Health Status and Living Conditions in an Enlarged Europe

*Executive Summary of the Monitoring Report prepared by the European Observatory on the Social Situation - Health Status and Living Conditions Network*
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EXECUTIVE SUMMARY

Improvements have been seen over the past few decades in both health status and living and working conditions in Europe. However, the level of heterogeneity in living conditions characteristics has and will continue to widen tremendously in the EU as it goes through enlargement. Inequalities in income, education, housing, and employment affect population health, both directly (for example good housing reduces risks associated with poor health) and indirectly through psychosocial factors (such as stress). The diversity in living conditions has translated into a diversity in patterns of health across the region.

Good health can be considered one of the most fundamental resources for social and economic prosperity. While the goal to improve average levels of population health is important for any government, there has been an increasing focus on disparities at the national and European level. Investigating differences in health status within and between European countries provides the focus of this report. The relationship between living conditions, socioeconomic factors and health will be discussed and analysed with the objective of stimulating a debate and policy action for creating a healthier and more equitable society. We aim to present an overview of key issues and not a comprehensive literature review or exhaustive analysis of the topics.

The report is in two parts. Part One provides a descriptive analysis of trends and living conditions across the EU and accession and candidate countries (ACC). It highlights the diversity in health status across Europe, attempting to identify current differences between countries, historical trends and possible future directions. In light of these differences and similarities, at the risk of oversimplification, four broad categories are discerned in terms of levels of health and accompanying risk factors in this report. These comprise: (1) the EU-15 plus Cyprus and Malta (2) central European EU member states plus Croatia (3) Baltic states and (4) the four remaining southeast European ACC (Bulgaria, TFYR Macedonia, Romania, and Turkey).

The report begins with an overview of mortality indicators, comparing the different groups. The focus then turns to disease patterns, beginning with an examination of trends in chronic conditions. The chronic diseases covered comprise: cardiovascular diseases, cancer, diabetes, respiratory diseases (focusing on chronic obstructive pulmonary disease and asthma), chronic liver disease and liver cirrhosis. Trends in mental health are also reported. Then follows an outline of communicable diseases in Europe, beginning with sexually transmitted infections, including HIV/AIDS. After this, trends in tuberculosis, pneumonia and influenza are described. Next, mortality and morbidity caused by injuries and road traffic accidents are reported. Following this outline of the main causes of mortality and morbidity in Europe, the section turns to the major underlying factors for observed patterns. These comprise tobacco use, unhealthy diet, including excessive alcohol consumption and excessive energy intake and physical
inactivity. Next, socioeconomic inequalities are discussed briefly, although a full exploration of these issues is beyond the scope of this report.

Part Two is concerned with the policies pursued by governments to address the health issues described in the first section. Sections on the following topics are presented: controlling two important risk factors for chronic diseases – tobacco consumption and obesity; screening for TB and HIV, two communicable diseases that are resurging in some parts of Europe; mental health problems; and finally, socioeconomic inequalities in health. The aim of these sections is to present new information and to draw contrasts and comparisons between countries in order to highlight possible areas of policy that are particularly successful, unsuccessful or underdeveloped. Policies at the EU level are also considered. Public health experts from a selection of EU countries were consulted in order to obtain topical and current information. This has been supplemented with published reports, academic papers and grey literature.

**Part One: Health status in the EU**

The EU–15 countries, Malta and Cyprus have experienced a steady increase in life expectancy over the last 25 years. Most of them have high life expectancies when compared to central and eastern European (CEE) countries. While initial improvements in longevity resulted from declining infant mortality rates, more recent gains are largely due to a significant fall in mortality at advanced ages, although there is a high degree of heterogeneity across countries.

The former Eastern Bloc countries that are now members of the EU experienced stagnating male mortality and only very minor improvements in female mortality in the 1970s and particularly the 1980s. Death rates among middle-aged men were about 2.5 times higher in CEE than in Western Europe. Most countries in the former Eastern Bloc experienced a mortality crisis in the early 1990s after the fall of communism. This worsening of mortality was in many cases short-lived and followed by improvements in health. Indeed Poland, the Czech Republic, Slovenia and Slovakia are now approaching or surpassing the EU average in certain health indicators. Ischaemic disease accounted for much of the mortality crisis in CEE and it is the leading cause of death in most EU and ACC countries. Overall, standardized death rates for heart disease have fallen in the last 20 years in Western Europe.

The Baltic States appear to have begun recovering only recently. In these countries men have been especially vulnerable to political and economic instability, as they have experienced a significant deterioration in health, probably associated with excessive alcohol consumption. Reflecting this, the Baltic countries have the highest sex differences in life expectancy in the EU.

Turkey, Bulgaria, Romania and TFYR Macedonia lag behind both the new Member States and EU–15 averages in many mortality and morbidity indicators. Croatia, on the other hand, has more favourable indicators and is comparable to the countries of CEE.
In all of Europe, women are expected to live longer than men. However, there has been a narrowing gender gap in life expectancy among many European countries, both in the east and west, over the past decade. Rising levels of smoking–related mortality among women contributed significantly to this pattern. Age standardized male death rates for lung cancer have been steadily decreasing in most western European countries over the last 20 years. Unfortunately, mortality for lung cancer among women is increasing almost everywhere, except the UK and to some extent Ireland and Denmark. This rise is associated with the failure to reduce rates of smoking among women.

While generally higher than the EU average, infant and child mortality rates in central and eastern Europe have been falling since the 1980s, and accelerated in the 1990s. Impressively, the Czech Republic and Slovenia are in fact now among the countries with the lowest infant deaths per 1000 live births in all of Europe. This has been attributed to a large extent to improvements in quality of health care.

The east–west health gap has mainly been attributed to three causes of death: injuries and violence, cardiovascular disease, and cancer; combined with underlying social and economic factors. These different mortality patterns across Europe are understood in this report by examining the common risk factors such as cigarette smoking, alcohol consumption and obesity. For example, the incredibly high smoking rates and binge drinking of vodka are identified as risk factors for elevated mortality in certain countries of CEE.

CEE countries also lag behind in avoidable mortality indicators. Avoidable mortality measures death from certain causes that should be avoided in the presence of timely and effective medical care; therefore providing a link between population health and the effectiveness of the health system. High performers in terms of avoidable (treatable) mortality include France, Sweden, Spain, Italy and the Netherlands, with consistently high levels of avoidable mortality (poor performers) in Romania, Latvia, Estonia, Bulgaria and Hungary. Romania and Bulgaria have the highest level of avoidable mortality among the countries analysed, accounting for almost half of total mortality in men in the former. The data suggests that in these countries, more needs to be done to improve public health policies to address lifestyle related risk factors – such as in the areas of tobacco control – and improve access to and quality of health care services.

Regarding young people, a worrying trend is that smoking among young people seems to be increasing in several countries in Western Europe and CEE, both among boys and girls. Furthermore, the rising figures of child and adolescent overweight and obesity are also very worrying.

Disaggregating trends within countries also reveals that by analysing the relationship between living condition factors and health, people at the lower end of the social ladder are more likely
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to report ill health than those near the top, both at the individual and population level. A health gradient is present all along the social spectrum, although no clear time trends can be detected.

Part Two: National public health policies in the EU

The second part to this report is concerned with the policies pursued by governments to address the health issues described in Part One. The first two sections explore policies designed to control two underlying risk factors for chronic diseases: tobacco control and obesity. Next, policies addressing mental health problems are presented. The following section discusses screening for TB and HIV, two communicable diseases that are resurging in some parts of Europe. The last policy section reviews national policies aimed at reducing socioeconomic inequalities in health.

Various policies and initiatives have been implemented across Europe to reduce the prevalence of tobacco use. Policies in Ireland, the UK, Norway, and Iceland appear to have been the most effective in reducing national smoking rates between 1985–2005, where prevalence declined by 20% to 25%; the least successful were Luxemburg, Romania, and Latvia. Ireland was in the forefront regarding the prohibition of smoking in public areas, followed by Norway, Malta, and Italy. While more research is needed to evaluate the effectiveness and cost–effectiveness of national tobacco strategies, evidence suggests that increases in cigarette prices and taxes and the implementation of comprehensive clean air laws have been successful in reducing smoking rates. In light of the increasing rates among young people in many countries, further policy action is needed targeting youth; evaluations of the impact of recent tobacco control measures aimed at children and adolescents are needed. Also, numerous studies point to the link between socioeconomic status and smoking habits, such that individuals in lower socioeconomic groups have higher rates of smoking in all countries. Therefore, policies need to take this into account and to target the more disadvantaged groups. Encouragingly, initial evidence suggests that recent tobacco control measures have reduced health inequalities.

At the national level, there has been renewed attention to obesity with many countries in all parts of the EU recently introducing public health programmes. These largely focus on improving nutrition and levels of physical activity in the population. Recognising that childhood obesity requires urgent attention, many countries have also introduced policies focusing on schoolchildren to reduce obesity. Some countries, including Sweden, Belgium, the Netherlands and Ireland, have taken action to restrict advertising of low-nutritional value products to children. However, difficulty in assessing the effectiveness of individual policy interventions to combat obesity has hindered EU–wide strategy development. EU–wide policy holds a particularly important place because of the transnational nature of some aspects of factors influencing obesity rates, such as food manufacturing and agricultural policies. The results of the 2005 European Commission green paper for consultation on fighting obesity are eagerly awaited.
In recent years, European and several national governments have raised mental health problems up the political agenda, but both the development and implementation of policies and the level of funding for mental health are highly variable across Europe. Mental health promotion continues to be a low priority in many countries. This is reflected by relatively low spending: most countries spend less than 10% of their health budget on mental health, with less than 3% in Bulgaria and the Czech Republic. While the evidence base on the availability of cost effective pharmaceutical and psycho-social treatments continues to grow, there are substantial gaps in our knowledge on the prevalence of mental health disorders. Steps to encourage the collection of such data would be helpful to future European comparative analysis.

There are wide differences in screening policies for communicable diseases, in particular TB and HIV, both in the population and in high risk groups. Some countries continue with testing and vaccination of school children while seven countries do not use vaccination systematically. Some countries have no specific policy regarding TB screening in new entrants while some have legal requirements for TB screening (Malta, Latvia, the Netherlands, France and the Czech Republic fall into the latter category). HIV screening policies during pregnancy have been adopted in most EU countries. Bulgaria, Belgium, some parts of Germany, Cyprus, Greece, Spain, Estonia, Latvia, Hungary all have requirements for HIV testing for non-EU immigrants, while the other EU countries do not. This variation may be due to cultural differences between countries and the lack of clarity on both the public health benefits and cost effectiveness of the different approaches.

Reducing inequalities in health is a specific goal of public health or broader health policy in most EU countries. Although significant policy developments aimed at reducing health inequalities have been seen in some countries (e.g. England, Sweden and at local level in the Netherlands), to date there has been little evidence that they have been successful. This relative lack of evidence is due on the one hand to the long time lags from policy implementation and changes in population health, and on the other hand limited capacity for research and evaluation. Furthermore, in many countries, data collection and accuracy on health and health inequalities is limited, making developing policies difficult. In new Members States and ACC, policies to tackle health inequalities are more limited than in the west, although actions to address poverty and social exclusion have been or are in the process of being developed and implemented. It is vital that countries move towards formal coordination across sectors if improvements in health inequalities are to be realised.

The picture that emerges from the five policy sections is one of considerable activity and attention paid by governments to addressing key health challenges. Much has been achieved in recent years. However, a common limitation observed across these policy interventions is the lack of evidence to support policy decisions and to evaluate effectiveness of programmes. Finally, it is important to note that there are several limitations with the surveys available for comparing data between European countries. Improvements are needed in: (1) scope; (2) comparability; (3) motivations of behaviours; and (4) accessibility.

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