Edited Standard Paragraphs for Highlights on Health in the candidate countries for accession to the EU

OVERVIEW

TECHNICAL NOTES

Highlights on Health provide an overview of the health of a country's population and the main factors related to it. When possible, international comparisons are used as one means of assessing the country's comparative strengths and weaknesses; and to provide a summary assessment of what has been achieved so far and what could be improved in the future. The country groups used for comparison are called reference countries and are chosen based on:

- similar health and socioeconomic trends or development; and/or
- geopolitical groups such as the European Union (EU), the newly independent states, the central Asian republics or the candidate countries for EU accession.

For*{*country*}, the reference countries are ten central and eastern European candidate countries for accession to the EU (Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia).

To make comparisons between countries as valid as possible, data for each indicator have, whenever possible, been taken from one common international source (such as WHO, EUROSTAT, the Organisation for Economic Co-operation and Development or the International Labour Office). This is done to ensure that they have been harmonised in a reasonably consistent way. It should also be noted, however, that other factors such as recording and classification practices and cultural differences can influence the comparability of the data. Unless otherwise mentioned, the source of all data is the health for all statistical database of the WHO Regional Office for Europe (*WHO Regional Office for Europe, {*year*}*). Information on national policies has been obtained from health for all evaluation reports from national authorities and by personal communication with them and from *Health in Europe 1997 (WHO Regional Office for Europe, 1998a)*.

A special case of comparison is when each country is given a rank order. Although useful as a summary measure, ranking can be misleading and should be interpreted with caution, especially if used alone, as the rank is sensitive to small differences in the value of an indicator. Also, when used to assess trends (such as the table at the start of the section on health status), ranking can hide important absolute changes in the level of an individual country. Mostly bar charts (to indicate a country's position versus the reference countries according to the latest data) or line charts (usually to show time trends from 1970 onwards) have been used. Line charts present the trends for all the reference countries and for the EU, as appropriate. Only the country in focus and the appropriate group average are highlighted in bold and identified in the legend. This enables the country's trends to be followed in relation to those of all the reference countries, and performance in relation to observable clusters and/or the main trend or average can be recognized more easily. To smooth out fluctuations in annual rates caused by small numbers, 3-year averages have been used, as appropriate. For example, this is the case for maternal mortality for all reference countries.

Comparisons should preferably refer to the same point in time. However, the countries' latest available data are not all for the same year. This should be kept in mind, as the country's position may change when more recent data become available.

THE COUNTRY AND ITS PEOPLE[1]

Demography

The shape of an age pyramid shows the stage of the demographic transition of a population. The overall changes in population structure, caused by changes in fertility, mortality and migration, can be easily seen when the age pyramids for two different years are compared (Fig. 1). The countries of the EU have generally reached an advanced stage of demographic transition, with the younger age groups becoming smaller in relation to the middle and, at times, older age groups. The reference countries are, in general, developing a similar population structure.

Migrant population and ethnic profile

Immigrants and ethnic minorities can have specific patterns of disease and health needs because of cultural, socioeconomic and behavioural factors and exposure to a different environment in their country of origin. Obtaining access to health care that can meet such specific needs and that is culturally and linguistically acceptable can also be difficult. Moreover, many such people have a higher risk of living in relative poverty and being marginalized, which can result in reduced health status compared with other minority groups. Illegal immigrants, in particular, can find it difficult to obtain health care, and following up any care given can be problematic.

Social conditions and economy

The relevance of educational attainment to health is well documented. The literacy rate among the adult population (aged 15 or older) has often been used as an indicator, but the uniformly high adult literacy rates in Europe (all reference countries report a literacy rate of 96% or more) limit its value for comparison. As all the reference countries have universal primary education with almost all children participating, the enrolment ratio[2] for primary education is also an insensitive indicator for detecting differences in educational levels.

Comparable data on enrolment ratios in secondary education (such as middle school, high school and vocational and technical schools) are more useful.

HEALTH STATUS

Main causes of death

Comparing the death rates from main causes between countries can indicate how far the observed mortality might be reduced. As almost all the causes underlying the deaths attributed to cardiovascular diseases, cancer and accidents are influenced by collective and individual habits and behaviour, a wide variety of health promotion and prevention measures can bring about changes to reduce health risks and thus disease and premature deaths.

---

[1] These introductory paragraphs are based on the material from *The statesman's yearbook (Turner, 2000)*.

[2] The net enrolment ratio is the number of enrolled students in the official age group, divided by the population of the same age group which corresponds to a specific level of education. National regulations are used to define the level of education and, therefore, the official age group *(UNESCO, 1999)*.

Cancer

This section provides comparative data on total cancer mortality. More detailed data on breast cancer and cervical cancer among women are presented in the section on women's health, whereas that on cancer of the trachea, bronchus and lung is presented in the section on smoking.

External causes of death and injuries

External causes of death and injuries covers all deaths caused by accidents, injuries, poisoning and other environmental circumstances or events such as violent acts (homicide) and suicide.

Mental health

Although mental and psychosocial wellbeing are important aspects of health-related quality of life, too little information is usually available to allow these important dimensions of the population's health to be described reliably. Suicide rates can be used as a surrogate indicator of the overall level of mental health.

Infectious diseases

The acquired immune deficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV), which can be transmitted in three ways: sexual transmission; transfusing infected blood or blood products or using non-sterile injection equipment; or from mother to child. The incubation period between initial HIV infection and developing AIDS is about 10 years or more. The number of notified cases of AIDS is rising in central and eastern Europe, although more people have been diagnosed with AIDS in western and northern Europe.

Long-term illness and disability

The prevalence of long-term illness and disability is an important indicator of a population's health status and health-related quality of life. Those countries which do provide data are difficult to compare because of differences in definitions, data collection methods and in national legislation on disease-related social benefits (where disability statistics are based upon those receiving such benefits).

Self-assessed health

Data are also not routinely available on the proportion of the population assessing their own health positively. Among the reference countries, seven of the countries had some national level data with Bulgaria having the largest proportion of adult respondents assessing their health as being good (62%) and Latvia the least (26%). The large observed variation may be caused by the differences in study settings, in data collection or by cultural differences.

Health of children and adolescents

The main causes of infant mortality in {*country*} generally follow the pattern in western Europe, with the most frequent cause being malformations and perinatal conditions, which cause 82% of all infant deaths in the EU.

Children with disabilities and others who experience difficulty in learning are often marginalized within or even excluded from school systems. In the countries of central and eastern Europe, the dominance of a traditional medicalized approach resulted in such children being educated in separate special institutions. In the 1990s, most of the ten reference countries had moved towards integrating these children in the normal school system, even though progress was slowed by economic problems *(Ainscow & Haile-Giorgis, 1998).*

One of the few routinely available indicators for adolescents' sexual health and behaviour is the rate of teenage childbirth, which can reflect social factors as well as access to and use of contraception.

Women's health

Women as a group live longer than men and have lower mortality rates for all the main causes of death.

However, women have higher reported rates of morbidity and utilization of health care services (especially around childbirth), and they can be more affected by social welfare policies than men.

Violence against women has received limited attention as a public health issue. Data on the incidence and type of such violence are lacking. The SDR for homicide and purposeful injury for women can be used as a surrogate indicator.

LIFESTYLES

Among the factors (including genetics and the physical and social environments) influencing health, behaviour substantially affects the health and wellbeing of each individual and the population. Lifestyle patterns such as nutritional habits, physical activity and smoking or heavy alcohol consumption together with the prevalence of such risk factors as elevated blood pressure, high serum cholesterol or overweight influence premature mortality, especially from cardiovascular diseases and cancers. These diseases are the main causes of death in Europe. Unhealthy behaviour also contributes to a wide range of other chronic illnesses and thus affects the quality of life in general.

Lifestyle, however, is also influenced by behavioural patterns common to a person's social group and by more general socioeconomic conditions. Evidence is growing that, at least in most western European countries, improvements in lifestyles have largely been confined to the more socially and economically privileged population groups, who are better placed to adopt health-promoting changes in behaviour *(WHO Regional Office for Europe, 1993 and 1999b).*

Tobacco consumption

Since men smoke more than women, there are large gender differences in SDR for lung cancer.

Illicit drug use

Comparable data on drug use are rare. In general, the reference countries have reported increased drug use in the 1990s, even though the level is still lower than in the EU.

Nutrition

Nutritional habits are rooted in cultural traditions and food production. Nevertheless, in recent decades changes have occurred with increasing globalization, as global food markets have opened up, transport has become more rapid and more efficient techniques for conserving food have been developed. These factors together with increased mobility and increases in purchasing power are some of the reasons why the historically different nutrition patterns in Europe appear to converge.

The historical differences in western Europe between the northern and southern dietary patterns are confirmed by data relating to the amount of food available (national food balance sheets) in each country collected since the 1960s by the Food and Agriculture Organization (FAO) of the United Nations.[3] Typical of northern Europe is a high availability of saturated fat and a low availability of fruit and vegetables. This pattern is reversed in southern Europe.

Physical activity

As physical activity in daily life and at work declines, exercise in leisure time becomes more important in maintaining an activity level beneficial to health.

Overweight

Overweight and obesity are commonly assessed with the body mass index (BMI), calculated as weight in kilograms/(height in metres)^2.

High blood pressure

A systolic blood pressure exceeding 160 mmHg and diastolic pressure exceeding 95 mmHg are considered as levels where treatment is indicated to reduce the risk of cardiovascular disease.

High cholesterol

A cholesterol level over 250 mg/dl places the individual at significantly increased risk of cardiovascular diseases.

[3] The rapid increase in international trade accelerated in 1994, when food was incorporated into international free trade agreements (the GATT Uruguay Round). This has affected the reliability of national food statistics, making international comparisons more difficult.

ENVIRONMENT AND HEALTH

Environmental conditions affect humans through short-term and long-term exposure to noxious factors. In the long term the main objective is to promote sustainable development compatible with good health, and especially to protect the food chain (water and agricultural products) from the effects of harmful substances. Short-term environmental protection means avoiding or at least reducing potentially harmful situations, bearing in mind that people are not exposed equally to adverse environmental conditions and not all people and social groups are equally vulnerable to them. Thus, children, pregnant women, elderly people and ill people are more likely to be affected by polluted air or contaminated food. Also, specific population groups tend to experience more adverse environmental conditions. Low income, for instance, is often associated with exposure to environmental hazards at work (noxious substances and risk of accidents) and poor housing conditions (such as crowding, air pollution and noise). These situations may affect health and wellbeing either directly by causing discomfort and stress, or indirectly by giving rise to unhealthy coping behaviour such as the use of drugs or heavy drinking.

The increased recognition of the importance of the effects of the environment on health and the need for intersectoral action at all levels has been demonstrated by the development and implementation by nearly all European countries of national environment and health action plans (NEHAP).

Microbial foodborne diseases

The number of microbial foodborne outbreaks and the number of people who have suffered from these diseases can be used to indicate the quality of food and its production, even though some of the observed variation can be caused by differences in definitions and data-collection methods.

Housing

Whereas housing conditions, such as quality, location and infrastructure, affect people's health and wellbeing, lack of housing is even more crucial. Homeless people are more vulnerable to health problems, such as malnutrition, infectious diseases and psychosocial stress caused by solitude and insecurity, than the rest of the population. Whereas data on the quality of housing (albeit not always comparable) are increasingly becoming available, reliable data on homelessness are lacking.

Occupational health and safety

Exposure to health hazards at the workplace is still an important cause of ill health and death. However, information about exposure in terms of the type, frequency and intensity of hazards and the number of workplaces or people affected is not always available and comparable data are scarce.

The rates of injuries from work-related accidents per 100 000 population varied substantially among the reference countries, which suggests that the figures may describe different phenomena in the countries. Nevertheless, the number of such injuries has declined in all reference countries by an average of {percentage} from {number} to {number} per 100 000 population between {start year} and {end year}.

The data on deaths from work-related accidents may be more comparable than the data on injuries. The number of deaths has decreased in all reference countries indicating improvements in occupational safety. Between start year} and {end year}, the number of deaths in work-related accidents decreased from {number} to {number} per 100 000 population in the reference countries (a decrease of XX%).

HEALTH CARE SYSTEM[4]

Health care finance and expenditure

International comparisons of health care expenditure are extremely difficult because the definitions underlying health statistics as well as accounting practices vary from one country to another. The following data on health care expenditure should therefore be used with caution, as the boundaries of what constitutes health care can vary substantially between countries.

[4] This section is largely based on Health care systems in transition. {*country* } *(WHO Regional Office for Europe, {year}).*

GLOSSARY

Incidence rate: the number of new cases of a disease occurring in a population per 100 000 people during a specified period (usually 1 year).

Infant mortality rate: the yearly number of deaths of children aged less than 1 year per 1000 live births.

Life expectancy at birth: an estimate of the average number of years a newborn child can expect to live provided that the prevailing age-specific patterns of mortality at the time of birth were to stay the same throughout the child's life.

Prevalence rate: the total number of people in a population who have a disease or any other attribute at a given time or during a specified period per 100 000 of that population.

Purchasing power parity (PPP): a standardized measure of the purchasing power of a country's currency, based on a comparison of the number of units of that currency required to purchase the same representative basket of goods and services in a reference country and its currency (usually US dollars). The EU uses the purchasing power standard to measure this.

Standardized death rate (SDR): a death rate (usually per 100 000 population) adjusted to the age structure of a standard European population.

Total fertility rate: the average number of children that would be born alive per woman during her lifetime if she were to bear children at each age in accordance with prevailing age-specific birth rates.