mental disorders continued to be placed in institutions, which indicates a lack of appropriate care and rehabilitation. Nevertheless, some western European countries showed a decreasing use of long-term psychiatric hospital care and improved community-based care and treatment facilities. Since 1985, the number of beds for psychiatric care declined by about one half in Denmark and Finland, one third in Sweden and one fifth in the United Kingdom.

Awareness of and interest in improving the quality of life for physically and mentally disabled people are growing, although only in certain areas. Increasing difficulty in finding appropriate work for physically and mentally disabled people has been reported, mainly owing to economic conditions.
Table 2.2. Progress towards the achievement of selected targets

<table>
<thead>
<tr>
<th>Target</th>
<th>Number of countries and share of Region's population (%) with:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>target achieved</td>
</tr>
<tr>
<td>6. Life expectancy</td>
<td>19 (44%)</td>
</tr>
<tr>
<td>7. Infant mortality</td>
<td>22 (46%)</td>
</tr>
<tr>
<td>8. Maternal mortality</td>
<td>29 (54%)</td>
</tr>
<tr>
<td>9. Cardiovascular mortality</td>
<td>19 (44%)</td>
</tr>
<tr>
<td>10. Cancer mortality</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>11. Mortality from external causes</td>
<td>7 (19%)</td>
</tr>
<tr>
<td>12. Suicide</td>
<td>27 (51%)</td>
</tr>
</tbody>
</table>

Achievement of quantitative targets

The objective of monitoring progress towards health for all is to assess the level of achievement of the 38 targets for the European Region. A look at the achievement profile of the Region reveals a clear dichotomy. In general, target achievement is far better in western Europe than in the eastern countries of the Region. Table 2.2 describes the level of achievement for the targets that lend themselves to precise quantitative assessment.

Key sources


Health for all statistical database. Epidemiology, Statistics and Health Information Unit, WHO Regional Office for Europe, 1994.


Health policies

Health for all policy gaining in influence throughout the Region

For decades, health seemed a relatively isolated and undisturbed field. Today it is perhaps the sector most affected by the current political and economic crises. Health has become a favourite theme of the mass media and public opinion, and is therefore at the centre of political debates that influence the choice of policies. The outcomes of these debates are translated into the important reforms of policy and health systems that are under development in most countries of the European Region.

The severe financial constraints on all Member States have reinforced the need to set priorities. In response to the prevailing market-oriented climate, many western European countries, such as Belgium, France, Ireland, Luxembourg, the Netherlands, Norway and the United Kingdom, have undertaken health reforms in recent years. The development of an overall public health policy has often accompanied the implementation of reforms. This offers new opportunities to reorient health services towards primary care, and to focus on health promotion and disease prevention. Some western countries that resisted or did not see the relevance of developing health policies at the national level have recently started to work towards them.

With the legacy of a centralized approach to health policy and health services management, all the CCEE and NIS focus their health reforms on systems of care: primary health care, hospital care, personnel and the quality of care. Frequently the reforms are even broader, encompassing the whole field of health: disease prevention, health promotion and the environment and health. This is the case in, for example, Armenia, Kazakhstan, Kyrgyzstan, Lithuania, the Russian Federation and Ukraine.

From east to west, health policy and health care system reforms often refer to the regional policy for health for all, particularly when the reforms take an intersectoral and comprehensive approach. In the CCEE and NIS, new policies are being formulated, based on health for all but tailored more closely to local circumstances.

In recent years, many countries have elaborated national health policy documents to stimulate public debate and to secure ratification of the policies by their parliaments. The Regional Office has made critical comments on documents prepared for example, in Croatia, France (Stratégie pour une politique de santé), Luxembourg, Turkey and the United Kingdom (England – The health of the nation). In addition, the Regional Office made an external review of Finland’s national policy for health for all. A meeting held in late 1992 to consider the value of the review recognized that it had had a strong impact on health policy development in Finland.

Approaches on a regional level are increasingly developed in Member States with centralized health systems, as well as in those with a federal structure. For the first group of countries, the United Kingdom has set an example of how to translate a national policy based on health for all into action by creating “task forces” and “alliances for health” at the community level. In countries with a strong federal structure, such as Switzerland, the process of policy development started with the coordination of activities such as collecting data and reporting on health, or sharing know-how and resources within coalitions tackling particular tasks. In addition, the autonomous regions in Spain are implementing policies based on health for all.
At the international level, members of the United Nations family, particularly the United Nations Children's Fund (UNICEF) and the World Bank, have entered the field of health development in the Region, while European organizations such as the EU, the Council of Europe (CE) and the European Bank for Reconstruction and Development have expanded considerably. The EU's mandate in the field of health policy, until now very limited, has been enlarged, notably through Article 129 of the Treaty on European Union (often called the Maastricht Treaty).

Despite the efforts of some international organizations, including WHO, coordinating international development has been difficult. This decreases the efficiency of international aid. The situation seems to be improving, although only two organizations active in the Region, the CE and the International Federation of Red Cross and Red Crescent Societies, have adopted health for all as a basis for health policies.

**Equity also an ethical issue**

Equity is an underlying principle of the philosophy of health for all, which all Member States have endorsed. Variations in mortality and morbidity rates between and within countries, however, seem to have grown in recent years. There is evidence of widening gaps in health-related behaviour, access to care and health service utilization, quality of care and, most important, access to the prerequisites for health.

As already mentioned, the economic recession has led to poverty, unemployment and homelessness for increasing numbers of people in many countries. In some countries, the restriction of public spending has led to a reduction in the health and support services provided. This seems to have affected people of lower socioeconomic status more than others. Countries can and must do much: to improve their information systems in order to reflect inequities in health, to formulate and implement intersectoral policies to promote equity in health, and to safeguard vulnerable groups in the present climate of cost constraint.

The health gap between east and west demands urgent measures. It is essential that Member States, along with WHO, make a very determined effort to reduce inequities, if the targets for health for all are to be achieved.

**Foundations of public health action**

**Emergence and strengthening of a new model for public health action**

Since the mid-1980s, the European strategy for health for all has been the key vehicle for the emergence of a new model for public health action that synthesizes individual responsibilities and rights and purposeful community action. It has bridged old divisions between disciplines and brought together, into a common public health framework, social and political scientists, epidemiologists, biomedical scientists and health care practitioners, health managers and economists. The emphasis on a broad social commitment to explicit health targets has provided a sense of cohesion. The focus on effectiveness in public health action, as well as its requirement for monitoring and evaluating progress towards targets, is profoundly changing public health thinking.

In the early 1990s, this action model gained strength throughout and even beyond the Region. National policies, the Regions for Health Network, and the expanding Healthy Cities and Healthy Schools movements are being inspired by this model. Community-based initiatives to prevent and control disease have been moving beyond mere biomedical intervention programmes. The stronger emphasis on health effectiveness and outcomes of health care is influencing health care reforms and work to improve the quality of care.
One of the most significant effects of the model has been the emergence of many different forms of health partnership. Those of particular importance bring public and economic interests closer together – in the food industry and commerce, the pharmaceutical industry, tourism and recreational industries, or the information and telecommunications industries. These partnerships have heightened the capacity of public health to cooperate with industry. They have also shown that attempts by some economic interests to discard or discredit solid scientific evidence are a less useful course of action than open cooperation.

The current international debate on population and environment issues, the UNDP agenda on human development, the UNICEF approach to children's wellbeing and the World Bank's recent report on investing in health have all reinforced this public health renaissance. The European Commission's framework for public health action, which addresses some important aspects of public health development in Europe, is also of great significance.

**Public health research: a pending upgrade**

Most countries still do not have a national policy on public health research. Such research remains centred on traditional public health disciplines such as epidemiology and individual risk factor models. It has not been sufficiently reoriented towards emerging priority areas such as economic evaluation and quality assurance. Public health research needs to extend beyond assessing the population's health needs to supporting the efficacy of health intervention.

The most important need is for a new type of alliance between policy-makers and the research community. An effective strategy demands that policy-makers and researchers help each other to fulfil their complementary roles. The central question for public health research is how to be relevant to the policy process; this is the major concern of health systems research.

Competent people in health systems research are scarce, especially in the CCEE and NIS. These countries have no trained generation of younger researchers in social sciences. In the rest of the Region, too, there are not enough qualified researchers in health systems and related areas. In some countries, such as the United Kingdom, a research and development strategy is being built into the overall health strategy, to bring together the existing research so that it influences policy, including identifying where dis-investment is necessary.

The EU research programme BIOMED is moving towards developing a more strategic approach to public health and health systems research, particularly through the establishment of an advisory committee in 1994.

**Health information: who is becoming healthier, and why?**

The explosive development of information and telecommunication technology has reached the health sector through the rapid expansion of information networks such as the Internet or the development of more health-specific information networks such as ENS/CARE. The latter was developed by WHO, the European Commission and their partners.

While the information products available to potential users (such as publications, databases and presentation tools) have considerably improved and diversified, the content and quality of the data collected remain basically unchanged. The main driving force for changing information systems appears to be information-related industries. Thus, technological innovations have more influence than new concepts on developments in the type and structure of information that is needed for public health policy and action. The users of information systems and their products are insufficiently involved in developing these systems.

Reforms in health services have created a greater demand for information support. Unfortunately,
the lack of information is a bigger stumbling block than ever. The most striking examples of this are:

- the continuing failure to report on inequities in health;
- the inability to describe the real costs of health services;
- the difficulty in agreeing on the common standards needed for international comparisons; and
- a lack of explicit links between health care expenditure and health gain achieved.

The Region continually confronts the contrast between the rapid growth of knowledge in clinical medicine and health-related industries, and the paucity of information on who becomes more healthy, and who becomes less healthy, and why.

In the CCEE and NIS, information systems are in the midst of a crisis of transition. The decentralization and the redistribution of power have left central administrations with little capacity to support traditional information systems, which focus on health facilities and their activities. In addition, several factors exacerbate the shortcomings of the established information structures in the health sector. These factors include: limited resources to modernize equipment, the move of trained personnel to the private sector, a lack of adequate enforcement of (mostly outdated) reporting regulations and, perhaps most important, the lack of a clear vision of the future of the health system.

Throughout the Region, ownership of and access to public health information is a major problem. While ensuring that the health of the population is analysed according to the best scientific standards is obviously in the public interest, users of public health data are frequently discouraged when they seek access to such information.

On the positive side, the profound changes in the socioeconomic environment and the effort to adapt to the new realities in the Region provide unique opportunities for gradually arriving at a more flexible, socially effective and user-friendly information culture. The experience accumulated in developing the international database of health for all indicators provides a model of the kind of political process that is necessary if all parties are seriously to use information as a tool for health development.

Developing schools for the new public health

Despite the new roles that public health professionals are expected to play, training in public health has not substantially changed in the Region. Nevertheless, some initiatives are underway in most Member States. In a few countries, such as Germany and Spain, new schools of public health have been established that have adopted the principles of health for all as a base for learning. Nevertheless, most developments have taken the form of new programmes, such as those on health economics, health education and health promotion, which have been added to the existing ones. While the new programmes are welcome, they reflect a continuation of the trend towards hyper-specialization.

Most postgraduate training programmes focus on a single discipline and often on a single type of professional. Public health training programmes are as numerous as professional careers in public health. This is a major constraint on building up the interdisciplinary policy-making and planning that are inherent in the strategy for health for all. The European strategy for health for all notes that:

The overall result of existing training policies and methods has been an overemphasis on producing specialists with very specific competences and skills, rather than generalists with broad vision who are capable of integrating their own work with that of others, both within and outside the health sector.

The persistence of the split between the traditional hygiene role of public health and the roles of
management of services, and especially of hospital services, is the most difficult feature of the current situation. Most of the renewed interest in management in the health sector remains narrowly focused on hospitals. The challenge is to develop competences in management for health. Otherwise, there is a risk of producing a generation of hospital managers who do even better what they should not do at all.

What is needed is a common core curriculum or track for all public health students. This would provide them with a common understanding of the new public health and a focus on the health of populations and a global model of health and health gain. This common track (perhaps the core of a European degree of Master of Public Health) is the sort of public health training needed to systematize the philosophy of public health behind the strategy of health for all.

In close collaboration with the Regional Office, the Association of Schools of Public Health of the European Region (ASPHER) has contributed to the development of the new schools and programmes.

### Key sources

*Research policies for health for all.* Copenhagen, WHO Regional Office for Europe, 1988 (European Health for All Series, No. 2).

*Health for all targets. The health policy for Europe.* Copenhagen, WHO Regional Office for Europe, 1993 (European Health for All Series, No. 4).

Healthy lifestyles

Policies, structures and programmes to address broad lifestyles issues are being implemented at the national, regional and local levels in a number of Member States. Health promotion continues to be rather narrowly focused on issues such as smoking, drugs and HIV and AIDS. Financial constraints remain the major obstacle to modernizing health promotion infrastructures. A significant development in such modernization, however, is the fast growth of the WHO Healthy Cities and Healthy Schools projects. The former includes 33 cities and 20 national and several regional networks involving more than 600 cities and towns throughout the European Region. The project is expanding to an increasing number of the CCEE and NIS.

With the economic recession, many Member States have to deal with the adverse effects on lifestyles of chronic unemployment and job insecurity. Powerful economic changes are having profound effects on the quality of life of large groups in the Region.

A considerable part of the Region's population still faces obstacles to adopting healthy lifestyles. Changing one's lifestyle is often not economically feasible, in either the western or eastern countries. In some parts of the Region, people are exposed to environmental hazards beyond their control.

In many countries, however, a positive trend is emerging. The public is requiring governments to enact health promoting legislation on smoking, food labelling and the removal of lead from fuel, for example. In several Member States, government and nongovernmental and voluntary organizations increasingly take action to strengthen the national and local infrastructures for health promotion. This is the direction to go in order to implement the principles of health for all. Time will be needed to break the habit of community passivity and to establish a sense of community ownership of health, including an appreciation of the rights, obligations and opportunities connected with health.

Despite the great diversity in delivery systems for health care and health promotion in the Region, most are undergoing some kind of reform. Most current reforms are restricted to issues in the financing and provision of medical services. Only very few Member States are introducing reforms that are firmly based on the type of policies needed to create lifestyles conducive to health.

Call for tougher tobacco policies

Success in reducing the prevalence of smoking has been mixed (Fig. 4.1). While the number of cigarettes smoked has risen, the number of adults who smoke has fallen steadily in all parts of the Region. As this trend has largely applied to moderate male smokers, the improvement hides a worsening situation among females, particularly in the CCEE and NIS. The WHO survey on the health behaviour of schoolchildren revealed increasing levels of weekly smoking, most notably among girls (Fig. 4.2).

The total number of deaths attributable to smoking is still rising in the Region, and is predicted to reach 1.4 million by 1995. These deaths increasingly affect people of middle age. For instance, tobacco will kill every second Polish man who dies between the ages of 35 and 59.

In recent years, concern has increased about the activities of the tobacco industry, particularly in the CCEE and NIS. The western tobacco industry has invested to take advantage of the considerable opportunities to increase their market share, especially among women. These countries have witnessed aggressive blanket advertising to often inexperienced audiences. Foreign investment in purchasing and building factories, and introducing new
Fig. 4.1. Estimates of smoking prevalence in the European Region, early 1990s

Source: data from the WHO Regional Office for Europe.

Fig. 4.2. Regular smoking among girls aged 11, 13 and 15 years, 1990

Source: Kannas et al.
technology will undoubtedly lead to a supply of products more attractive to women and young people.

Although national strategies against smoking have proven effective in diminishing lung cancer mortality in Finland and the United Kingdom, the political commitment to setting up national plans for tobacco control and the funding required to implement them are usually low, especially in the CCEE and NIS. In contrast, studies show that public opinion favours tobacco control policy measures such as banning tobacco advertising. Since 1987, about 20 countries have adopted new legislation or programmes for tobacco control; the countries acting between 1990 and 1994 included France, Hungary, Norway, Sweden and the United Kingdom. Many countries still seem to overlook the importance of price policies, although the experience of countries such as Sweden clearly demonstrates that a sharp increase in tobacco taxes, accompanied by broad information campaigns, results in substantial drops in sales.

**Drinking: some progress but for how much longer?**

Alcohol consumption has fallen noticeably in southern Europe, where overall consumption was previously high (Fig. 4.3). In northern Europe, with its markedly lower consumption levels, the situation is stable, while alcohol consumption has risen in the CCEE and NIS.

Young people’s drinking behaviour is a cause for concern because of a widespread increase in consumption, particularly of beer. Girls’ drinking is changing faster than boys’. This pattern is also seen in women, who show a trend towards increasing consumption. The economic recession throughout western Europe is likely to have reduced consumption, although it was falling in some areas even before the recession occurred. When this eases, however, consumption may rise as a result of increases in disposable income.

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**Fig. 4.3. Annual pure alcohol consumption in selected countries, from 1980 to the latest available year**

- **Italy**
- **France**
- **Spain**
- **Netherlands**

*Source:* data from the WHO Regional Office for Europe.
Indicators of alcohol-related disease show a similar picture: a decline in southern countries, and little change in northern ones. Evidence suggests a worsening pattern in the CCEE and NIS in recent years, however, following some improvements in the former USSR during the 1984/1985 campaign to control alcohol.

Interest seems to be increasing in a public health approach to alcohol control. Most of the CCEE and NIS are preparing new alcohol legislation. Action is particularly noticeable in southern Europe, where alcohol policies had been weaker. France, for example, has introduced a new law on advertising, and strong regional public health initiatives have been taken in Italy and Spain. Italy is the first country to achieve a 25% reduction from the 1980 consumption level. France and Spain also have a good chance of reaching this target if present trends continue. Nevertheless, policies differ widely between countries, as do their enforcement and implementation.

Psychoactive drugs: the rising tide

The use of psychoactive drugs has almost certainly increased throughout the Region, but monitoring trends is difficult owing to the lack of reliable and comprehensive information. Young people have been experimenting more than previously. The use of so-called hard drugs, as well as of soft drugs, seems very likely to have risen, particularly in the CCEE and NIS, but also in western countries. This is apparent from the increasing rates of drug-related deaths in countries with effective monitoring systems, such as Germany.

On the positive side, virtually all countries have mounted action programmes. Some changed their strategy, giving priority to reducing demand rather than supply. Harm reduction schemes involving syringe and needle exchange are widespread. Progressive changes in the practices of treatment services have occurred, including greater use of substitution therapy (with methadone). The public health perspective in dealing with drug problems is now widely accepted and political commitment has been high, as expressed by the pan-European conference of ministers on rehabilitation and drug policy in 1993. Intersectoral collaboration has been considerable, and included high levels of community participation.

Nevertheless, the situation is likely to continue to worsen. In part, this will be due to an increasing supply of drugs from the CCEE and NIS, as well as Asia, where there are real economic incentives to produce. Growing marijuana or opium poppies as a cash crop can be very profitable. There is a great danger of increased trafficking from the east to the west of the Region. In addition, the demand for drugs is likely to increase in the CCEE and NIS as the influence of western lifestyles grows.

The imbalance between the action taken and the return required is leading some countries to reassess their strategies. In Germany, for example, more emphasis is placed on the treatment of drug-dependent people than on punishment. Further, many opportunities to integrate work on drugs with that on other public health issues seem to have been missed. Programmes tend to be vertical, with little integration with those on such issues as tobacco, alcohol and especially HIV and AIDS.

Nutrition exemplifies what lifestyle means to health

Except in countries with armed conflict, the European Region does not face severe malnutrition or suffer from shortages of food. Shortages and economic difficulties, however, prevent many people from eating healthy diets, especially in certain areas of the CCEE and NIS. The problem is more pronounced for women because of the effect of the mother's poor diet on children. In 1990, the prevalence of anaemia among pregnant women aged 25-49 years in the Region was estimated to be 17%. At the same time, a high proportion of the population in most countries is overweight or obese, and this proportion may be rising (Fig. 4.4). The imbalance in the nutritional value of the diets
consumed contributes to the high levels of, for example, coronary heart disease, stroke, diabetes and certain types of cancer.

In recent years, a regional nutritional pattern has become more visible. In the north, diet-related health is improving. In the south, diet has always been better than in the rest of the Region and this remains the case on the whole. In the east, the situation is worsening: the consumption of cereals and potatoes has declined, while high levels of animal fat are still consumed. Positive elements, however, include the increased intake of fruit and vegetables. The information available provides good evidence that dietary behaviour can change over quite a short period.

Political interest in food and nutrition issues has become stronger, and awareness and activism have increased in national nutrition groups, as well as consumers and the groups that represent them. In addition, the food industry has started doing business on the basis of healthy eating, using marketing and advertising strategies that lay much more stress on the social meaning of food and on nutritional behaviour.

Nevertheless, health campaigns and education programmes, whether on nutrition, sensible drinking or tobacco use, rarely address some important aspects of lifestyle. In a way, health as a behavioural outcome is competing with more immediate “effects” such as self-expression, self-presentation and self-gratification. These are fairly strong determinants of behaviour and potential motivators for change, and should therefore be targeted in health promotion.

Making physical exercise more attractive

Despite the well documented benefits of physical activity for physical and mental wellbeing, only few countries of the Region monitor levels of physical activity, and explicit policies on exercise and health do not yet have great prominence. Western Europeans, especially children, spend a ridiculously low amount of time in sporting activities, in comparison with that spent watching television (Fig. 4.5). In the CCEE and NIS, adult levels of physical activity may be somewhat higher, mainly owing to more frequent manual work, but this situation is likely to change.
Intensified public health action is therefore needed throughout the Region to prevent an aggravation of the situation. To this end, alliances may be formed with sports associations, clubs and other organizations to carry out activities that are attractive and immediately beneficial. Special efforts should be made to analyse more thoroughly the potential for contributions by other policy areas, and innovative action should be pursued for women, older people and children.

**Sexual health: a continued concern**

Political commitment to the prevention of sexually transmitted diseases, HIV and unwanted pregnancies has increased over the past decade.

Complacency remains, however, along with the risk of losing the gains made. In spite of continued improvements in preventive approaches and the delivery of services (such as counselling), most people with risk behaviour still do not practise safe sex.

The danger of HIV transmission makes this situation particularly worrying. The incidence of HIV infection is still increasing among intravenous drug users, as well as among heterosexuals and men who have sex with men. Women are at increasing risk. Member States reported a cumulative total of 116 000 AIDS cases by August 1994. It is estimated that 500 000 people in the Region have been infected with HIV. Trends in the incidence of AIDS, however, merely reflect the situation of HIV infection some 10–13 years ago.

Several countries have made progress in developing public policy and strong intersectoral action. Other countries, however, show evidence of a weakening response and reduced funding. In general, the prevention of HIV has not been closely coordinated with that of sexually transmitted diseases, or with programmes on family planning or the prevention of intravenous drug use.

Improvements seem to have occurred in legislation and in the attitudes of the general public towards...
different sexual orientations and practices (such as homosexuality), particularly in the CCEE and NIS. This is an important prerequisite for the implementation of comprehensive prevention programmes. Sharply increasing numbers of “traditional” sexually transmitted diseases in some of the eastern countries highlight the need for such programmes.

Healthy environment

Agreement on policy: time to act

The results of the First European Conference on Environment and Health, held in 1989, included the European Charter on Environment and Health. Many countries followed up the most important decisions of the Conference, and several based their policies on health and the environment on the principles laid down in the European Charter. Countries across the Region have made new laws and new or stricter standards for the quality of the environment. The field of environment and health has received new emphasis in the policies of most Member States.

Growing public awareness has played a specific role in these achievements. Economic recession and armed conflict, however, have had serious effects on developments in the environment and health in the whole Region.

According to a WHO survey on environmental health management, most Member States devote much of their infrastructure and human resources to control activities. In contrast, prevention, the response to emergencies and the assessment of the impact of environmental hazards on human health suffer from shortages. In addition, very little information is available about the application, and comparative efficiency and effectiveness of different tools and instruments developed for environmental control.

Despite considerable investment in collecting environmental data and in monitoring by many European countries, comparable data for assessing the status or effects of environmental conditions on human health and wellbeing are scarce (Table 4.1). The WHO European Centre for Environment and Health carried out a comprehensive analysis of the state of the environment and health in the European Region. The resulting report, *Concern for Europe’s Tomorrow*, was presented to the Second European Conference on Environment and Health, held in Helsinki in June 1994. It yielded background information for preparation of the Environment and Health Action Plan for Europe.

The main task of Member States is now to implement the Action Plan adopted by ministers of the environment and of health in Helsinki. Individual countries have to set priorities in environmental health, but action on these priorities requires support from the international community. As part of the necessary machinery, a European Environment and Health Committee will be established with effect from 1 January 1995, with support from the Regional Office.

Safe drinking-water and proper sanitation still lacking for over 100 million people

About 12% of the population of the European Region, mainly in the eastern countries, still lacks access to safe drinking-water. Even more people are not served by adequate sewage treatment facilities. Waterborne infections are a major problem, particularly in the CCEE and NIS. The incidence of typhoid, cholera and hepatitis A, and the rising incidence of gastrointestinal and parasitic diseases, particularly in the central Asian republics and the Russian Federation, are causes for extreme concern. They also indicate the need for basic sanitation systems as a top priority in many countries.

Waste disposal sites and increasing pollution threaten substantial proportions of drinking-water resources. Other problems to be addressed include difficulties in providing reliable water supplies, and inadequacies in water treatment and the maintenance of distribution systems.
Table 4.1. Estimated exposure of the general population to selected environmental risk factors and their potential health effects

<table>
<thead>
<tr>
<th>Environmental factor</th>
<th>Level or circumstance of concern for health</th>
<th>Size and type of reference population (million)</th>
<th>Estimated people exposed at level of concern</th>
<th>Potential health effects</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Air pollution</strong> (ambient)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SO₂ - short-term exposure</td>
<td>&gt;24-hour WHO air quality guideline level for at least 1 day/year</td>
<td>700 Total west of the Urals</td>
<td>200</td>
<td>29</td>
<td>Transient respiratory disorders, aggravation of (existing) chronic respiratory diseases potentially precipitating death</td>
</tr>
<tr>
<td>NO₂ - short-term exposure</td>
<td>&gt;24-hour WHO air quality guideline level for at least 1 day/year</td>
<td>314 Urban west of the Urals</td>
<td>31</td>
<td>10</td>
<td>Lower respiratory tract illness in children, throat and eye irritation in adults</td>
</tr>
<tr>
<td><strong>Water and food</strong></td>
<td>Occurrence of microbiological contamination (<a href="https://www.cdc.gov/salmonella">Salmonella</a>, <a href="https://www.cdc.gov/cholera">Campylobacter</a>)</td>
<td>852 Total in the WHO European Region</td>
<td>130</td>
<td>15</td>
<td>From mild gastrointestinal disturbances to severe gastroenteritis</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td>Lack of piped water</td>
<td>852 Total in the WHO European Region</td>
<td>110</td>
<td>12</td>
<td>Waterborne infections</td>
</tr>
<tr>
<td><strong>Noise</strong></td>
<td>&gt;65 dBA</td>
<td>700 Total west of the Urals</td>
<td>180</td>
<td>26</td>
<td>Annoyance and sleep disturbances</td>
</tr>
<tr>
<td><strong>Chemicals</strong> (work environment)</td>
<td>Above occupational limits</td>
<td>400 Working</td>
<td>40</td>
<td>10</td>
<td>From acute intoxications to permanent health impairment or death</td>
</tr>
</tbody>
</table>
Finally, armed conflict has resulted in the destruction and disruption of water supplies and other essential environmental health services, threatening the health of entire communities.

Air quality improved in the west, often unacceptable in the east

Progress has been made in all parts of the Region, and particularly in western countries, in reducing pollution with sulfur dioxide, particulate matter and lead from stationary sources. About one third of the Region’s population, however, still lives in urban areas where pollution levels continue to exceed the WHO air quality guidelines. Most of these areas are found in the CCEE and NIS.

In addition, the rapid expansion of road traffic in most parts of the Region is increasing air pollution from nitrogen oxides, volatile organic compounds and particulate matter from both diesel and petrol emissions. Pollution with nitrogen oxides and volatile organic compounds leads to the formation of ozone and the creation of summer-type smogs in many cities of southern and western Europe.

Air pollution, whether indoors or outdoors, helps to increase ill health, including allergic reactions. Lead emissions from industry and road transport increase the lead burden on children in source areas. Reducing levels of these and other pollutants requires much greater effort to implement comprehensive approaches and strategies.

Food: limited progress and marked increase of microbial diseases

Microbial diseases due to contaminated food have increased markedly in recent years throughout the Region, with the ensuing costs estimated at several billion US dollars per year. Perhaps as many as 130 million people, 15% of the population in the Region, suffer each year from gastrointestinal symptoms of foodborne or waterborne infectious diseases. These diseases are mainly due to Salmonella and Campylobacter spp.

Many of the problems arise during the primary production of food, but more attention needs to be paid to the storage and distribution phases, as well. Centralized food production may increase the likelihood of the wide dissemination of contaminated food.

Waste and soil pollution: production and consumption patterns must change

While some countries have made good progress in separating municipal waste, and in reducing and recycling waste, others lack adequate arrangements. In certain areas, such as those close to metallurgical plants or highways, the sedimentation of air pollutants leads to soil pollution. Moreover, inappropriate waste disposal over decades (from industrial and military activities, for example) has created many “problem sites” throughout the Region. These sites pose many potential environmental health hazards.

Further, Member States have a common major problem in the uncontrolled growth in waste production. Nearly half the countries of the Region, including those at war and most of the CCEE and NIS, show little or negative development in practices for managing waste and soil pollution.

Housing situation worsens in urban areas

The major health risks related to housing remain the lack of safe water supply and sanitation, poor indoor air quality and climate, and construction deficiencies that encourage accidents. In urban areas, problems have worsened in the past few years with hygiene factors, crowding and homelessness, at least partly due to increased migration. Other problems, such as unemployment, loneliness and the weakening of supportive social networks resulting from changes in the social structure, have not yet been adequately addressed. Levels of deprivation and squalor are already unacceptable in many places.
Housing is associated with about 60 000 deaths and around 50 million cases of injury and disability that are treated in clinics each year. About 15–25% of the population of industrialized countries is exposed to levels of noise that cause serious nuisance.

As to ionizing radiation, background radiation contributes most to average human exposure. Background radiation may increase, however, in areas with high amounts of radon. Under routine operating conditions, nuclear power production contributes smaller doses than background radiation, but the safety of certain types of nuclear reactors needs urgent improvement.

**Health at work: huge potential for improvement**

The health impact of exposure to hazards at work remains a cause of great concern. The situation in occupational health varies widely, according to many complex factors such as economic recession, the transition to a market economy, and structures for environmental health and other services.

About 50% of the Region’s workforce is estimated to be without access to occupational health services. The main shortcomings are found in small-scale industries, and particularly in the CCEE and NIS. An adequate solution has not yet been found to deal with exposure to psychosocial stresses (such as monotony, overwork and lack of job satisfaction), although the ensuing health problems are increasing.

Across the Region, 25 000 fatal accidents occur at work each year and 10 million workers are estimated to be injured. Data deficiencies prevent Region-wide comparisons of figures other than those for deaths from accidents or particular diseases. Nevertheless, about 2 million cases of occupational disease are estimated to occur each year. Improvements in the work environment would be cost-effective; they would lead to savings from the reduced loss of productivity and social costs (such as those of treatment). In addition, occupational health services provide a unique opportunity for health promotion.

**Appropriate care**

**Health for all principles influence agendas for health care reform**

Appropriate care is an important part of the European strategy for health for all. The strategy assumes that the analysis of the shortcomings of the Region's health care systems and the current efforts to remedy them focus on promoting health development and health gain. These goals may be easier to achieve, and the outcome is more likely to be properly monitored and evaluated, if the following conditions are met.

- A health policy clearly focused on health development and health gain has been adopted.
- The key actors in the health development process (citizens’ and patients’ organizations, the professional elite, professional organizations, health care managers and administrators, and the health care industry) have explicitly expressed commitment to the targets of the policy.
- A mechanism has been established that ensures health advocacy and investment in the infrastructures of both the community and health services.
- The criteria for analysing health care reform options and “trade-offs” include targets for health, and the indicators for monitoring organizational development are in place.
- A clear link has been established between resource management decisions (on financing, human resources, technological solutions, pharmaceuticals, facilities) and targets for health development and health gain.
As mentioned, many countries and regions have produced policy documents based on or making use of the strategy for health for all, including: Finland (in 1987), Wales (1990), the former Czechoslovakia (1992), England (1992), the Netherlands (1992), Turkey (1993), Ireland (1994) and Kyrgyzstan (1994). These initiatives, along with current work on this subject in Bulgaria, Hungary, Lithuania and by many regional authorities across the Region, are helping to give a sharper focus to health care policy-making and reform. A strong link between health care reform and health policies is more likely when a health policy statement includes explicit policy options for health care. This has not always been the case in the examples given in Table 4.2.

Nevertheless, considerations of health gain can influence the development of health care systems in countries or regions in which political culture, institutional settings and/or administrative constraints hinder the adoption of a comprehensive and explicit health policy. This influence can work through the agenda for health care management or the quality of care.

After an expected incubation period of some years, the philosophy of health for all is influencing health care reform agendas throughout the Region.

**Health care financing: mounting pressure on public entitlement to care**

Factors including economic problems, the aging of the population and continuous developments in health technology have brought the issue of health care expenditure to the top of the policy agenda. In addition, a more general debate on the nature and future of the welfare society and, more specifically, on different sets of beliefs about the merits of public and private health care financing, have helped to focus attention on the public's entitlement to health care.

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### Table 4.2. Assessment of the health policy documents of selected countries

<table>
<thead>
<tr>
<th>Assessment criterion</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A health policy focused on health development and health gain</strong></td>
<td>A</td>
</tr>
<tr>
<td><strong>Explicit commitment of the key actors in the health development process to the policy targets</strong></td>
<td>B</td>
</tr>
<tr>
<td><strong>Mechanism ensuring health advocacy and investment in both community and health service infrastructures</strong></td>
<td>C</td>
</tr>
<tr>
<td><strong>Criteria for analysing health care reform options and trade-offs that include targets for the attainment of health gain</strong></td>
<td>D</td>
</tr>
<tr>
<td><strong>Clear link between resource management decisions and targets for health development and health gain</strong></td>
<td>E</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Criterion met in full</th>
<th>Criterion met in part</th>
<th>Elements present</th>
</tr>
</thead>
</table>
Public financing of health care is much greater than private financing in most countries of the European Region. As the examples in Fig. 4.6 indicate, this predominance is most pronounced in the wealthier countries. In the last several years, however, the share of private financing has risen in many countries, and there are indications that this trend has accelerated in the early 1990s.

Is this a beneficial long-term tendency? Two basic approaches to financing can be identified.

The first is mainly normative and restrictive in character, and uses implicit rationing and explicit cutting back. Implicit rationing means that some services are unavailable or limited, resulting in delays and queuing. Explicit cutting back of social protection systems results when the central government introduces a “basic basket” or package of essential services and cost-sharing mechanisms outside a clear health care policy framework, aiming at improving the efficiency and effectiveness of the health care system as a whole. Such measures are often seen as the first step towards a more general policy to place further limits on the scope of the social protection systems.

The second trend is mainly linked with the development and empowerment of decision-making at the local level. This requires more rigour and better horizontal integration between the main social protection systems, and between health care and community care. This permits:

- general principles and rules on entitlements to services at the national level to be further pursued at the local level;
- negotiations and shared decision-making by health service managers, health care providers and citizens or patients; and
- the agreement and monitoring of explicit local targets on health gain, efficient use of resources, and the satisfaction of patients and providers.

An appropriate mix of policy tools at the national and local levels plays a major role in these developments. This allows decision-makers to design market mechanisms that promote choices on: quality and prices, the planning of capital investment, contracting between purchasers and providers, and
promoting patients’ rights. Important elements of the health care debate in countries such as Germany, the Netherlands, Spain, Sweden and the United Kingdom focus on these aspects. Countries with more decentralized decision-making structures, such as the Nordic countries, have an added advantage when pursuing this line of development.

It seems clear that the social protection systems of the Region will need reform in depth, rather than simple reductions in their financing and benefits. This may become one of the major political issues of the turn of the century.

“Insurance reform” in the CCEE: policy tool or a goal in itself?

Many of the CCEE have set the attainment of a health insurance system as the main policy objective of health care reform. The appeal of insurance reform lies in the belief that it results in a more effective mechanism for mobilizing financial resources for health care. Further, it is thought that health insurance will more readily provide the policy and managerial means for rapidly improving the status and pay of undervalued health professionals, especially physicians. In the current phase of transition to a new political, social and economic environment, insurance reform in health care has come to symbolize the change to a more pluralistic and open society.

Countries have approached this transition in different ways. The Czech Republic has moved rapidly into a more pluralistic model, and the Baltic countries, Bulgaria, Hungary and Slovakia are working rapidly but through a more structured solution. Poland is treating it cautiously as a policy option, while Kazakhstan and Kyrgyzstan are working in a more experimental way.

All countries work within considerable financial constraints. Deep recession and increasing unemployment impede resource mobilization of the magnitude required to replace budgetary funding of health care, and there are not enough mechanisms to regulate escalating costs. The complexity of the health care reform process and the deeply rooted historical, cultural and political features of each country’s health care system have often been severely underestimated. In some cases, as in the Czech Republic, insurance reform has started a substantial change in the national health care culture. Only recently, however, has health insurance begun to be understood as a policy tool, rather than as a goal in itself.

Table 4.3 shows the difficult and rapidly changing situation in the countries moving towards health insurance. Even before legislation comes into force, debates begin about changing or amending it. Some countries have passed laws but been unable to implement them. The countries need a wider consensus and a more realistic view on the implementation of health insurance.

Privatization and decentralization: what is the role of market mechanisms in health care effectiveness and efficiency?

During the 1980s, the notion emerged in many countries that the health sector in modern European society was particularly inefficient. The pursuit of efficiency has taken many forms, including introducing mechanisms for incentive remuneration, increasing competition between providers and adopting policies that foster prevention, primary care and community care. In addition, decentralized responsibility for management and financing, privatized provider services and increased consumer choice and influence in decision-making have all been pursued to varying degrees. They can also be seen as ways of increasing efficiency.

In the European Region, privatization is first and foremost a political concept. In some countries, the privatization of health care facilities entails nothing more than a change of ownership from state to municipal authorities, while health insurance operates with public funds. Some private systems include virtually no competition, and some public systems base salaries on productivity.
### Table 4.3. Development of health insurance legislation in selected CCEE

<table>
<thead>
<tr>
<th>Country</th>
<th>Action</th>
<th>Comments</th>
<th>Technical information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
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<tr>
<td>Belarus</td>
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<tr>
<td>Bulgaria</td>
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<tr>
<td>Czech Republic</td>
<td>Law passed</td>
<td>Branch insurance law passed</td>
<td>Implementation of the law</td>
</tr>
<tr>
<td>Estonia</td>
<td>Law passed</td>
<td>Law amended (debate to change the law)</td>
<td>21 regional funds (central compensation fund)</td>
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<tr>
<td>Hungary</td>
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<td>Sickness funds become self-governing</td>
<td>Debate to change the law</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>Draft law presented</td>
<td>Breathing self-governing</td>
<td>Pilot-testing of health insurance</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>Law passed</td>
<td>Law not implemented</td>
<td></td>
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<tr>
<td>Latvia</td>
<td>Law passed</td>
<td>Law not implemented</td>
<td>1 central fund</td>
</tr>
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<td>Lithuania</td>
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<tr>
<td>Poland</td>
<td>Proposals presented</td>
<td>New proposals presented</td>
<td>Debate goes on</td>
</tr>
<tr>
<td>Romania</td>
<td>Draft law presented</td>
<td>Debate goes on</td>
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<td>Russian Federation</td>
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<td>Law amended</td>
<td>Debate on implementation</td>
</tr>
<tr>
<td>Slovakia</td>
<td>Law passed</td>
<td>Debate on implementation</td>
<td>1 central fund</td>
</tr>
<tr>
<td>Slovenia</td>
<td>Law passed</td>
<td>Implementation of the law</td>
<td>1 central fund</td>
</tr>
</tbody>
</table>

*No law yet passed.*
Innovations gaining popularity in the western European and Nordic countries with a national health service include: market principles, competition, the purchaser-provider split, mixed remuneration systems (using both fee-for-service and capitation methods), contracting of services, funding by general practitioners, and the principles of freedom of choice and of the money following the patient. A serious effort to evaluate these innovations across countries is underway.

Elements of privatization and market mechanisms can have a positive impact (such as reducing queues) on more regulated health care systems, such as those in Germany, the Nordic countries and the United Kingdom. The impact so far, however, has been mainly on efficiency, while improvements in effectiveness, cost-containment and equity remain to be proven.

Some areas in central Europe (Croatia, the Czech Republic and the eastern Länder of Germany) have shifted rapidly from a centralized, state-run organization of health care to a health insurance system. With the exception of Germany, where considerable know-how support came from the west, attempts to privatize public health services have been slow, complex and difficult.

Pharmacies in western Europe have traditionally been private, even in countries with national health services. Those in the CCEE were often among the first health facilities to be privatized. The shortages of more advanced and expensive western drugs disappeared, but the prices skyrocketed almost overnight. In addition, liberal drug registration policies resulted in a proliferation of brand names, causing confusion among consumers.

Decentralization and privatization are concepts that are debated from different perspectives and implemented with different objectives in the countries of the European Region. The regionalization of Europe is already a fact, and this trend seems set to prevail in health service reforms. In some countries, the health care systems of regions differ so much that they have few common features. A key problem with privatization and decentralization is that they are being used as goals in themselves, not as the means to achieve better health outcomes.

Citizens’ voice still squeaking, choice increasing

Over the past few years, greater freedom of choice for patients has been one of the most common explicit objectives of health care reform in the European Region. Current trends reinforce the belief that empowering citizens and patients to become stronger advocates of their own health care is of paramount importance for the attainment of true patient choice. In addition, well informed and satisfied patients have been proved to have better health outcomes.

The increasing vitality of the European patients’ rights movement is important here. At a WHO consultation in March 1994, 35 European Member States adopted a resolution on the promotion of patients’ rights that builds on the achievements already attained by countries such as Finland, the Netherlands and the United Kingdom. This important resolution provides a clear agenda for action on patients’ rights in the Region.

Health professionals have usually decided what kinds of health service are good for people. In most countries, health care systems frown on the practice of referring to patients as clients or consumers; they expect patients to be patients.

Nevertheless, the growing importance of consumer movements is clearly apparent in the health sector. In the CCEE and NIS, this may create problems, especially as these countries have so many unmet needs. On the other hand, paying attention to consumers’ views and patient satisfaction seems to be an area in which relatively small investments could achieve considerable improvements. Making services more user-friendly is not a question of money; it depends more on the attitudes of professionals and administrators.
Well established role for primary health care

The role of primary health care (PHC) in the delivery of health care is well established in the Region. The large amounts of funds devoted to development in the CCEE and NIS by the EU PHARE programme and the World Bank, for example, testify to this.

Countries with a traditional focus on specialized care have made a commitment to PHC in their national policy statements (Sweden) or in recent organizational arrangements (Germany). In addition, countries are clearly shifting from a PHC that is structured and based on input to one that focuses more on functions, output and outcomes. The numerous projects on communications technology in PHC, sponsored by the EU, show the growing information and communication needs in this area.

During the 1980s countries such as Denmark, Finland, France, Iceland, Italy and the Netherlands transferred resources into PHC. In southern countries of the region, such as Greece and Spain, no significant increase in PHC financing in relation to hospital care occurred, despite the emphasis placed on health care reform based on PHC.

PHC has shown impressive progress and aroused renewed interest. Nevertheless, a group of key PHC experts from Greece, Italy, the Netherlands, Portugal, Slovenia, Spain, Turkey and the United Kingdom identified barriers to access to PHC services in 1993. These included out-of-pocket co-payments and uneven geographic availability, which particularly affect poorer people, immigrants, members of ethnic groups, and people living in inner cities or remote rural areas.

Changing hospital care

Today, as hospitals become more like businesses, they are spinning off some of their traditional functions, such as hotel or casualty services (hospitals without beds), and extending some services to the home (hospitals without walls).

Information systems, the use of modern communication technologies, management, quality of patient care and communication with consumers have considerably improved. Hospitals are providing more outpatient services. Very large hospitals are no longer being built. Medium-sized general hospitals and community-based facilities for residential treatment and rehabilitation seem gradually to be replacing specialized hospitals, including mental health institutions.

Three key factors have helped to move hospitals into this position. They are:

- greater accountability with associated changes in financing;
- increasing competitive pressures resulting from the purchasing of services, and consumers’ greater knowledge of, choice of and demands for health care; and
- the increasing cost of medical technology.

Some hospitals are taking steps to increase their work on health promotion for their staff and the surrounding community by joining or endorsing the new movement of health-promoting hospitals. More than 20 hospitals from Austria, the Czech Republic, France, Germany, Greece, Hungary, Ireland, Italy, Poland, Sweden and the United Kingdom have participated in a pilot project since 1993, and national networks are being developed. In addition, the east-west hospital twinning project reflects increasing hospital autonomy and prospects for cooperation.

Modern hospitals are making alliances and developing other, more stable links and networks to search for economy of scale and in better differentiating their products.
Health care professions in transition: strong movement in general practice, more recognition of nursing

In most western countries of the Region, general practice has made progress in defining its contribution to health care during the past two decades. This shows how building up a professional profile needs a long-term perspective, to allow acceptance by the public, academics and other professional groups. This necessity should not be underestimated in the countries that have recently adopted strong general practice policies.

In most countries, medical graduates can no longer enter general practice without formal education leading to official recognition as specialists in the field. EU Directive 93/16/EEC requires two years of full-time training in general medical practice as from 1 January 1995 in all member countries. University departments of general practice, professional and scientific associations of general practitioners, academic bodies and scientific journals have all multiplied.

In the CCEE and NIS, general practice is increasingly related to family medicine, and has been recognized as a crucial element of better primary medical services. This implies both more freedom and a broader professional perspective for physicians, who seek to achieve the status of independent contractors and to secure a better income, and more choice for citizens in deciding whom to consult. The introduction of more stringent training and the expanding role of professional associations in this area are other examples of the vitality of the profession.

The role of general practice in the delivery of health care continues to evolve. It is assuming new functions, in addition to its traditional therapeutic ones, to meet communities' needs, along with nurses and other health professionals.

A variety of factors impedes the effective delivery of nursing services in most countries of the European Region. These include the virtual absence of nurses from policy-making and decision-making at all levels of the health care system, shortages of well trained nurses, insufficient resources to support the work of nurses and midwives, and the undervaluation of nursing with its concomitant subordination to medicine. Countries vary widely in the progress made in overcoming these barriers to effective nursing. Recognition seems to be growing, however, of the need to appraise the role of nursing to fulfil its potential in health care delivery.

As nurses' starting points, initial conditions, and professional roles and functions differ widely between countries, so do approaches to each. Nevertheless, some newly emerging trends can be distinguished.

First, nursing is part of the more general trend to increase the cost-effectiveness of health care delivery. This includes efforts to measure the outcomes of nursing interventions, particularly in the United Kingdom and northern Europe. Second, interest is growing in nursing education. Key issues here include: the review and reorientation to PHC of curricula, the development of new programmes (especially in higher education), training of nurse educators, provision of better educational materials, schemes for continuing education, and closer links between nursing education and services. Third, attitudes towards the position of nursing in society and health care delivery are changing. The perception of nursing as a low-status occupation requiring minimal training, and the associated undervaluation of psychosocial elements of care are beginning to shift, though progress is still slow and uneven among countries.

Continuous quest for quality of care throughout the Region

There is general consensus on the objective of quality assurance activities: to improve the outcome of health care in terms of health functional ability, patient wellbeing, consumer satisfaction and cost effectiveness. There is also consensus on the need
to strengthen quality assurance at all levels of the health care sector: among providers of health care, third-party payers, health institutions, and national and international authorities.

Further, it is agreed that making assessment, self-evaluation and comparison with peer results a permanent component of health professionals' activities would achieve quality assurance at all levels of health care.

In collaboration with the WHO Regional Office for Europe, the European Forum of Medical Associations (EFMA) endorsed a policy on quality of care development in 1992. This has been the cornerstone of such a policy in the Region. National medical associations from 35 countries participated in framing the policy. It recommends that national medical associations take a leading role in quality of care development. Securing the quality of medical care is primarily the responsibility of physicians, and is therefore an ethical, educational and professional responsibility inherent in the independence of the profession.

Some countries have confirmed that quality of care will be included in future legislation. These include Belgium, Germany, Italy, the Netherlands, Norway and the United Kingdom.

Countries have carried out considerable research in quality assurance. The work is coordinated at both the international and national levels. Countries still use different parameters, however, which has often prevented the comparison of results.

Nevertheless, significant progress has already been made in identifying common quality indicators in some fields. European consensus meetings have been held that validated indicators for perinatal and obstetrical care, mental health, diabetes, hospital infection and the use of antibiotics, and oral health care.

Pilot European databases on common outcome indicators have been designed for perinatal and obstetric care (to be hosted in Germany and United Kingdom), hospital infection (Denmark), diabetes management (Germany), orthopaedic surgery (Norway) and oral health care (Denmark).

The CCEE and NIS have shown considerable interest in outcome indicators. These countries have a long tradition of data collection although with weaker standardized methodologies and use.

In surgical interventions, a computerized information system using a basic indicator set has been established and widely tested, particularly in Belgium, Denmark and the Netherlands. Results in Denmark show a 25% reduction of hospital-acquired infections in general surgery, and over a 50% reduction in wound infection in vascular surgery in the last three years. Belgium and the Netherlands are setting up a joint database to monitor results and achievements.

Progress in diabetes and oral health management based on outcome indicators has been considerable. The European Commission has supported the establishment of a quality network in the EU and some CCEE through its Advanced Informatics in Medicine programme. In addition, active participation and support from industry are important in this area.

### Key sources


*Air quality guidelines for Europe.* Copenhagen, WHO Regional Office for Europe, 1987 (WHO Regional Publications, European Series, No. 23).


Reform OVERviews (ROVERs) on selected countries. Copenhagen, WHO Regional Office for Europe, 1993-1994.


CONCLUSION

The European Region could be much healthier. Political transition, wide-ranging reforms, shifting public health priorities and unprecedented change characterize the Region today. The combined effects of unfavourable socioeconomic trends, social unrest, migration and war in some parts of the Region have taken their toll on health. The rise of poverty and violence, especially in the CCEE and NIS, has had a serious impact on the most vulnerable.

The health gap between the CCEE and NIS and the rest of the Region continues to widen. It is largely due to cardiovascular diseases, external causes and cancer, which are linked to unhealthy lifestyles, and deficient disease prevention services. Many early deaths can be prevented.

Experience in western Europe shows that comprehensive programmes for health promotion and disease prevention pay dividends. Smoking, alcohol abuse and unsafe sex continue to be responsible for substantial ill health and mortality throughout the Region. More and more countries are developing infrastructures and programmes for health promotion.

The main obstacles are not only financial but also an adherence to outdated approaches to promoting health. Anti-tobacco legislation is gaining ground.

Life expectancy continues to improve in western Europe and is perhaps approaching a ceiling. Clearly, appropriate measures are needed to compare improvements in the quality of life across countries. Infant mortality remains high in some central Asian republics of the NIS, exceeding 40 per 1000 live births. Maternal mortality is falling. Issues needing more attention include equity and the special needs of women and the elderly, particularly in relation to chronic illness and disability, social support, domestic violence, and access to services.

The policy for health for all has gained influence throughout the Region. A new model for public health action has emerged. Central governments, regions and cities are integrating a broader philosophy of public health into their policies, with emphasis on disease prevention, health promotion and primary care.

There is political commitment to environmental policies. It is disturbing, however, that 12% of people in the Region (mainly in the NIS) do not have access to clean water, and that one third of the Region's population lives in cities with air pollution levels above the WHO guideline limits.

The strategy for health for all should now influence health service and public health reforms more than ever. The Region is a vast laboratory of experimentation with different ways of financing and supporting health care. The evidence to demonstrate which approaches work, and which do not, is still scarce. The challenge is to ensure a high quality of care and sensitivity to special needs that bring about health gain. Increasing opportunities for citizens and patients to express their rights, exercise choice and influence health care, are of major importance in improving health services and health care outcomes.

The Region today has gained breathtaking momentum for change. The opportunities to make a difference are immense. This is the main challenge for the WHO Regional Office for Europe in its cooperation with Member States.
ANNEX 1

WHO European Public Health Knowledge Base

The public health knowledge of the Regional Office is based on information from national and international sources and from the databases and information bases of technical units in the Regional Office. These databases are at different stages of development and are maintained either in the Regional Office or by WHO collaborating centres and other key information partners (see Table A).

Information infrastructure

The European public health knowledge base has been designed according to the structure of the strategy for health for all: prerequisites for health, health status and determinants of health (lifestyles, environment, health care) and support mechanisms. Table B describes its main components.

Partners and users

The partners and human networks include people in health and other ministries, WHO liaison offices, national documentation centres, WHO collaborating centres and other specialized centres, or local authorities of areas participating in specific WHO projects. The wide range of users of the Regional Office's information range from national authorities and international organizations to individual citizens and local health care providers.

Communication strategy

The communication strategy of the WHO Regional Office for Europe, combines the following communication means: personal communication through meetings, conferences, country visits, workshops, etc. and communicating through electronic means. The main development in the latter in the European Regional Office is WHO-CIPHER (Centre for Information on Public Health in the European Region) and its demonstration model. It includes six communication applications (mail, TElenet, mail-list, FTP, Gopher, Web) to illustrate the potential possibilities in these services. These can add a new dimension to the communication between Member States, and between the Member States and the Regional Office.

Units in the Regional Office are linked to each other, to WHO headquarters in Geneva and to selected international organizations by electronic mail. Some of the Member States (mostly the liaison offices in the CCEE and NIS) have also been connected through electronic mail facilities, primarily on the Internet. Diskettes with data from the health for all database are widely available. CARE Telematics is a pilot project on an electronic communication network, carried out by different partners under WHO's leadership and as part of an EU initiative. Another example of a pilot project is the telematic system for quality assurance in oral health care (ORATEL).

The Regional Office also communicates through the mass media, building a network with key European media to disseminate information on its policies, programmes and activities. Finally, the Regional Office generates an immense amount of information in the form of books and documents. The books are sold through WHO headquarters in bookshops around the world, while the Regional Office and its technical units distribute the documents.
<table>
<thead>
<tr>
<th>Name/Acronym</th>
<th>Content and coverage</th>
<th>Data collection mechanisms and sources</th>
<th>Location</th>
<th>Type</th>
<th>Stage of development</th>
</tr>
</thead>
<tbody>
<tr>
<td>European AIDS (Euraids) data set</td>
<td>Incidence and prevalence of AIDS by sex, age and mode of transmission and some data on HIV and STDS</td>
<td>Periodic reporting by Member States every 3 months</td>
<td>WHO Collaborating Centre, Paris,</td>
<td>Numeric</td>
<td>Operational</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Environmental Health Database</td>
<td>Data in 9 main fields of environmental health from 35 countries (from water through housing)</td>
<td>Questionnaires to national counterparts</td>
<td>Bilthoven and Rome centres</td>
<td>Numeric and textual</td>
<td>Operational for CET purposes</td>
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<tr>
<td>Expanded programme on Immunization (EPI)</td>
<td>Morbidity (EPI diseases) Vaccine coverage</td>
<td>Annual questionnaire to EPI Managers in countries and reporting every month for 3 diseases (Diphtheria, Pertussis and Measles)</td>
<td>Regional Office and WHO headquarters</td>
<td>Numeric</td>
<td>Operational</td>
</tr>
<tr>
<td>Health for All Database (HFADB)</td>
<td>Indicators related to 38 regional HFA targets including mortality, demography, lifestyles, life expectancy, communicable diseases, availability of health services, manpower and other health-related data</td>
<td>Triennial questionnaires to Member States, existing reporting system from Member States to WHO, various specialized agencies, statistical publications</td>
<td>Regional Office</td>
<td>Numeric</td>
<td>Operational</td>
</tr>
<tr>
<td>Parasuicide data</td>
<td>Rates of attempted suicide Risk factors for suicide among attemptors (study areas in 13 countries)</td>
<td>On-going monitoring through questionnaire</td>
<td>Regional Office</td>
<td>Numeric and textual</td>
<td>In process of development</td>
</tr>
<tr>
<td>Databank on evaluative studies on community-based psychiatry</td>
<td>Conclusions of MNH services evaluation research</td>
<td>Data collected from published reports or articles on the subject</td>
<td>WHO Collaborating Centre for Research and Training in MNH, Warsaw</td>
<td>Textual</td>
<td>In process of development</td>
</tr>
<tr>
<td>Food and health indicators</td>
<td>FAO Food Balance sheets; food related indicators and related mortality rates in 51 countries (32 EUR). Time frame: 1961-91</td>
<td>FAO (agricultural production statistics and trade statistics) and EURO statistics</td>
<td>Regional Office</td>
<td>Numeric</td>
<td>Operational</td>
</tr>
<tr>
<td>ESADT (European Summary Alcohol, Drugs and Tobacco)</td>
<td>Trends in consumption of alcohol, drugs + tobacco; harm arising from use, policy responses</td>
<td>3 questionnaires elaborating the 3 areas to counterparts in countries and reliable published reports</td>
<td>Regional Office</td>
<td>Numeric and textual</td>
<td>In process of development</td>
</tr>
<tr>
<td>Clearing-house Database (CHDB)</td>
<td>Vaccines Drugs Medical equipment (in process) Donations Imports, production, pledges, requests, stocks.</td>
<td>Questionnaire to Ministries of Health (main source) + various reports, e.g. UNICEF or donor agencies</td>
<td>Regional Office</td>
<td>Numeric</td>
<td>Operational</td>
</tr>
</tbody>
</table>
## HEALTH IN EUROPE

<table>
<thead>
<tr>
<th>Name/Acronym</th>
<th>Content and coverage</th>
<th>Data collection mechanisms and sources</th>
<th>Location</th>
<th>Type</th>
<th>Stage of development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Cities Database</td>
<td>Indicators on: • health • environment • economy • general information</td>
<td>Questionnaire to participating cities</td>
<td>Regional Office</td>
<td>Numeric and textual</td>
<td>Early operational stage</td>
</tr>
<tr>
<td>European Longitudinal Study on Aging (ELSA – eleven-country study)</td>
<td>Data on: • functional capacity • living conditions • lifestyles, and • use of services</td>
<td>Questionnaire + proxy interviews (well-trained interviewers in countries)</td>
<td>WHO Collaborating Centre in Jyva Kylä.</td>
<td>Numeric and textual</td>
<td>Operational for ELSA purposes</td>
</tr>
<tr>
<td>European Risk Factor and Mortality (ERICA)</td>
<td>Coronary heart disease + risk factors</td>
<td>Population surveys</td>
<td>3 centres: Heidelberg, Kaunas and Rome</td>
<td>Numeric</td>
<td>Operational for ERICA purposes</td>
</tr>
<tr>
<td>Kaunas-Rotterdam Intervention Study (KRIS)</td>
<td>Coronary heart disease + risk factors, including psychosocial factors</td>
<td>Population surveys and disease registers</td>
<td>Rotterdam, Kaunas + Regional Office</td>
<td>Numeric</td>
<td>Operational for KRIS purposes</td>
</tr>
<tr>
<td>MONICA psychosocial substudy</td>
<td>Data on psychosocial risk factors of CVD 9 countries</td>
<td>Population surveys, official vital statistics and disease registers</td>
<td>Munich</td>
<td>Mainly numeric</td>
<td>Operational for MONICA Psychosocial substudy purposes</td>
</tr>
<tr>
<td>CINDI children's component</td>
<td>Prevalence of CVD risk factors + intervention activities</td>
<td>Population surveys</td>
<td>Kaunas</td>
<td>Numeric + textual</td>
<td>Operational for CINDI children's component purposes</td>
</tr>
<tr>
<td>Health promotion and development in Member States</td>
<td>Health Promotion Infrastructure • major developments in health promotion • organisational structure: legislative bodies, advisory bodies, etc. • priorities of countries in the field of health promotion</td>
<td>Questionnaire that is adjusted every year, e.g. this year focusing on budget for health promotion. Developed closely with health promotion collaborating centres and sent to national counterparts</td>
<td>Regional Office</td>
<td>Textual</td>
<td>In process of development</td>
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<tr>
<td>DIABCARE</td>
<td>Data on diabetes St Vincent Declaration network</td>
<td>Questionnaire with approved indicators on diabetes filled by Q-net participants from countries</td>
<td>DIABCARE Centre, Munich</td>
<td>Numeric + textual</td>
<td>Operational for DIABCARE purposes</td>
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<tr>
<td>Perinatal care (OBSQ ID)</td>
<td>Data on perinatal care</td>
<td>Questionnaire</td>
<td>University of Tübingen</td>
<td>Numeric + textual</td>
<td>In planning stage</td>
</tr>
<tr>
<td>Oral Health</td>
<td>Oral health status based on indicators identified at European level</td>
<td>Questionnaire</td>
<td>Danish Dental Association</td>
<td>Numeric + textual</td>
<td>In planning stage</td>
</tr>
<tr>
<td>WHOCARE</td>
<td>Hospitalization: • surgery • antibiotics • blood Users of WHOCARE software tool</td>
<td>Questionnaire</td>
<td>Danish Serum Institute, Copenhagen</td>
<td>Numeric + textual</td>
<td>In planning stage</td>
</tr>
<tr>
<td>School of Public Health (SPH)</td>
<td>Schools + departments of public health Training programmes (research programmes) Persons Relational database</td>
<td>Inquiry by WHO headquarters in 1991/92 ASHER questionnaire On-going-process</td>
<td>Regional Office/ASHER and CITI2</td>
<td>Textual</td>
<td>In process of development</td>
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</table>

**Note:** Potential databases to be developed to support existing products:
1. Highlights on health in countries
2. Health Care in Transition (HITs and ROVERs)
3. Nursing Profiles
4. Women's Health Profiles
Table B
WHO European Public Health Knowledge Base: Information Infrastructure

Information Bases
- Other International Agencies
- UNDP
- UNICEF
- World Bank
- FAO
- ILO
- EUROSTAT
- Council of Europe

Regional Office Information Products*
- Across Countries
- Country-specific

Regional Office Information Products*
- HEALTH IN EUROPE. Health for All Reports
- Regional Office Publication Series
- "Country Highlights"
- 'Highlights' on Women's Health
- Hospital Infection Package
- Nursing Profiles

HEALTH FOR ALL STRUCTURE
- Prerequisites for Health
- Health Status
- Lifestyles
- Environment
- Health Care
- Support Health Development

Prerequisites for Health
- AIDS
- Communicable Diseases
- Aging
- Noncommunicable Diseases Intervention (CINDI)
- Cardiovascular Diseases
- Parasuicide
- Food & Health Indicators
- European Summary: Alcohol, Drugs, Tobacco
- Health Promotion
- Environmental Health
- Health Care Reforms
- Immunization
- Clearing-house, Vaccinations, Pharmaceuticals
- Community Psychiatry
- Diabcare
- Perinatal Care
- ORATEL
- Hospital Infection
- Healthy Cities Indicators
- Schools of Public Health

* Selected examples
## ANNEX 2

### Basic socioeconomic indicators: countries of the WHO European Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated population (millions), 1992 (1)</th>
<th>GDP (PPP $)(^a) per head, 1991 (2)</th>
<th>Total health expenditure (% of GDP), 1991 (2)</th>
<th>Mean years of schooling, 1992 (2)</th>
<th>Infant mortality (per 1000 live births), 1992 (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
<td>3.3</td>
<td>3 500</td>
<td>4</td>
<td>6.2</td>
<td>33.8</td>
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<tr>
<td>Armenia</td>
<td>3.6</td>
<td>4 610</td>
<td>4.2</td>
<td>5</td>
<td>18.9</td>
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<td>Austria</td>
<td>7.9</td>
<td>17 690</td>
<td>8.5</td>
<td>11.4</td>
<td>7.5</td>
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<tr>
<td>Azerbaijan</td>
<td>7.2</td>
<td>3 670</td>
<td>4.3</td>
<td>5</td>
<td>22.9</td>
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<tr>
<td>Belarus</td>
<td>10.2</td>
<td>6 850</td>
<td>3.2</td>
<td>7</td>
<td>12.1</td>
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<tr>
<td>Belgium</td>
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\(^a\) PPP = purchasing power parity.

Sources:

Everyone knows that the WHO European Region is undergoing profound, sometimes violent, political, social and economic change, particularly in the central and eastern countries and the former USSR. This book tracks the effects of these changes on health and some of the ways in which countries are responding to them.

Regular monitoring and evaluation are vital parts of the European strategy for health for all. While the 1990/1991 evaluation took place just as the wave of change struck the Region, the 1993/1994 monitoring exercise could measure its effects on health. This book gives the results of the exercise, including a brief and easily understood summary.

The report traces changes in the prerequisites for health and notes progress and problems in countries' work against the major causes of death. It also indicates the most important trend in the Region: increasing inequities in health. The clearest sign of this, and thus the clearest call for action, is the gap in life expectancy between the eastern and western halves of the Region. The gap is 6 years wide, and growing.

This book is essential reading for professionals, researchers and policy-makers in health and related fields, and anyone interested in the tides of health in Europe.

ISBN 92 890 1320 6 Sw.fr.17.-