The health of Europe

THE HEALTH OF EUROPE

WHO Regional Publications
European Series No. 49

European Member States
FEATURED IN THIS REPORT

Country	Abbreviation
Albania	ALB
Austria	AUT
Belgium	BEL
Bulgaria	BUL
former Czechoslovakia	ex-CZE
Denmark	DEN
Finland	FIN
France	FRA
Germany	DEU
Greece	GRE
Hungary	HUN
Iceland	ICE
Ireland	IRE
Israel	ISR
Italy	ITA
Luxembourg	LUX
Malta	MAT
Monaco	MON
Netherlands	NET
Norway	NOR
Poland	POL
Portugal	POR
Romania	ROM
San Marino	SMR
Spain	SPA
Sweden	SWE
Switzerland	SWI
Turkey	TUR
former USSR	ex-SSR
United Kingdom	UNK
former Yugoslavia	ex-YUG

In the text, the terms "former Czechoslovakia", "former USSR" and "former Yugoslavia" are used to denote those Member States that existed at the time of the evaluation but no longer existed at the time of going to press. The respective terms used in figures are "ex-CZE", "ex-SSR" and "ex-YUG".

The German Democratic Republic ceased to exist with German reunification on 3 October 1990; whenever Germany (DEU) is mentioned, this refers to the Federal Republic of Germany before reunification and the respective data are those for the Federal Republic of Germany before 3 October 1990.

THE HEALTH OF EUROPE

Summary of the second health for all evaluation

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WHO Regional Publications
European Series No. 49

World Health Organization
Regional Office for Europe
Copenhagen

Text editing M.S. Burgher
Design Grethe Lystrup
Layout Wendy Enersen

WHO Library Cataloguing in Publication Data

The health of Europe : summary of the second health for all evaluation

(WHO regional publications. European series ; No. 49)

1.Health for all strategy coordination 2.Health for all – trends 3.Health status indicators 4.Program evaluation 5.Europe I.Series

ISBN 92 890 1313 3 (NLM Classification: WA 900)
ISSN 0378-2255

PRINTED IN FINLAND

FOREWORD

1

During the half century since the end of the Second World War, Europe has been a quiet place – a region where political boundaries were sharply drawn and where individual countries proceeded at a slow and steady pace, each seemingly content with its particular approach to social development. However, in the late 1980s a process of change started, slowly at first and then gathering pace. Now a political change of enormous magnitude is under way in the countries of central and eastern Europe. At the same time, most national economies are facing severe problems, and unemployment is rising to levels last seen during the great depression of the 1930s.

During this period, and in line with a timetable agreed by Member States, a large-scale evaluation of the health for all strategy was undertaken in each country of the European Region in 1990 – 1991. Its results were presented to the Regional Committee in September 1991 and are being published as Volume 5 (European Region) of the Eighth Report on the World Health Situation. It is possibly the last and most extensive overview of the health situation in Europe on the brink of the new era, and presents the health of Europe at that time. This small publication is a summary of the main findings of the evaluation.

The evaluation shows that, on balance, health in the European Region improved in the 1980s. Member States have increased life expectancy, advanced towards eliminating some infectious diseases, reduced mortality from most of the leading causes of death, and reduced infant and maternal mortality.

Progress in promoting lifestyles conducive to health is moderate, the most dramatic and visible change being the growing trend towards the majority of people being nonsmokers. Progress towards healthier environments is also moderate, although food safety is a cause for concern. Work to reform health services is widespread, but progress towards quality and efficiency in health care remains a long way from being as good as it could be.

Endorsement by every Member State in the Region of the WHO-inspired framework for national policies for health for all is very encouraging. Health policy development in Europe has taken a big step forward, and has provided to other sectors an example of formulating common policies. There is as yet, however, no real progress towards the primary target for health for all – equity. On the contrary, there is a widening gap between the northern/western and the central/eastern parts of the Region. Because of this health divide, many targets have not yet been achieved for the Region as a whole. Closing this gap as far as possible (at least to the level of the differences that existed at the beginning of the 1970s) by raising the level of health of the appropriate population groups is the task for the coming decade.

Since the Regional Office started working with the new democratic structures that have emerged in central and eastern Europe, evidence has accumulated that the fundamental approaches laid down in the European strategy for health for all and in its 1991 update do indeed provide the best framework for the analyses and choices that these countries have to make.

It is also becoming evident that those countries in transition need to make their development priorities more clear to themselves as well as to their international collaborators. So far, the debate in these countries has not adequately addressed the fundamental issues that influence health risk factors or the quality of the health service systems. The serious health problems of these countries can be addressed in new and imaginative ways by bringing together a much wider array of partners who can contribute to better health development in a country. Unfortunately, more recent data indicate a deterioration in health status – at least in some vulnerable population groups and particularly in some of the former Soviet republics – due to acute shortages of vaccines, essential drugs and financial resources in general.

WHO's international mandate is to work for better health and quality of life for people all over the world, and to help countries find more effective ways of achieving the same. In view of the current situation in Europe, central and eastern European countries will for a considerable time have to be a priority focus for WHO's work. At the same time, considerable effort has to be spent on finding a closer rapprochement between WHO, the European Community and the Council of Europe, in order to exploit better the individual strengths of the three organizations. The health for all evaluation exercise carried out by the Member States of the European Region offers a unique insight into the state of health in Europe. The baseline, trends and priorities are there to provide the launching-pad for joint Europe-wide action to improve the health of the new Europe of tomorrow.

J.E. Asvall
WHO Regional Director for Europe

2 A COMMON HEALTH POLICY FOR EUROPE

The 1980s saw the Member States of the WHO European Region working to improve health in unprecedented unity. In 1977, WHO and its Member States had chosen as their goal the attainment of health for all by the year 2000. The European countries noted that, despite the high development of their health systems, many people's health was worse than it could have been.

This knowledge spurred the European Member States to adopt a regional strategy for health for all in 1980 – thus choosing a single health policy as a common basis for development. In 1984, they adopted 38 regional targets, whose attainment would mean the realization of their goal.[a]

The targets showed the improvement that could be expected if the will, knowledge, resources and technology already in existence were pooled in pursuit of the common goal. All the targets share a base year of 1980 but their suggested dates for completion ranged from 1990 and 1995 to 2000. The two main issues for Europe were equity in health and strengthening health. Equity meant reducing the gaps in health status between countries and between groups within countries. Strengthening health meant:

> adding life to years by helping people achieve and use their full physical, mental and social potential;
>
> adding health to life by reducing disease and disability; and
>
> adding years to life by reducing premature deaths and increasing life expectancy.

Attaining these goals required the creation of healthy lifestyles and environments and a shift in the health systems to primary health care. Various types of support and more active participation by individuals, families and communities were needed to make these changes.

While adopting the targets, the Member States also accepted a number of indicators to use in measuring their progress.

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

Measuring progress

The health for all movement opened a new era of cooperation in health development. The widely different countries of the Region would pursue their common policy and targets with their own methods and priorities and they also agreed fully to share their experience and progress within a common framework. This framework included systematic monitoring, with reporting every three years and a thorough evaluation of progress every six years. The first such evaluation took place in 1984/1985, followed by a monitoring exercise in 1987/1988.

The second evaluation, made in 1990/1991, is based on a detailed consideration of the regional targets and indicators.[b] Member States reported on their progress, as well as routinely sending data to the WHO Regional Office for Europe. The information received was assessed and analysed by a variety of experts, and used for this second evaluation of progress towards health for all in the European Region. The regional indicators and mechanisms for evaluation and monitoring have been continuously improved. All the same, the data used in the evaluation differ in reliability. Sometimes data are not available, or the time series may be too short to reveal trends. The accuracy and completeness of data may also vary between and within countries. Nevertheless, the data used are probably the best source of comparative health information in Europe.

Begun in the early 1980s, the European health for all movement calls for fundamental changes in health development. Tremendous political, social and economic changes followed at the end of the decade, and continue today. This summary gives a picture of long-term trends in health in a Europe on the threshold of the 1990s and in the midst of change.

[b] The results are given in full in *Implementation of the global strategy for health for all by the year 2000, second evaluation: eighth report on the world health situation. Volume 5. European Region.* Copenhagen, WHO Regional Office for Europe, 1993 (WHO Regional Publications, European Series, No. 52).

INFLUENCES ON HEALTH – MAJOR TRENDS

Political, economic and social factors influence health. Changes in these factors form the backdrop to conclusions about health in Europe.

Changing population patterns

The population of the European Region was around 842 million in 1990. It is expected to increase slowly (Table 1), mainly in Turkey and the republics that used to constitute the former USSR.

Table 1. Estimates and projections of population in the WHO European Region, 1980 – 2000 (millions)

Area	Year		
	1980	1990	2000
Eastern Europe	109	114	117
Northern Europe	82	83	85
Southern Europe	139	141	145
Western Europe	154	156	158
Israel	4	5	5
Turkey	44	56	67
former USSR	266	288	308
Total	798	843	885

Source: Global estimates and projections of population by sex and age, 1988 revision. New York, United Nations, 1989.

Fertility rates have dropped everywhere in Europe. Marriage is becoming less frequent, and divorce rates are increasing steadily. Childbearing patterns have changed and are roughly the same in most countries. Cohabitation is increasing, and births out of wedlock account for as many as 40% of all births in, for example, Denmark and Sweden.

The population of the Region continues to age, with a notable increase in people aged 60 – 79 years. The economically active population is also aging. These trends have four implications.

Young people are growing up in smaller families than ever before.

The percentage of active, middle-aged people who can support those in need is declining and may drop to a critically low level.

Prolonging life in an aging population has led to higher spending on services and greater concern about the quality of life; it is thus imperative to use the knowledge available to prevent disability and ensure healthy aging.

Elderly people should have useful and rewarding roles in the community; this calls for special measures.

Immigration to the Region as a whole, and particularly to Israel, has increased, whereas emigration from the countries of central and eastern Europe has increased sharply and is likely to continue. As a sizeable, if marginal, proportion of the population in some countries, immigrants are more often subject to inequities. In general, immigrants have poorer health, less education and poorer access to health services, and they are more likely to engage in behaviour that endangers their health.

Wider economic gaps

At the end of the 1980s all countries for which data are available, except Poland, showed slower economic growth. Differences in wealth widened, however: the rich countries, regions and social groups have become richer and the poor relatively poorer. The evaluation confirms the conclusion reached in 1987/1988: problems of social deprivation are growing worse.

Improvements in equity are difficult to expect unless this issue is better known and studied, put on the political agenda and widely discussed.

Need for employment

In Europe, at least, employment is not so much a matter of income as a prerequisite for a dignified and meaningful life. Fulfilling and rewarding employment is also a major factor in promoting good health. Unemployment, on the other hand, is associated with overuse of health services, self-destructive and aggressive behaviour, suicide and homicide.

Unemployment increased in western and southern Europe throughout the 1980s. Recent data indicate a possible reversal of the trend in some countries, but unemployment is expected to rise in the countries of central and eastern Europe. The under-registration of unemployment in these countries complicates the problem. In all countries, therefore, but particularly those of central and

eastern Europe, training the employed and retraining the unemployed in new skills is a top priority.

Inequalities in education

Education is the basis for ensuring that each person has a proper standard of living, an understanding of health, and the ability to participate usefully in society. The level of education in the European Region is among the highest in the world but great inequalities still exist between and within countries. Women still receive less education than men. Certain groups, such as disabled people, may need special education and training to find useful occupations.

After the cold war

Peace and the absence of the threat of hostilities are the most important prerequisites for health.

With the end of the "cold war", the fear of war in Europe has markedly receded. Nevertheless, hostilities between some ethnic and religious groups have erupted in countries where antagonisms were previously under control, and have continued in several others. For many people, the threat of an uncertain future has replaced the threat of war, and offers them difficult choices. There is no reliable account of the human suffering resulting from these civil conflicts. Health authorities have a major role to play in initiating broad intersectoral programmes to lessen such suffering.

Health for all in Europe

All Member States endorsed the regional policy, and many have made their own policies and strategies for health for all. Some were developed at the national level and others in counties, municipalities and communes.

Implementation of health for all policies in Member States has varied. In general, northern and western Europe have reported good progress; in central and eastern European countries, recently confronted with economic and health problems, progress has slowed down.

Equity – a receding goal?

Equity in health raises increasing concern. Measures aimed at improving the health of disadvantaged countries and groups reduce inequities and improve health in general. Despite increasing concern, measuring equity and assessing progress are difficult. Differences between social groups – in the incidence of preventable diseases, conditions that can be effectively treated and avoidable deaths – indicate inequities and should be closely monitored. In the Netherlands, the municipalities receive data on the health differentials that have been found and then decide on the measures required.

Greater concern about equity has led to intensified action in many countries. The approaches used naturally depend on the particular circumstances. Private and voluntary organizations, which disadvantaged groups often approach, seem to be more useful in some Nordic countries. Other countries, such as France, also make use of charitable organizations. The countries of central and eastern Europe, too, are making obvious progress along these lines. Further, the Netherlands established a programme committee on socioeconomic differences in health, and Norway a special project aimed at reducing inequities. Some countries have shown reductions in the infant mortality rates of different social groups. Several countries report better access to health services.

Despite these gains, in general, inequities seem to increase more often than decrease.

Creating better opportunities for health The conditions facing European countries seem likely to increase the number and size of disadvantaged groups. Immigrants, the unemployed, the old, youth – the list is still incomplete. Action that promotes equity by improving health development in these groups is thus more and more necessary.

Countries have made some progress in legislation, policies, programmes and social movements for disadvantaged people. Better access to health care facilities and the development of social networks and support to cope with physical and mental problems have been constant concerns in many countries. In addition, the perceived health of populations has been successfully used to assess the quality of life. The proportion of the European population reporting good health ranges from 95% down to 78%. As estimated by means of representative population surveys in several countries, the lowest values are found in the countries of central and eastern Europe. Women consistently score lower than men on reported good

health, and this gap seems to be wider in populations with poorer health. Information is still very limited on the factors that determine women's health and how they are changing over time.

Current trends towards less human contact and weaker social networks may undermine progress towards better social health. The increasing number of people living alone is particularly significant.

Adding life to years

In some countries, recent legislation seems to show more concern about disabled people and specifically their opportunities in social and working life. Other countries prefer to avoid special legislation for the disabled and focus on developing self-help programmes. Large-scale action on particular issues (transport, work and access to rehabilitation services) has been found essential to maximize opportunities for disabled people. The public is taking a more favourable attitude, and governmental and nongovernmental organizations are coordinating their activities better.

Comparative quantitative data are lacking, however, to show whether the disabled have moved much closer towards lives that are socially and economically fulfilling and mentally creative. To be able to monitor progress, countries should make special efforts to improve information on the quality of life of disabled people.

Adding health to life – progress against disease and disability

One of the regional targets calls for an increase of at least 10% in the average number of years that people live free from major disease and disability. This requires a combination of health promotion and primary prevention with early detection and the appropriate treatment of disease. Progress is hard to measure because of the lack of appropriate systems to help gather relevant information in countries. Nevertheless, some countries certainly show improvements in preventing or postponing a number of disabling conditions when indicators are measured over periods longer than 4 – 5 years.

Specific areas of success include the reduced frequency of severe congenital disorders, including Down's syndrome and thalassaemia. Oral health also showed a substantial improvement between 1985 and 1989, when the average number of decayed, missing and filled permanent teeth at the age of 12 years decreased substantially in many European countries. While oral health is deteriorating in other continents, many preventive programmes in Europe have proved successful.

Preventing chronic disease Some chronic diseases that are highly likely to lead to disability (such as cardiovascular diseases, diabetes and cancer) can be largely prevented. These diseases share a number of common major risk factors that are linked to lifestyle and can be changed. These risk factors include:

an unhealthy diet with high intakes of saturated fat and cholesterol, low fibre intake and caloric imbalance;

sedentary habits and conditions linked to them – such as obesity, high serum cholesterol and high blood pressure;

cigarette smoking; and

excessive drinking of alcohol.

Population surveys have examined the prevalence of many of these factors, including combinations that increase the potential for contracting disease.

Their exceptionally high prevalence in quite a number of countries in Europe, especially in men, cries out for more action aimed at both individuals and populations. Community-based programmes, tested in demonstration areas, need greater support, expansion and coordination. The concept of addressing high-risk groups through primary health care systems should be continued. This approach has proved particularly effective in middle-aged people.

Preventing communicable disease AIDS poses an increasing problem in Europe. More effective solutions are not likely to be found in the near future, although some research raises expectations of a vaccine against HIV infection for practical use by the end of the century. By the end of 1990, a cumulative total of 47 481 AIDS cases had been reported; 45% of those affected had died. Educating everyone about AIDS and how to prevent its transmission remains a central public health measure. This is expected also to prevent the spread of other sexually transmitted diseases.

Immunization can prevent a number of fatal or debilitating infectious diseases for

which treatment is not effective enough. These include poliomyelitis, neonatal tetanus, diphtheria and rubella.

When outbreaks of infectious disease occur, immediate publicity helps to increase immunization coverage and thus reduce the risk of further outbreaks. The countries of central and eastern Europe suffered some outbreaks of poliomyelitis in recent years, to which the rapidly changing conditions in these countries contributed. Immunization programmes must be sustained.

Occasional cases of vaccine-associated disease have been reported, a problem that requires careful consideration, continued vigilance and sustained work to produce safer vaccines. It also requires factual and unbiased reporting from public health authorities and a responsible concern from the mass media.

The incidence of diseases preventable through immunization varies widely between countries. These diseases are likely to be eliminated by the year 2000, however, if present progress in developing and implementing national expanded programmes on immunization is sustained.

Adding years to life – reducing premature death

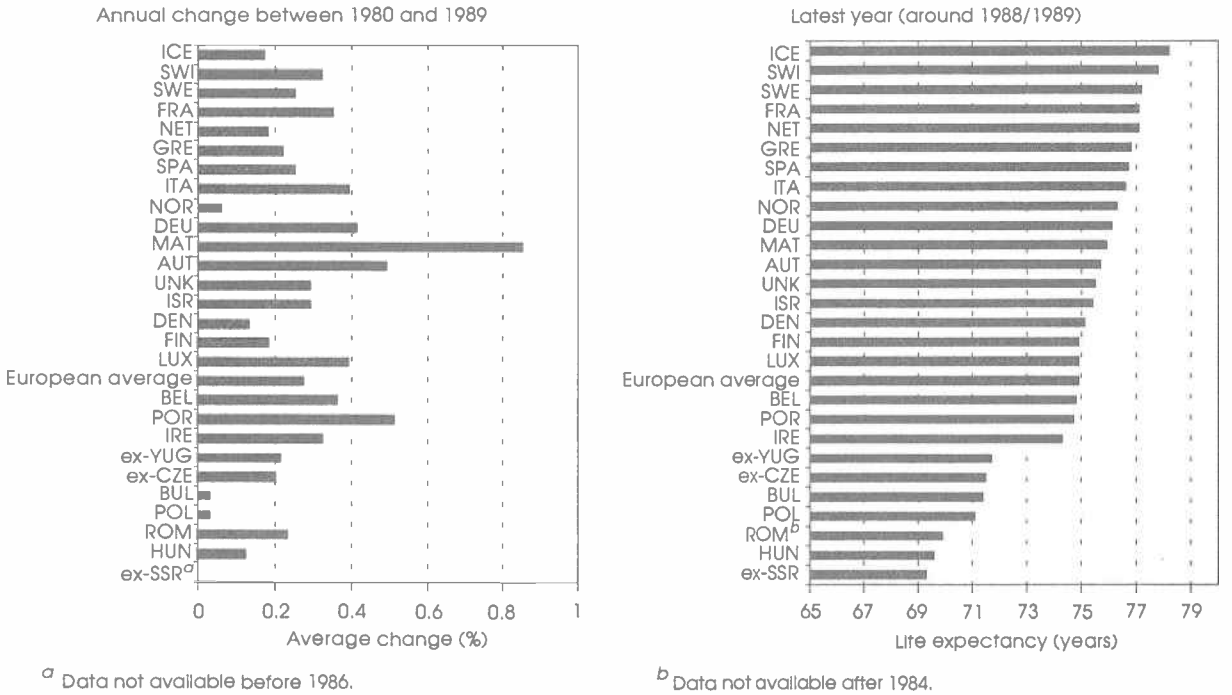
Data on death rates are available for all Member States except Albania, Monaco, San Marino and Turkey. These are used to assess longevity and to describe health, because they are more accurate and more readily available than other statistical data. Further, mortality rates allow detailed comparisons between countries, and give clear evidence of trends even over short periods.

The best overall indicator of mortality is the expectation of life at birth. This figure gives the average length of life for infants born at a particular time and place, assuming the prevailing death rates at all ages remain constant.

Differences in life expectancy The regional target for life expectancy at birth calls for a level of at least 75 years by the year 2000. Two thirds of the countries in the European Region have already achieved this goal or are very likely to do so. Given current trends, however, eight countries – Bulgaria, the former Czechoslovakia, Hungary, Poland, Romania, Turkey, the former USSR and the former Yugoslavia – seem unlikely to reach the goal (see Fig. 1).

In the countries with figures available throughout the period (which have 60% of the Region's population) life expectancy at birth increased from 73.2 years in 1980 to 74.9 years around 1989. After taking account of estimates from Turkey and the former USSR the regional average, representing

Fig. 1. Life expectancy at birth in the European Region



[a] Data not available before 1986.

[b] Data not available after 1984.

99.6% of the Region's population, was only about 72.4 years around 1989. The health for all evaluation revealed the following facts.

Tne eight countries that seem unlikely to achieve a life expectancy of 75 years by the year 2000 account for some 54% of the Region's population.

The difference in average life expectancy between seven central and eastern European countries that are not likely to attain the target and the rest of Europe (except Turkey) is more than six years. Mortality differentials in all age groups contributed to this gap.

The average gap in life expectancy between women and men in the Region is 6.8 years. Only ten countries have shown any reduction in this gap since 1980, and in several the difference is still increasing.

The reduction in cardiovascular disease is the most important cause of the increase in life expectancy in the 1980s. Fig. 2 shows the sources of this increase, according to cause of death and age group. Declining infant mortality contributed only 21% of the total increase according to age group. The reduction in mortality in people aged 65 years and over made a larger contribution than the reduction in deaths of people aged 1 – 64 years.

Mortality from cardiovascular diseases accounts for much of the difference in mortality between western Europe, eastern Europe and the former USSR (Fig. 3). In addition, the latest figures on mortality in countries show:

a threefold difference between the lowest and highest rates of death from diseases of the circulatory system;

a twofold difference between the lowest and highest rates of death from cancer;

a threefold difference between the lowest and highest rates of death from external causes.

These differences show the benefits of reducing risk factors and of unrestricted access to efficient health care.

Falling mortality in infants and mothers Infant mortality (deaths under one year of age per 1000 live births) has continued to fall in the European Region, often dramatically (Fig. 4). The slightly increasing tendency in Norway is attributed to an increase in the sudden infant death syndrome. The average infant mortality for countries with about 60% of the Region's population was 16 in 1980, 12.8 in 1985 and 10.8 around 1989. According to the latest available figures, only four countries (Romania, Turkey, the former USSR and the former Yugoslavia) have not yet reached the regional target for infant mortality of fewer than 20 per 1000 live births by the year 2000.

Fig. 2. Contributions to the increase of life expectancy in Europe, 1980 – 1989, according to causes of death and age groups

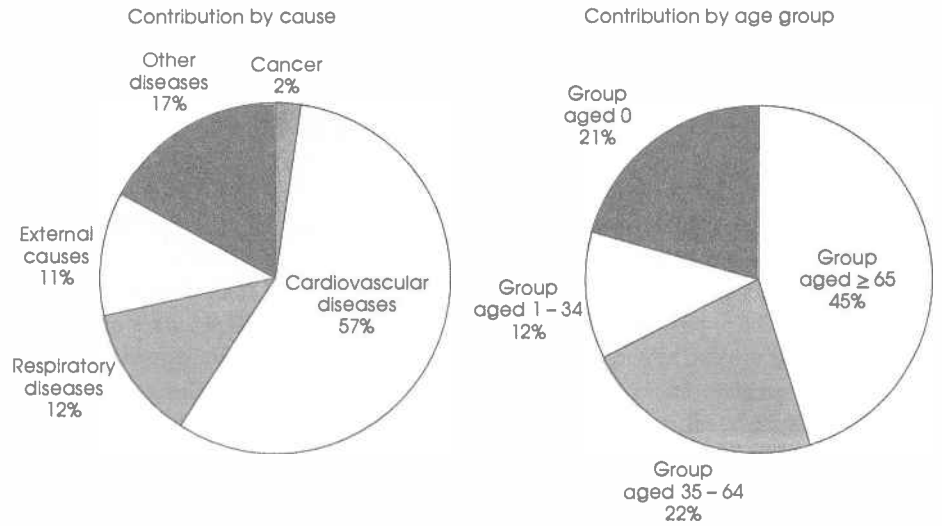
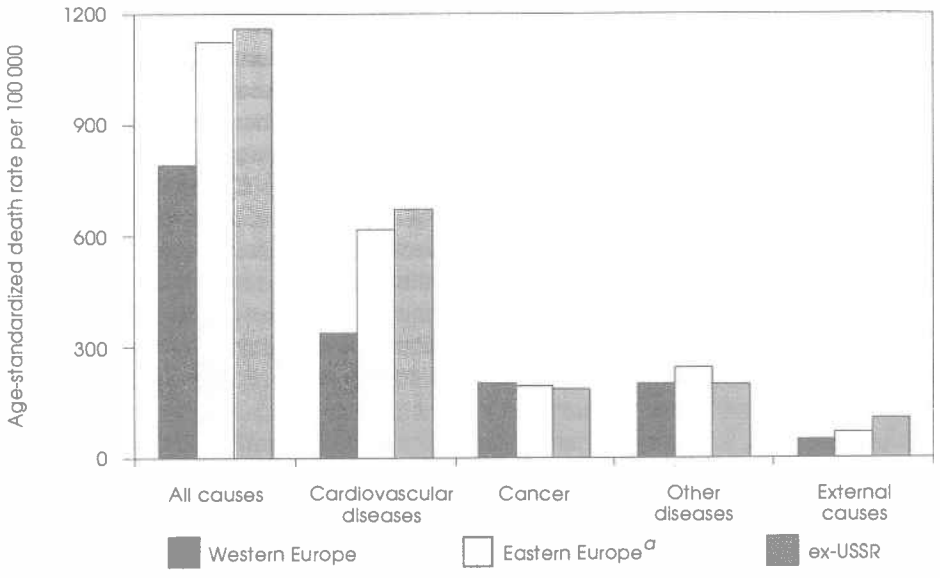


Fig. 3. Differences in cause-specific mortality in different parts of the European Region around 1988/1989



[a] Average for eastern Europe includes Bulgaria, ex-Czechoslovakia, Hungary, Poland, Romania and the former Yugoslavia.

These four, however, account for nearly half of the population of the Region.

Apart from ensuring the availability and rational use of technology at birth, appropriate prenatal and perinatal care will remain the essential factors in improving infant death rates, along with other well established socioeconomic factors. A further decrease in countries whose rates are already very low will be more difficult and costly. Nevertheless, the existing variations between social groups offer considerable scope for improvement. The most important issues are low birth weight, appropriate infant nutrition, the sudden infant death syndrome, and better prenatal diagnosis of malformations.

Maternal mortality (deaths related to pregnancy and childbirth) has also fallen remarkably (Fig. 5). Differences in the proportion of women's deaths that follow abortion account for much of the variation in maternal mortality. On average, 35% of maternal mortality is attributable to abortions that could be avoided through better family planning and sex education. Almost all countries of the Region have achieved or most probably will achieve the regional target of fewer than 15 deaths per 100 000 live births. Low maternal mortality does not normally require expensive technology and sophisticated equipment but the scrupulous application of low-cost, widely available techniques, particularly in prenatal care.

Mixed progress against the major causes of death Two of the regional health for all targets call for reductions of 15% in deaths from cardiovascular diseases and cancer in people under the age of 65. Reaching these targets would be an important contribution to increasing overall life expectancy. Reducing accidents and suicide would also lead to significant reductions in premature mortality.

Clear gains against cardiovascular diseases The latest available figures from several Member States show clear progress in reducing mortality from chronic heart disease and cerebrovascular atherogenic diseases. These are similar to trends observed in Canada and the United States. It can be confidently predicted that most countries of the European Region will achieve the target for cardiovascular diseases before the year 2000. The declining mortality figures in countries where such figures are available throughout the whole period of the 1970s and 1980s support this prediction (Table 2). This trend is very likely to have an important economic impact, owing to the significant saving in productive years before the age of 65.

Great concern remains, however, about five countries – Bulgaria, Hungary, Poland, Romania and the former USSR – with 45% of the European population. These countries still show rising trends in mortality from diseases of the circulatory system, and the levels are twice those in the rest of Europe. The two most likely reasons for this situation stem from the slower overall socioeconomic development in these countries. First, efficient and effective disease prevention and health promotion have not received real priority either as policies or as action in the community. Second, their health services have not been as efficient and techological capabilities have been inadequate.

If more accurate projections are to be made, details of earlier mortality rates for Turkey and the former USSR are needed.

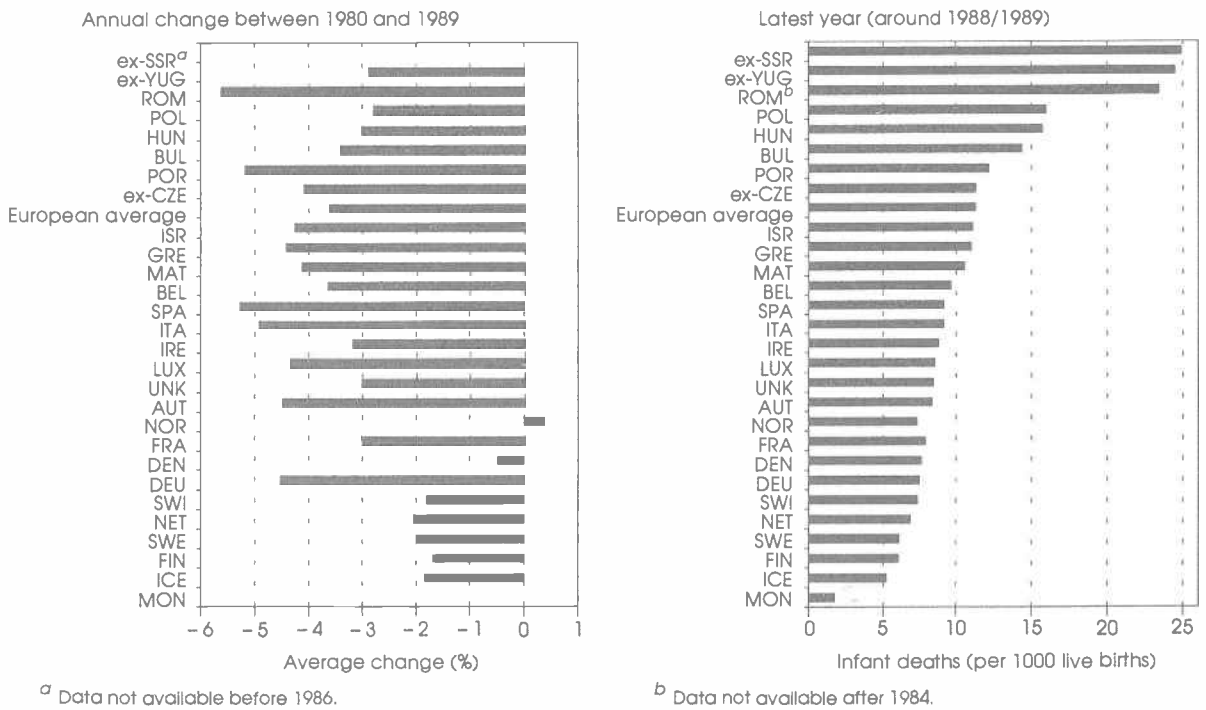
Rising cancer mortality On average, cancer mortality in European countries is still rising, and the regional target calling for a 15% reduction will not be achieved in the Region as a whole.

Only six countries (with only 3.7% of the Region's population) are likely to achieve the target. In a further nine countries (with 26.4% of the European population) mortality is falling, but not fast enough to achieve the 15% reduction by the year 2000. The outlook for the rest of the European population is worse. The evaluation of these regional trends, along with age, sex and cancer site comparisons, provides important information; while not encouraging in itself, this information points to the most useful strategies for the European Region.

The trends in lung cancer are particularly noteworthy. Lung cancer remains the leading cause of cancer deaths in Europe, particularly in men and in central and eastern Europe. Its annual average increase exceeds those for all other cancer sites. Lung cancer also remains the main contributor to the rising trend of total cancer mortality.

Nevertheless, some countries have already demonstrated that the reduction of tobacco use can prevent lung cancer, even though the impact of smoking control programmes on lung cancer mortality takes some time to appear. Thus, the European Region should direct its long-term strategy for cancer control towards reducing tobacco use. When coupled with improvements in nutritional habits, carried out as part of an integrated approach, this strategy can be expected to reduce the incidence of two or three other types of cancer. Among these would be breast cancer, whose mortality is still rising. Organized screening programmes in countries, however, would have a positive effect on breast cancer mortality within the 1990s. Many countries have similar programmes for

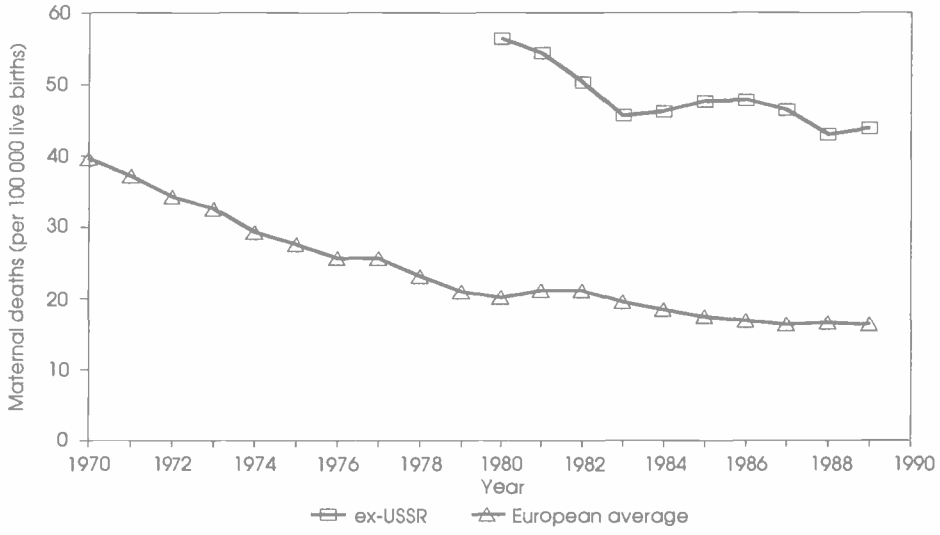
Fig. 4. Infant mortality rate in the European Region in the 1980s



[a] Data not available before 1986.

[b] Data not available after 1984.

Fig. 5. Maternal mortality in the European Region, 1970 – 1989



Note. Latest estimate for Turkey (around 1989) is about 130 – 135 maternal deaths per 100 000 live births.

Table 2. Changes in mortality from cardiovascular diseases in people under 65 years of age between the 1970s and the 1980s[a]

	Annual percentage change in age-standardized mortality	
	1970 – 1980	1980 – 1989
All cardiovascular diseases	– 0.5	– 1.5
Ischaemic heart disease	+ 0.4	– 0.6
Cerebrovascular diseases	– 0.3	– 0.4

[a] Averages of figures from 27 countries with 60% of the population of the Region.

the early detection of cervical cancer. The steadily decreasing mortality from cervical cancer shows the effectiveness of these programmes.

Progress against accidents Much of the mortality from accidents could be prevented. A regional target calls for a reduction of at least 25%. The average mortality from all external causes (accidents, injuries and poisoning) for 27 countries fell from 63.4 per 100 000 population in 1980 to 56.1 around 1989. The target is predicted to be achieved by the year 2000. Three facts are particularly noteworthy.

A decrease in deaths from traffic accidents accounts for about 40% of the reduction in mortality from external causes.

Men suffer 2.5 times more deaths from external causes than women.

The average mortality from external causes in central and eastern Europe, including the former USSR, is almost twice as high as in the rest of the Region.

The struggle against suicide Mortality from suicide (the average for 25 countries with 55% of the European population) peaked around 1984 and now shows a slightly declining trend. In 1989, the male suicide rate was nearly three times the female rate. When considered over a longer period of time, sex differences in suicide mortality have tended to increase, mainly due to male rates increasing up to the mid-1980s. The southern part of the Region still has the lowest rates, but some of the countries show increases.

LIFESTYLES CONDUCIVE TO HEALTH

There is overwhelming evidence that lifestyles are one of the major determinants of health. One of the major successes of the regional health for all strategy during the 1980s was to draw attention in Europe and elsewhere to the particular issues of healthier lifestyles, and to forge the link between public policy and health-related behaviour on the political agenda. Work to improve lifestyles and change behaviour increased at all levels during the 1980s; it took many forms and

progressed at different rates in the Member States. Nevertheless, despite the progress towards healthier lifestyles much remains to be done. The main potential for health gains in the future will stem from action in the area of healthier lifestyles. The momentum has been established, and the commitment of Member States to joint action has been demonstrated by their endorsement of the European action plans on tobacco and alcohol.

Nutrition problems

The percentage of dietary energy derived from fat – a major sign of how unhealthy people's eating habits are – is unfortunately rising steadily in nearly all European countries (Fig. 6).

Only about a third of European countries, mainly those in southern and eastern Europe, have a fat intake below the recommended average level of 35%.

Northern and western European countries have reached a level of around 40%.

Countries in southern, central and eastern Europe used to have a lower level of fat intake, but are experiencing a rapid increase.

Further, southern European countries have largely abandoned their traditional food pattern to adopt that of northern and western European countries. Meat, poultry and eggs have replaced cereals as the main foods.

Obesity and overweight are still major problems in most European countries. Severe obesity (body mass index > 30) in the population, reported by only eight countries, ranges from 5% for men and 8% for women in Sweden to 10% and 15%, respectively, in Ireland. Finland reports 51% overweight women and 55% overweight men. In Switzerland, overweight differs between cultural regions, with ranges of 75 – 82% for women and 54 – 66% for men. More generally, the available data indicate that obesity is a particular problem in middle-aged women and in the southern and eastern parts of the Region.

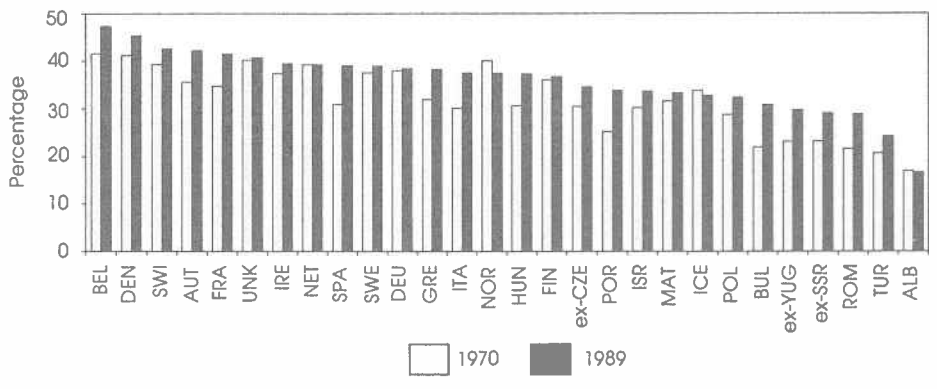
Only seven countries (Denmark, Finland, Iceland, Malta, the Netherlands, Norway and Sweden) have so far adopted a nutrition policy, as suggested in 1974 by the World Food Conference. The framework for action discussed at the First European Conference on Food and Nutrition Policy in Budapest in 1990 should be used to start the improvement of national food policies and nutrition action plans. Measures to promote the production of nutritious foods and to ensure easy and equal access to them should receive priority. In this connection, an important task is to improve catering at work, in schools and in private settings so that healthy, low-fat food is widely available.

In central and eastern European countries, some of which are still below the 35% fat intake level, fat consumption is rising and action is needed to prevent a further increase. The requirements for better nutrition include: better information on actual dietary patterns, availability of everyday foods low in fat and salt, information on modern principles of nutrition for all population groups, and training for nutrition experts.

Uneven progress against tobacco

In 1990, the ill effects of smoking killed about 1.2 million Europeans. Half of them were under

Fig. 6. Proportion of total dietary energy derived from fat in the European Region, 1970 and 1989



65 years of age. Despite appalling mortality and morbidity, progress in reducing tobacco consumption in the Region is slow and uneven.

Thirteen countries achieved a steady decrease in tobacco consumption between the mid-1970s and mid-1980s, with a further decline predicted for the future (Fig. 7).

Twelve countries had stable or rising tobacco consumption. Such increases are predicted to continue (Fig. 7).

Overall tobacco consumption in Europe declined slightly between 1985 and 1990. Nevertheless, tobacco production remained almost unchanged, owing to increased exports to countries outside Europe. Cigarette production in western Europe has recently shown signs of increasing so as to cater for newly opened markets, including those in central and eastern Europe.

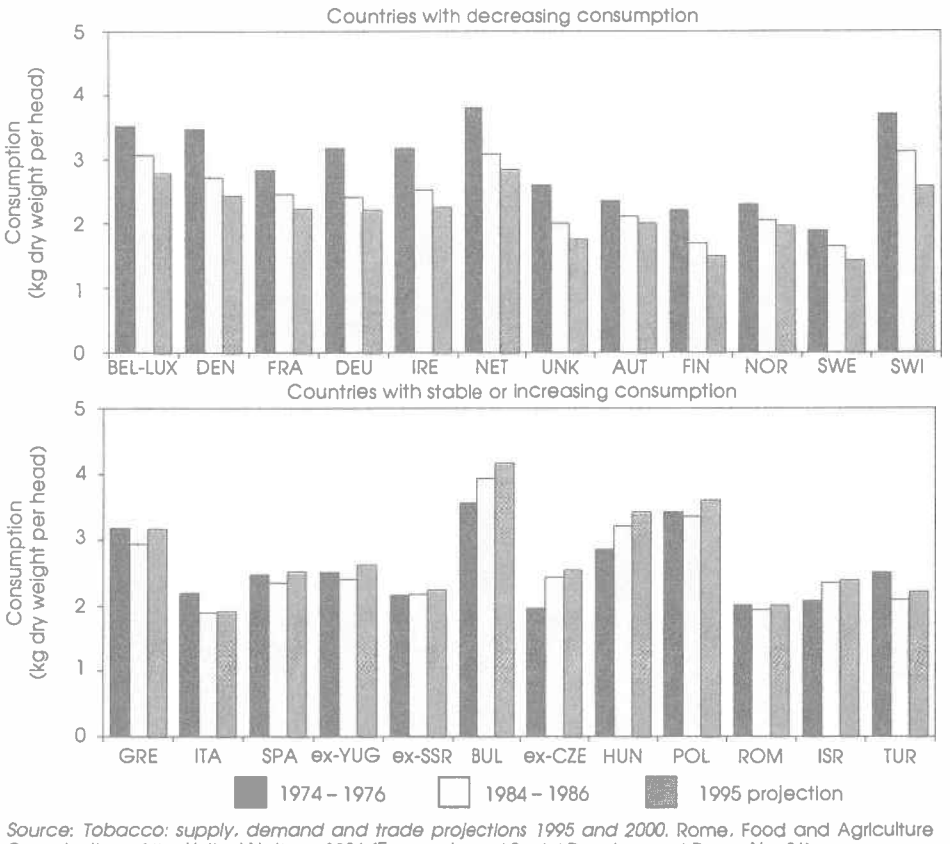
Current smoking patterns give little hope of a significant reduction in mortality in the Region in the near future. The picture in the countries with declining cigarette consumption is brighter; some may achieve a 50% reduction in consumption by 1995. These countries include Finland, Sweden and the United Kingdom, which already have comparatively low consumption levels. They also include Belgium, the Netherlands and Switzerland, where consumption is relatively high.

Because of the smaller proportions of female smokers in most European countries, two thirds of the general population are nonsmokers. This majority should form an interest group for nonsmoking, and work to extend strategies for smoke-free workplaces and public areas.

The number of people aged 15 – 24 years who now smoke (Fig. 8) is a special concern. This age group shows less difference between the proportions of men and women who smoke. In some populations, female smokers outnumber male smokers.

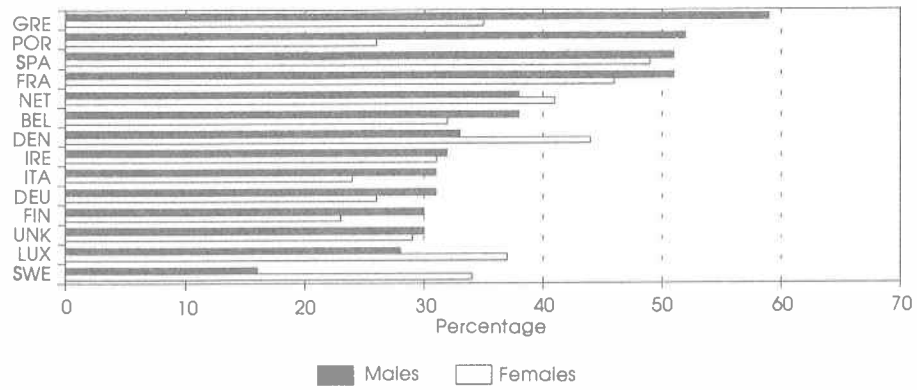
Faced with the high mortality from and prevalence of smoking, all Member States have taken steps to curb tobacco use and to support the WHO action plan for a smoke-free Europe. The measures used vary widely in scope, application and effectiveness, and

Fig. 7. Changes in tobacco consumption in the European Region



Source: Tobacco: supply, demand and trade projections 1995 and 2000. Rome, Food and Agriculture Organization of the United Nations, 1986 (Economic and Social Development Paper No. 86).

Fig. 8. Prevalence of smoking in the group aged 15 – 24 years in selected countries, 1988



include controlling or banning tobacco advertising, printing a health warning on cigarette packets, providing smoke-free public areas, taxing tobacco, restricting the sale of cigarettes (e.g. to minors and in certain places such as hospitals) and a variety of educational activities.

Finland and the United Kingdom are beginning to demonstrate the benefits of a comprehensive, long-term tobacco policy. They are the first countries to show a reduction in mortality from lung cancer.

Problems of alcohol use

Levels of alcohol consumption per head are strongly correlated with the health, economic and social problems resulting from alcohol use. In all countries, these problems rise or fall with consumption.

Since the late 1970s, consumption has declined in one third of European countries, remained stable in one third, and risen in one third. Worldwide, Europe is the continent with the highest alcohol production, export trade and consumption: in 14 countries, consumption exceeds 8 litres of pure alcohol per head per year.

The health and social welfare, transport and criminal justice systems and the workplace bear the brunt of alcohol-related problems. In some Member States, alcohol use creates an economic burden estimated at 5 – 6% of the gross national product, and alcohol-related deaths account for as much as 8 – 10% of all deaths in people aged between 15 and 74 years.[a]

[a] See, for example, GODFREY, C. & MAYNARD, A. *A health strategy for alcohol; setting targets and choosing policies*. York, Centre for Health Economics, 1992.

Dependence on and excessive consumption of alcohol are widely known to cause health and social problems. Such problems, however, also arise from moderate drinking. Because of the larger number of "normal" drinkers in the population, the resulting problems have wider health, social and economic significance.

Some developments could lead to further increases in consumption and thus in the harm associated with it. These include political liberalization, industrialization, migration, changes in family structure, increases in purchasing power, reductions in the real consumer prices of alcoholic drinks and intensive alcohol marketing.

Progress in reducing consumption and its immediate harmful effects has been made through a number of measures. These include stricter regulations on drinking and driving, increasing control of alcohol advertising (partly on the basis of agreements on stricter codes for self-regulation by the alcohol industry) and encouragement of the consumption of non-alcoholic drinks. The outstanding example here is the increasing availability and consumption of alcohol-free beer. Alcohol-free wine, though available, is still not consumed to the same extent as alcohol-free beer.

Drug abuse – changes in trends and approaches

Data on drug abuse in Europe are becoming increasingly available, but their comparability is low. At a very conservative estimate, the Region has about 500 000 addicted users of opiates and amphetamines, 400 000 cocaine users, and more than 15 million users of cannabis (hashish and marijuana).

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Reports from those countries that experienced a drug epidemic relatively early show that increases, particularly in the use of heroin, seem to have stopped. On the other hand, some countries that previously had few problems with drugs, particularly those in central and eastern Europe, now report increasing drug abuse.

Approaches to drug abuse seem to be changing. In general, there are few signs that drug laws will be enforced more severely. Countries are more likely to follow the recommendations of the ministerial summit in London in April 1990 and shift the emphasis from an attack on global supply towards work to prevent and reduce demand.

Supporting health promotion – policies and structures

The slow progress towards healthier lifestyles indicates a need for more emphasis on multisectoral policies, community participation and the development of infrastructures for health promotion.

Increasing multisectoral action Intersectoral policies have been adopted more widely, but are mainly confined to coordination between government departments. Policies shared with other public bodies and the private sector are needed. Environmental and ecological movements in many European countries provide good opportunities for such policies. Linking health policies with industrial policy and overall economic development is particularly important; this will require regarding expenditure on health as an investment rather than a burden. In addition, examples of good practice in countries should be thoroughly evaluated so that other countries can use the experience gained.

Another approach is to link multisectoral action with urban planning. The WHO Healthy Cities project provides an outstanding example. With the aim of putting health higher on the municipal agenda, it now involves more than 30 WHO project cities, and over 400 European cities in national networks in 18 countries.

Increasing community participation People's increasing demand for a say in matters concerning their health indicates favourable conditions for community participation. Different forms of self-help, self-care and local health initiatives have developed rapidly, particularly in western Europe. Major European cities now have hundreds of self-help groups and the numbers continue to grow. At all levels, self-help support centres and patient and consumer organizations have become influential new pressure groups for health.

The best way to activate these potential social support systems is to concentrate on places in which people live and work as the best settings for health promotion.

Strengthening infrastructures Good progress has been made in strengthening infrastructures for health education and health promotion. Government agencies, sickness funds, adult education centres, universities and other organizations have all contributed. The 1986 Ottawa Charter for Health Promotion is considered a general guideline in health education and health promotion.

Coordination in this area is still at an early stage. Setting up a European health promotion network will be one of the major tasks for the 1990s. Another will be to coordinate the increasing number of health promotion training courses in the Region and to find new ways to give information and training to professionals outside the health sector. Finally, the emphasis of work on health-related behaviour should shift from changing damaging behaviour to promoting positive behaviour in terms of appropriate physical exercise, balanced nutrition and good stress management.

ENVIRONMENTS CONDUCIVE TO HEALTH

In the 1980s, few issues advanced so markedly and steadily towards the top of the political agenda in all European countries as the demand for a healthy environment. Public concern and awareness of the fundamental importance of preserving the human environment has spurred countries to act. Work to create environments conducive to health addresses both particular issues and the need for multisectoral policies.

Progress on policies, monitoring and information

The regional strategy for health for all in Europe urges countries to establish policies on the environment and health that ensure the involvement of:

all the sectors concerned

the community

other countries, when international efforts are needed.

The European Charter on Environment and Health, adopted by the Region's ministers of health and of the environment in 1989, confirmed this approach. Under the Charter, a European Centre for Environment and Health was established, with project offices in Bilthoven and Rome. (A third project office was subsequently established in Nancy.)

In addition to increased awareness of the importance of the environment, there have been positive developments in the handling of environmental problems that cross national borders. Countries have signed several international conventions and protocols, and worked together on some issues, particularly in central and eastern Europe.

In almost all countries, monitoring systems for drinking-water, food and ambient air are improving. They are usually used to control pollutant emissions and contaminants, and only rarely to assess human exposure and health risks. Aspects of monitoring that are directly linked to human health need more emphasis.

People are showing more concern about their right to know and the quality of the environment as a whole. Better information on environmental health is needed. Critical indicators should be carefully selected and used to facilitate the assessment of trends and the setting of priorities for environmental health management.

Questions of water quality

Piped water is now available to 94% of the European population, although the figure is lower in rural areas. Easy availability, however, does not necessarily mean that the quality of the water supplied is adequate. A water tap in the home might sometimes provide unsafe water, and water from a fountain is not necessarily any less safe than that piped to the home. The quality of water supplies is therefore increasing in importance.

Water quality is improving as far as microbiological standards are concerned, but greater protection is needed against chemical impurities in both groundwater and surface water. Sanitation is also improving, but there is still a long way to go to ensure the adequate treatment of wastewater.

The International Drinking Water Supply and Sanitation Decade, which ended in 1990, led to many activities to protect water sources. Such work must be continued if the objectives set – a safe water supply and good sanitation for all – are to be achieved.

Mixed progress against air pollution

Progress towards protecting everyone in the Region from the recognized health risks of air pollution has been mixed. Air pollution levels vary greatly, but the following trends are discernible.

Emissions of solid particles and sulfur dioxide have decreased, but this decline has levelled off in recent years.

Countries have made a good start in phasing out lead in petrol, but the introduction of catalytic converters in all cars still requires a major effort.

The increasing traffic on the roads has increased total emissions of exhaust gas. This has prevented a decrease in nitrogen oxide concentrations in the air.

Despite some improvement, the quality of air in many large cities continues to cause concern, especially in eastern Europe.

More needs to be done to monitor the health risks associated with indoor air and to improve its quality.

Concern about food safety

In recent years agricultural practices have changed greatly, often as a result of government policies, with major implications for the control of chemical and biological food contaminants. Changes in the distribution of foodstuffs and the increase in mass catering have also been considerable.

The general trend has been for food hygiene to improve. Nevertheless, many countries have recently suffered from food contamination with *Salmonella*, mainly from poultry. Although the exact size of the problem is not known, as not all cases are notified, epidemics of food poisoning have occurred in the Nordic countries, the former Czechoslovakia, Germany, Hungary, the United Kingdom and many other countries. Fig. 9 shows the increase in diarrhoeal diseases in

one country – Sweden – over the last few years. Similar increases have occurred in many others.

Nevertheless, encouraging developments have been seen in the Region. Except in most central and eastern European countries, toxic chemicals in food have decreased and the use of persistent pesticides reduced.

Hazardous waste – old and new concerns

As more hazardous waste is produced, its disposal presents a problem of which both governments and the general public are increasingly aware. Most countries have taken steps to organize and control central plants for waste disposal. The increasingly recognized hazards of leaking from chemical dumps and the international movement of toxic waste, however, are arousing new concern.

Safer homes and workplaces

The quality of housing – particularly its heating, insulation and sanitary facilities – continues to improve. This has an enormous influence not only on the incidence and outcome of many diseases but also on well-being in general. More important now is the psychological environment in people's dwellings, which influences social health. Urban planning considers the social aspects of housing and settlements, but the results need more careful evaluation.

Only a small minority of the Region's population is homeless. Countries define homelessness in different ways, but some show evidence of increasing numbers of people sleeping out of doors, especially in big cities.

As to health at work, the number of cases of occupational diseases that are notified is rising. It is difficult to know to what extent this is a true increase in incidence and to what extent it reflects more complete case finding. The increase in knowledge of the relationship between work and health has led to more diseases being accepted as notifiable. Nevertheless, both fatal and non-fatal work-related accidents declined throughout the 1980s.

The workplace is increasingly being seen as a setting for health promotion and as an important means of reaching out to the general population. A number of countries reported concerted programmes to improve workers' health, organized either by companies or by national institutes.

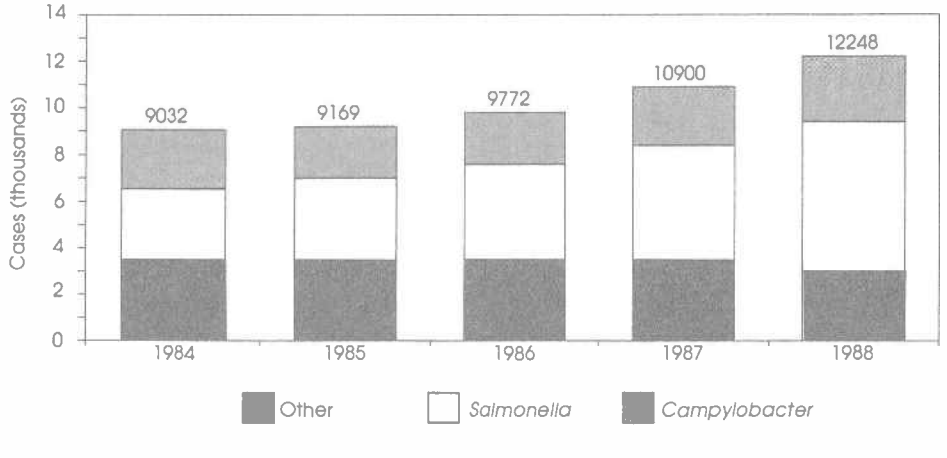
APPROPRIATE CARE

In addition to healthy lifestyles and healthy environments, appropriate health care is required to attain health for all. The regional targets on appropriate care underline the importance of basing health care systems on primary health care. This means that care at the first level of contact between the community and the health care system should be the centre of the system, supported by secondary and tertiary care.

Improved access and efficiency

The health care reforms in Greece, Italy, Portugal and Spain in the late 1970s and the first half of the 1980s stressed primary health care. In Greece and Portugal, for example, reforms throughout the 1980s helped make

Fig. 9. Diarrhoeal diseases in Sweden, 1984 – 1988: laboratory-confirmed cases



health care more easily accessible, particularly in rural areas and smaller towns. They also helped decentralize the making of decisions about health care, down to the regional level in Italy and Spain and down to the local level in Italy. These reforms also stimulated the development of general practice and fostered nurses' interest in primary health care. The more efficient teamwork that resulted can respond better to people's health care needs.

The 1980s also saw health services responding more efficiently to health care demands and making better use of resources. Some southern European countries began to address this need in the late 1980s and early 1990s. Portugal, for example, adopted a new Health Act in 1990 to tackle these problems. Many other countries showed renewed interest in improving health care. All discussions have addressed a difficult problem. How can resources be used more efficiently while work continues to ensure equitable access to health care and to improve its quality? Developments in a number of countries – reflected in the Dekker report in the Netherlands (1988), *Working for patients* in the United Kingdom (1989), the health care reform law in Germany (1989), the recommendation of the Israel High Commission for Health Care Reform (1990) and the Swedish "Crossroads" health care policy study (1991) – illustrate the wide interest in this question and its implications for health care policies.

The profound political, economic and social changes in the countries of central and eastern Europe since 1989 have led to many initiatives to transform their health care systems. These systems are likely to change significantly throughout the 1990s.

Improved quality

The quality of services is central to appropriate care. Interest in quality assurance has continued to develop and has reached the political agenda of many countries such as Belgium, Israel, Italy, the Netherlands, Norway, Spain and the United Kingdom. Certain approaches are fairly widely used; these include quality control in pathology laboratories, consensus reports on particular issues, and the collection of a minimum set of data on patients. Nevertheless, a systematic approach to quality assurance is often lacking. As a result, countries can rarely provide quantitative data – on, for example, surgical wound infections, readmissions to hospital or diabetes complications – to measure the quality of care.

High-quality care implies the appropriate use of health technology. Systematic assessments, however, remain extremely rare, particularly for low-cost technology.

Tasks for the 1990s

The health care reforms under way in Europe provide an important challenge for health for all in the 1990s. Three tasks lie ahead.

First, the principles of health for all and the experience gained in working towards the goal should form part of the current debate on health care. The various roles of the citizen and the various settings of care should be at the centre of the debate. This would contribute to a further democratization of health care.

Second, a clear and practical primary health care framework should form the basis for new developments in health care financing. This would balance the need to keep costs low with the need to deliver high-quality services.

Third, the importance of the appropriate use of resources in increasing the efficiency of health care systems needs continuous emphasis. This requires not only better use of financial and technical resources but also stress on the fundamental role of well educated and well trained people in effective care and better health.

RESEARCH AND HEALTH DEVELOPMENT SUPPORT

Health development in the sense and spirit of health for all demands support with knowledge, good management, information and trained personnel.

Research in Europe remains traditional and dominated by the biomedical sciences. Important new topics such as equity, lifestyles, environmental effects on health, and the quality of care still do not receive enough attention. Many countries have research policies or priorities in accordance with the policy established by the Regional Office, but only two (Finland and the Netherlands) have specific research policies for health for all.

The failure to manage resources properly causes slow implementation of health

policies in many countries. Resource management is the area in which most progress should have been made, because it is largely the responsibility of health authorities. Changes in management procedure are at the heart of health service reforms in most countries. Financial constraints and concern about the health of the population as a whole are important factors in triggering such reform. While spending on health tends to increase in most countries, it is probably too low (below 5% of gross national product) in large parts of the Region. Countries in central and eastern Europe generally have very small budgets for health.

Information support for health for all is improving only slowly. Comparable data are lacking on indicators that are measured by population surveys (such as perceived health, disability and lifestyles) and on the environment. In many respects, a lack of common standards and definitions, and not of data collection mechanisms as such, hampers the monitoring of key aspects of policies for health for all.

In the training of health personnel, the tide has started to turn in favour of health for all. Important policies have been made on education. The changes, however, have been confined mainly to postgraduate training and the medical professions. Unfortunately, there is little evidence of better planning for and utilization of health personnel.

Conclusion – narrowing the health gap

The second evaluation of progress towards health for all shows that, on balance, health in Europe improved during the 1980s. In general, progress towards better health was good and moderate progress was made in lifestyles and the environment. Reforms in health services are under way, but progress towards appropriate care is not as good as it could be.

Although the endorsement of policies for health for all by all Member States of the WHO European Region is very encouraging, there is no overall progress towards equity. On the contrary, a widening gap in health status between the northern/western and the central/eastern parts of the Region, with southern Europe intermediate in most respects, means that many targets cannot be achieved for the Region as a whole. Narrowing this gap as much as possible, by improving the health of the populations concerned, is the task for the coming decades.

Of course, closing the health gap in the Region will depend on many developments outside the immediate responsibility of health authorities. Nevertheless, governments could foster this goal in all areas, including health, through technical assistance and incentives for effective collaboration. Health should be one of the leading sectors in this process, not only for humanitarian reasons, but also to avoid the danger of subordinating or undervaluing health issues.

Health has been sacrificed far too long to be traded off again for dubious economic priorities. This notion is based on several observations of health developments in the 1980s, which the second health for all evaluation has confirmed.

Advances in health are slow – slower than is often assumed – and require sustained and cumulative effort.

On balance, health development on the basis of the principles of health for all is the most economic way of maintaining and promoting health.

Health and welfare are resources, not just areas of expenditure. They are just as important as other national resources, and therefore investment in them should be on a par with that in other sectors. This means that health and welfare must be put on the political agenda, regardless of the direction of current reforms.

All policy-makers should accept their social responsibility for health by being aware of the direct and indirect health consequences of their daily decisions. The responsibility for health for all policy does not rest only with governments or health professionals; it depends on the creativity, resources and commitment of a wide range of people and social groups outside the traditional health sector, including those in business and industry, legislation and jurisdiction, education and the media. These conclusions indicate the line of action for the 1990s that will be essential for the achievement of health for all.

The health of Europe

In the late 1980s, Europe saw the beginnings of a process of change. Slowly at first and then gathering pace, this process developed into the enormous political and social changes now under way in central and eastern Europe and the former Soviet Union. At the same time, all European countries are faced with severe economic problems.

It is against this backdrop that the results of the second large-scale evaluation of WHO's health for all strategy in Europe must be seen. Undertaken in each country of the Region in 1990 -1991, the evaluation is possibly the last and most extensive overview of the health of Europe on the brink of the new era.

The evaluation shows that, on balance, health in the Region improved in the 1980s, with increased life expectancy, progress on eliminating infectious diseases, and reduced mortality from the leading causes of death.

Development on other fronts, however, was moderate to disappointing with no real progress at all on the primary target for health for all – equity. But there are real grounds for optimism in the fact that health policy development has taken a big step forward.

It is surely within the framework of national policies based on health for all that the future health of all European peoples lies.

ISBN 92 890 1313 3
Price Sw. fr. 12.-