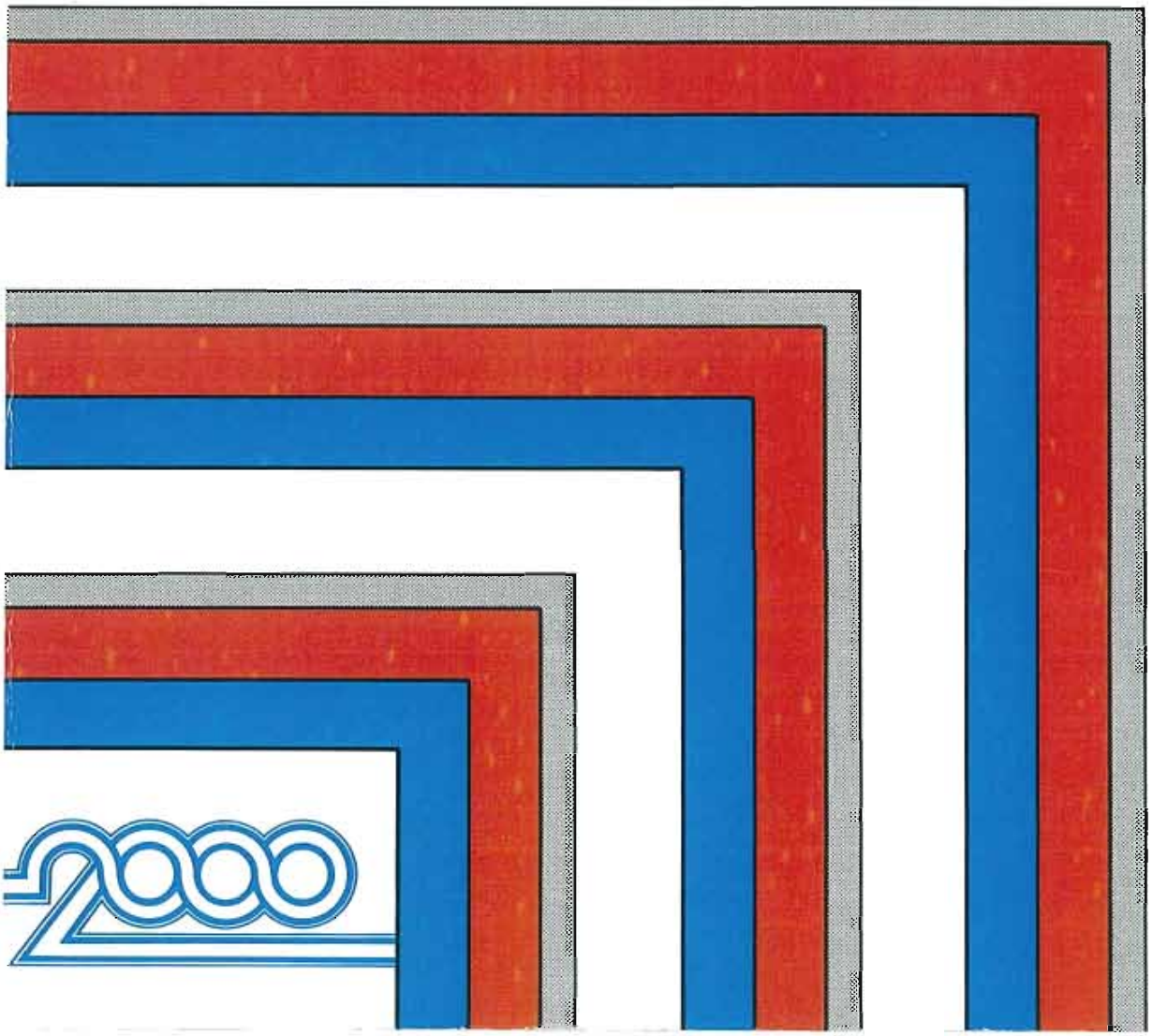
Targets for health for all



Targets for health for all

World Health Organization
Regional Office for Europe
Copenhagen

Targets for health for all

Targets in support of the European regional strategy for health for all

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Foreword to the second impression

When Dr Mahler wrote the Preface to the first impression of this book, he stressed that any achievement would depend on the countries orienting their own policies and strategies according to the new European health policy — the regional health for all (HFA) strategy and targets. What has happened in the eighteen months since then? Has the pledge of WHO's 33 European Member States led to any concrete results — or has this book on "Targets for Health for All" just been collecting dust on various library shelves?

For once, it seems that a new idea is really taking hold. Today, only eighteen months after the Regional Committee unanimously adopted the 38 regional targets, almost one third of the Member States have taken up the challenge to make a fundamental analysis of their own health policies to bring them into line with the new regional health policy. Of these, Finland has completed this task and had its national HFA policy adopted by Parliament; Poland and Yugoslavia are in the final stages of the same process; Malta has the first draft of such a national health plan along the lines of the regional strategy; the Netherlands has finished such policy analysis in the fields of aging and cardiovascular disease (and is well on its way with regard to oncology, lifestyles and health, accidents, health technologies, hospitals, and the environment); Bulgaria and Hungary have made extensive changes in their five-year development plans to incorporate such issues as lifestyles and health; Denmark, Italy and Norway are at various stages of the process, and other countries are contemplating starting. Major new developments are taking place in Portugal and

several of the Mediterranean countries in their drive to establish effective primary health care systems, and a number of countries have joined in a major intercountry project to develop broad, intersectoral programmes on lifestyles and health. Almost all these developments are collaborative projects with the WHO Regional Office for Europe.

No less encouraging is the recent trend for local communities or subnational administrations — in provinces or regions — to undertake similar analyses for their own populations. A special multicountry study (uniting Austria, Belgium, France, the Federal Republic of Germany, the Netherlands, Switzerland and the Regional Office) is currently looking at how HFA development can be promoted in countries with pluralistic systems.

Nongovernmental organizations, particularly those representing various categories of health personnel, can have very important roles to play in this process. The Regional Office is developing intensive dialogue with many of these, such as the national medical and nursing associations in Europe, the Association for Medical Education in Europe, the Association of Schools of Public Health of the European Region, the Association of Medical Deans in Europe, and the European Society for Medical Sociology.

In 1985 each of WHO's European Member States made an evaluation of its own progress towards HFA, using the 65 regional indicators adopted by the Regional Committee in 1984. This extremely interesting exercise revealed that good progress had been made in many areas in Europe but that serious problems remained, not least in the areas of lifestyles and health and in information systems development. It was realized that the knowledge of the regional HFA policy was still restricted to a limited number of senior public health administrators and other health professionals. With this in mind, the Regional Committee in 1985 approved a plan for a major promotional campaign to make this new health policy widely known throughout Europe.

Thus, a pan-European movement for health has been started and is escalating. However, there is still a very long way to go before all European Member States have truly made health a basic concern for all sectors of development, have truly created the social, economic,

cultural and physical environments that make "healthy lifestyles the easy lifestyles to choose" and have truly organized their health services in such a way as to ensure an appropriate level of care to all those who need it — a humane care, an effective care, and an efficient use of health care resources.

Before the meeting of the Regional Committee in 1980, few people thought that HFA had any relevance at all in Europe; nearly everyone felt that it was a concern for developing countries only. Today, we know that this is not so; the 33 countries of the WHO European Region — north, south, east and west — have joined hands and together developed a basic health policy with clear targets to be reached in Europe within the next 10–15 years. Each country needs to adapt this health policy framework to its own specific situation, and — as demonstrated above — recent developments in many countries do indeed reveal that there now is the political will, energy and drive to bring such changes about.

Thus, the European countries have, in a mere five years, come out as leaders in the HFA movement. This will not only change the health policies of the European countries, but will also have a profound influence on the many other countries around the world that traditionally look to Europe for new trends in health care and scientific development.

Making these many new developments flourish, take hold and spread will present us all — the peoples of Europe, their politicians, the health personnel and those of other sectors influencing health, the universities, the public health administrators, the national and international organizations — with some formidable challenges. The start has been very encouraging, and I believe that we have some fascinating years ahead in the health field in Europe.

J.E. Asvall
WHO Regional Director for Europe

Copenhagen, 1 March 1986

Preface

The countries of Europe, with their long experience and vast resources, have a special responsibility to the rest of the world as front-runners in exploring new avenues to solve health problems and reduce inequalities. Following the adoption in 1977 of health for all as the main social target of governments and WHO, the European Region has taken very important steps towards the attainment of that goal, with the formulation of a common health policy in 1980 and the adoption by the Regional Committee in 1984 of the texts presented here.

The regional targets have been developed for the European Member States through the active participation of their experts and their health and social institutions, in consultation with their health authorities. These targets represent, therefore, a common view of what could and should be health for all in Europe and are a challenge that the Member States have set for themselves. But this commitment is more than just enlightened self-interest; one of the major principles present throughout this book is that inequity in health can and must be reduced, and that people must be given the social and economic opportunities to develop and maintain their health. This concerns not only inequities within and among European countries, but also those existing between Europe and the rest of the world.

Around this central preoccupation with equity, the book proposes possible health improvements and possible ways of achieving these. Emphasis is placed on the promotion of healthier lifestyles and a healthy environment, and on the reorientation of health care systems based on primary health care. Even when addressing issues of major

concern to industrialized countries, the targets offer a basis for reflection to those countries that are just embarking on the industrialization process.

Obviously, the improvements proposed by the regional targets can only be implemented by the Member States themselves, and any achievement will depend on the will of countries to orient their own policies and strategies towards the common goal. The essential step in this direction is widespread dissemination of the message at all levels, from policy-makers to the people, through all possible channels involving the mass media, the health professions, consumer groups and the educational system. Such dissemination could stimulate wide debate around the major issues and create the necessary conditions for change.

The formulation of a regional health policy, taking into account the diversity of conditions and sociopolitical systems in the European Region and the development of regional targets, is the result of an impressive amount of work by national experts, sustained by the political will of the Member States. This common achievement is largely due to the initiative, leadership, diplomacy and political tact of the former Regional Director for Europe, Dr Leo A. Kaprio. For some 18 years, Dr Kaprio contributed to building up the confidence of the Member States in the work of WHO in Europe. He also helped instil among them a sense of solidarity and shared responsibility that has made it possible for them to adopt collectively a fundamental political approach that will shape health development for decades to come.

Dr Kaprio retired in January 1985, leaving the European Region with a head start in the race towards health for all by the year 2000. It is up to those who follow him, and to the countries of Europe, to ensure that the advantage is not wasted.

H. Mahler
Director-General

1

The broad perspective

This book is intended to set out the fundamental requirements for people to be healthy, to define the improvements in health that can be achieved by the year 2000 for the peoples of the European Region of WHO, and to propose action to secure those improvements.

Health for all

The Thirtieth World Health Assembly resolved, in May 1977, that "the main social target of governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (resolution WHA30.43). The urgency of this goal for the European Region is underlined by two basic facts.

1. Despite the financial resources devoted to the health sector and the development of new drugs and medical techniques in the last 30 years, people's level of health is far lower than it could be.

2. Despite the overall high level of development in the Region and the scientific, economic and educational level of most countries, the massive challenge of inequalities in health still has to be met.

It is within this framework that the representatives of Member States of the WHO European Region, on the occasion of the thirtieth session of the Regional Committee at Fez in 1980, approved their first common health policy, the European strategy for attaining health for all (document EUR/RC30/R8 Rev.2).

This regional strategy called for a fundamental change in countries' health developments and outlined four main areas of concern: lifestyles and health; risk factors affecting health and the environment; reorientation of the health care system itself; and, finally, the political, management, technological, manpower, research and other support necessary to bring about the desired changes in those three areas. Calling for a basic change in countries' health policies, the strategy urged that much higher priority be given to health promotion and disease prevention; that not merely the health services but all sectors with an impact on health should take positive steps to maintain and improve it; that much more stress should be laid on the role that individuals, families and communities can play in health development; and that primary health care should be the major approach used to bring about these changes. The strategy also called for the formulation of specific regional targets to support its implementation.

These events represented a landmark in health development among the European peoples. Never before had the countries of the Region agreed to adopt a single health policy as a common basis for subsequent development, both in individual Member States and in the Region as a whole. The 33 countries of the Region went even further, urging Member States to review their health developments and bring their health policies and programming in line with the health for all strategy (resolutions EUR/RC29/R6, EUR/RC30/R8 and EUR/RC33/R4).

To ensure that the pledge they had made did not remain a mere pious wish, but would be followed by concrete action, all Member States of the Region undertook to ensure systematic follow-up of their own progress in this development, by means of systematic monitoring and submission of a report every second year (from 1983 onwards) for consideration by the Regional Committee and

the World Health Assembly. They also undertook to make a thorough evaluation of this progress every six years from 1985 onwards and to report the results in the same way.

Thus, a new era in health development was inaugurated in which all governments agreed not only to intensify their efforts to improve health, but in a spirit of international solidarity to fully share their experiences and progress with other countries within the framework provided by WHO.

It may seem rather ambitious to formulate specific regional targets for health for all in the European Region, since Member States differ so much in socioeconomic development, in health status and in political orientation. However, while Member States do differ in many respects, years of working together in the Regional Committee have clearly demonstrated their common concern for improving health and their similar approaches to developing health policies. Setting regional targets is one more very significant step on the road along which they set out when they adopted the regional strategy for health for all by the year 2000.

Regional targets are intended to fuel the debate on national health policies and the formulation of health for all strategies in Member States. While not legally binding on individual countries, they could help them to set their own targets — targets that will reflect their specific needs, priorities and values.

This book was prepared in that spirit and its purposes are to:

- propose improvements in the health of the people in order to achieve health for all by the year 2000;

- indicate where action is called for, the extent of the collective effort required and the lines along which it should be directed;

- provide a tool for countries and the Region to monitor progress towards the goal and revise their course of action if necessary.

The way in which targets are formulated differs according to the nature of the problem, the extent of our knowledge concerning

the existing situation, the efficacy of the steps proposed, and the time expected to elapse between taking action and obtaining the desired results. It also depends on whom the targets concern. Targets in Chapter 3 — health improvements — concern the European Region as a whole, thus expressing the commitment to achieving health for all collectively made by Member States, while those in other chapters deal primarily with specific activities, and therefore concern the peoples and governments of individual countries.

The targets proposed are intended to indicate the improvements that could be expected if all the will, knowledge, resources and technology already available were pooled in the pursuit of a common goal. The target levels set are not the result of elaborate mathematical modelling, but are based on historical trends in the fields concerned, their expected future evolution and the knowledge available on the probable effects of intervention. These levels are intended to inspire and motivate Member States when they are determining their own priorities, targets and capabilities and thus the degree to which they can contribute to reaching the regional targets.

The base year for all the targets is 1980. The suggested dates of completion differ, however, in order to reflect the logical succession of events that will have to take place if health for all is to be reached by the year 2000. The year 2000 is the completion date retained for all targets in Chapter 3, related to health improvements. Targets in Chapters 4, 5 and 6, related to lifestyles, the environment and care respectively, have 1990 or 1995 as their date of completion unless specific problems, such as the amount of resources needed, justify the allocation of a later year. Finally, targets embodying measures to bring about the changes, such as those in Chapters 7 (research) and 8 (health development support) should be reached before 1990. The practical ways used to reach each target are the sole responsibility of Member States. They must individually reach a decision on the basis of their legal, political, social, cultural and economic position, as well as in the light of their health systems and organizational structures.

The regional health for all targets clearly set forth the minimum progress the European countries must make in improving health and health-related problems by the year 2000. To enable systematic monitoring and evaluation of progress in each Member State and in the Region as a whole, a set of regional health for all indicators has been devised (see Annex 2). They will be used by each country in reporting every second year to WHO on the progress made. Furthermore, a regional health for all plan of action, outlining the major steps that Member States and WHO should take in the years ahead to bring about these changes, has also been drawn up (see Annex 3).

The thrust of this book

Six major themes run throughout the whole book.

- Health for all implies *equity*. This means that the present inequalities in health between countries and within countries should be reduced as far as possible.

- The aim is to give people a positive sense of health so that they can make full use of their physical, mental and emotional capacities. The main emphasis should therefore be on *health promotion* and the prevention of disease.

- Health for all will be achieved by people themselves. A well informed, well motivated and actively *participating community* is a key element for the attainment of the common goal.

- Health for all requires the coordinated action of all sectors concerned. The health authorities can deal only with a part of the problems to be solved, and *multisectoral cooperation* is the only way of effectively ensuring the prerequisites for health, promoting healthy policies and reducing risks in the physical, economic and social environment.

- The focus of the health care system should be on *primary health care* — meeting the basic health needs of each community through

services provided as close as possible to where people live and work, readily accessible and acceptable to all, and based on full community participation.

- Health problems transcend national frontiers. Pollution and trade in health-damaging products are obvious examples of problems whose solution requires *international cooperation.*

Structure and content

Chapter 2 sets out the prerequisites for health. Peace, adequate food and income, decent housing, safe water, sanitation and a satisfying role in society are all essential for health. Moreover, there can be no effective action to secure health for all without strong political and public support.

Chapter 3 proposes health improvements that can be achieved by the year 2000 in the way of strengthening health as well as reducing disease and its consequences. Such improvements have four major aims.

The first aim is to ensure "equity in health" between and within countries, initially by reducing differences in health levels between countries and between different population groups within countries by at least 25% by the year 2000. There is a 20-year difference between the extremes of life expectancy in the countries of the Region, and one country has an infant mortality rate over 17 times as high as that of another. Even within one of the most highly developed countries of the Region, infant mortality is 2–3 times higher and life expectancy at birth almost 7 years less in the lowest social group than in the highest.

The second aim is to "add life to years", by ensuring the full development and use of people's physical and mental capacity to cope with life a healthy way.

The third aim is to "add health to life", by increasing the number of years people live free from major diseases and disabilities. This can be achieved by ridding the Region of those communicable diseases that can be eliminated by the technology at present available (measles, poliomyelitis, neonatal tetanus, congenital

rubella, diphtheria, congenital syphilis and indigenous malaria); by reducing disability caused by accidents and certain diseases; and by generally increasing the opportunities to use to the full individual capabilities for health.

The fourth aim is to "add years to life", by reducing the number of premature deaths, thus increasing life expectancy at birth in the Region at least to 75 years. It is proposed in particular to take action to reduce infant mortality by the year 2000 to less than 20 per 1000 live births, maternal mortality to less than 15 per 100 000 live births, and mortality from accidents by at least 25%, from diseases of the circulatory system by at least 15% and from cancer by at least 15%.

The next three chapters deal with the three major categories of change that can bring about such improvements in the health of the European peoples, such as changes in lifestyle, in the environment and in the care system.

The starting point in changing lifestyles (Chapter 4) is to recognize that to a considerable extent health depends on the political, social, cultural, economic and physical environment. The first aim is therefore to provide opportunities and develop capacities for adopting healthy lifestyles by formulating general policies that are consistent with the requirements of health promotion and protection, so that healthy lifestyles become the easiest choice. The second aim is to strengthen and develop caring interpersonal and family relationships that help protect health. The third aim is to increase the interest of individuals, groups and communities in actively promoting their own health and wellbeing and that of others. More specifically, this chapter proposes targets aimed at promoting positive types of behaviour, such as nonsmoking, balanced eating and physical activity, and discouraging behaviour that damages health, such as alcoholism, drug abuse and violence.

In Chapter 5, on the environment, specific targets are set for reducing water, air and food pollution, hazardous wastes, and risks in human settlements and in the working environment. A significant reduction in these risks will depend partly on adequate

machinery to monitor, assess and control environmental hazards, partly on community awareness and involvement, and partly on effective international action.

Chapter 6, on appropriate care, lays stress on primary health care, to which secondary and tertiary care provide crucial support. This is the key to greater equity, to prevention and to health promotion, as well as to the provision of adequate treatment and rehabilitation services to meet the basic health needs of the population. The targets call for a rational distribution, based on need, of health care resources, for cooperation between health personnel, individuals, families and community groups, and for coordination at the community level of all activities relevant to health. The need for systematic assessment of the quality of care is stressed.

The last two chapters set forth the measures needed to support health development. Chapter 7 deals with directing research strategies towards giving effective support to the attainment of health for all targets, and with the need to coordinate efforts in planning and carrying out this reorientation of research. Chapter 8 stresses that important prerequisites for health development in countries as well as at regional level are a strong political commitment; efficient management, supported by a good information system, that will turn health policies into effective health programmes; adequate planning of manpower requirements and education and use of health personnel; the provision of information and education on matters connected with health for personnel in sectors that have an impact on health; and the systematic assessment of the effectiveness, efficiency, safety and acceptability of health technology.

Priorities

This book specifies 38 targets, the relative importance of which will vary from country to country. Different countries will thus need to choose, on the basis of their own situation, what importance to attach to particular types of action in contributing to an improvement in their own health as well as to the efforts of the Region as a whole. There are targets for health improvement,

targets for activities needed to bring them about, and targets designed to promote implementation of the whole strategy.

In matters concerning the Region as a whole, priority will be given to major health problems, in the case of which sufficient knowledge is available about ways and means of achieving a change for the better, and in respect of which the necessary political drive for action will be forthcoming; typical examples are a reduction of infant mortality or of accidents related to work. Other major health problems, about which too little is known as yet for scientifically based action to be recommended, will become priority areas for research. Typical examples can be found in the field of positive health behaviour. It is a special responsibility of the Region to promote and coordinate concerted action on problems that cannot be solved by individual countries alone. Examples of this are transfrontier air pollution and efforts to change important aspects of lifestyle by means of long-term educational campaigns waged jointly by several countries, with a view to popularizing health-promoting types of behaviour such as nonsmoking.

The national priorities set will depend heavily on the basic political and cultural characteristics of the country concerned. The following paragraphs, therefore, can give only a general idea of the way priorities can be selected in groups of countries or areas within countries, since only an individual country can analyse its own priorities.

Activities in Member States

In countries where this has not already been done, the first priority must be to bring health policies closer to the principles of health for all and, as far as possible and appropriate, to develop health strategies setting out the major directions of change and how the change is to be brought about. At an early stage, it will be essential to determine what information is available so that steps can be taken to fill any important gaps. Special importance is attached to information on environmental risks and lifestyles, especially if it helps to determine which groups are particularly at risk. The education, training and retraining of health personnel will also require early attention.

Health development

A central aim must obviously be to ensure greater social equity by reducing poverty in its widest sense, by securing the basic requirements for health — food, water, sanitation, education and decent housing for everybody — and by ensuring that everybody has access to primary health care. Major health improvements could also be achieved through specific programmes such as immunization. A major political challenge is to mobilize the necessary support of the general population and of the specific groups most concerned, so as to make such programmes a priority at all relevant levels of health policy-making in Member States and to procure the resources needed to carry them out efficiently. In the years ahead, the richer countries of the Region should give more effective help to developing countries in their efforts to improve their socio-economic development in general and their health development in particular.

However, problems of poverty, inadequate nutrition, bad housing, functional illiteracy, poor sanitation and poorly developed primary health care are also to be found in countries with a high per capita income. Such countries may need to develop different priorities for different geographical areas or different social groups.

Strengthening people's ability and opportunity to choose healthy lifestyles and to reduce tobacco and alcohol consumption are high priorities for all countries, especially the most industrialized ones. It is in these fields that effective action is most likely to result in important improvements in health. No less important are the specific programmes to give all people, and in particular such groups as the elderly and disabled full opportunities to lead a productive and satisfying life. It is of major importance for the less developed parts of the Region to find paths to development that do not bring in their train the serious health hazards that afflict the more affluent countries. Cigarette smoking, alcoholism, accidents and the breakdown of family and community networks are hazards that are probably easier to prevent than to reduce once they exist. If the developing countries fail to tackle these problems when they first begin to arise, all their efforts to control their existing

problems may not in the end lead to the overall improvement in health hoped for.

One principle is true for all countries: the key to solving many health problems lies outside the health sector or is in the hands of the people themselves. High priority should therefore be given to stimulating the contributions that other sectors and the public at large can make to health development, particularly at local level. It is essential in this respect to accept the basic principle that people's involvement in health development cannot be merely passive. It is a basic tenet of the health for all philosophy that people must be given the knowledge and influence to ensure that health developments in communities are made not only for, but also with and by the people. Primary health care is the most important single element in the reorientation of the health care system and will require very strong support. It is also important to ensure more economical, effective and humane use of existing health care resources.

The future

The targets presented in this book are a deliberate attempt to change the course of European health development. What is at stake is ultimately the health and wellbeing of Europe's children, of the coming generations. Success of the health for all movement will mean that all children of the Region will have a much better chance of:

- being born healthy to parents who want them and who have the time, the means and the skills needed to bring them up and care for them properly;

- being educated in societies that endorse the basic values of healthy living, encourage individual choice and allow it to be exercised freely;

- being provided with the basic requirements for health and being effectively protected against disease and accidents.

It also means that all people would have an equal opportunity of:

- living in a stimulating environment of social interaction, free from the risk of war, with full opportunities for playing satisfying economic and social roles;

- growing old in a society that supports the maintenance of their capacities, provides for a secure, purposeful retirement, offers care when care is needed and, finally, allows them to die with dignity.

This is a challenge that goes to the heart of human aspirations. It will be necessary to create a broad consensus among the people of the Region that health for all is an objective that should, can and will be attained by the year 2000. A joint endeavour of this kind by the 33 Member States will not only ensure better health and a better life for people in the Region, but can also help to reduce international tension by creating solidarity and mutual support in health that will cut across political, cultural and ethnic barriers. In this way, it can be a major force in fostering greater understanding and trust among people of the Region and thus contributing to the satisfaction of the most basic need of all — peace.

2

Prerequisites for health

Other chapters in this book propose targets for health for all in the Region. To reach these targets, much will have to be done to improve specific health-related aspects of lifestyles, environmental conditions and health care, but such improvements will have little effect if certain fundamental conditions are not met. Without peace and social justice, without enough food and water, without education and decent housing, and without providing each and all with a useful role in society and an adequate income, there can be no health for the people, no real growth and no social development.

The main responsibility for attaining these objectives lies outside the health sector. This responsibility must be fully recognized at all levels of policy-making in countries so that priorities in overall national development take into account the need to strengthen those aspects of life that are a prerequisite for health. At the international level, it requires collaboration among Member States as well as concerted efforts by all the United Nations organizations who share the main responsibility for setting specific objectives in these domains and for ensuring that these prerequisites are met for all. This is in line with United Nations General Assembly resolution 34/58, which calls on the relevant bodies of the United Nations system to coordinate with and support by appropriate action within their respective spheres of competence the efforts of the World Health Organization in reaching the goal of health for

all. If this interdependence is not recognized, both within countries and at the international level, efforts to improve health will be at once more costly and less effective.

Above all, it is only with the firm commitment of both governments and the people that the action needed within Member States and the required collaboration among them can be strengthened sufficiently for the targets in the European Region to be reached.

Freedom from the fear of war

War is the most serious of all threats to health. The devastation that a nuclear war would entail in terms of people killed, wounded and permanently disabled simply defies imagination. The dropping of a one-megaton bomb over a large city would kill more than 1.5 million people and injure as many. It has been estimated that a "limited" nuclear war, with smaller tactical nuclear weapons delivering a total of 20 megatons on military targets in a relatively densely populated area, would exact a toll of about 9 million dead and seriously injured, while a full-scale war exploding 10 000 megatons of nuclear bombs would kill 1150 million people and injure 1100 million, so that more than half the world's population would be immediate victims. The impact of such an event on the world environment would be immense.

However, it must not be forgotten that conventional war is also a terrible threat to humanity. The immense devastation of the Second World War is only a small indication of what could result from a major international armed conflict today given the more destructive "conventional" weapons now available.

But peace is not just the absence of war. It is also a positive sense of wellbeing and security for people of all countries, implying the opportunity to freely determine their own destiny and fully exploit their human potential. It assumes the possibility of all nations actively participating on a basis of equality and in a true spirit of solidarity and reciprocity in the development of a more satisfying world for all people. An important point in this regard is that in Europe, at the present time, it is not war itself that presents health problems but the fear of war. The increasing international

tension in recent years has raised this level of apprehension to a point that severely hampers the opportunities for all peoples in the Region to work together in harmony for a better future.

All these elements contributed to the recent decision of the General Assembly of the United Nations to adopt resolution 38/113 stressing once again the urgent need for the international community to make every effort to remove the growing threat of war.

There are some things that the health sector can do that fit in with its basic role and that can help to reduce international tension. In each country, the health sector should take the lead in promoting close, long-term collaboration on health problems across national borders. The bilateral and international research, meetings and contacts involved, in addition to improving health, will increase understanding and forge links among individuals, institutions and countries, thus serving to reduce international tension and demonstrating the value of mutual cooperation.

Moreover, each national health sector should take responsibility for creating a better understanding of what a war, and particularly a nuclear war, would really mean for health, and thus strengthen the motivation for peace. By analysing objectively the extent of human destruction, suffering and disability that a war would entail in their country, by giving a realistic analysis of how little its health services would be able to do to treat the civilian and military casualties, and by making these facts known and understood by politicians and the general public, the health sector could help to encourage a more active search for ways of preventing war from ever breaking out again. At the international level, the World Health Organization has taken the initiative in this respect with the adoption by the World Health Assembly and the later distribution of the report concerning "Effects of nuclear war on health and health services". Such efforts should be continued.

Equal opportunity for all

In the commitment of the Member States of the European Region to health for all by the year 2000 lies a fundamental principle of social policy: all human beings have an equal right to health. That

right will be ensured by providing all the people of the Region with an equal opportunity to develop health to the full and maintain it. This principle has two aspects in the European Region: equity among nations and equity among the people within each country.

Very large inequalities at present exist among the countries of the Region. The European Region includes countries with widely different standards of living. Gross national product per head in 1980 varied from about US $700 in one Member State to over US $12 000 in another. Expectation of life at birth varied among Member States from 55 years to 77 years. In some richer countries there is a surplus of hospital beds and trained health personnel, while in some of the poorest even the basic health infrastructure is still not complete. These sharp contrasts in health status and health services are reflected in the differences in the degree of poverty among the various countries of the Region and within individual countries, the richer nations being by no means exempt from the overall problem of social inequity. There are similar variations in other respects, such as sanitation, water supply, housing and the availability of basic commodities. As is shown in detail in Chapter 3, these differences in socioeconomic development also translate into disturbing inequalities in health status.

A key problem in the less privileged countries of the Region is the lack of funds for investment in the health sector. A major challenge for the European Region is, therefore, how to bring about a more concrete policy of solidarity through which the more fortunate countries can collaborate more effectively with the less fortunate ones to ensure development of the health sector. This is in line with the Charter of Economic Rights and Duties of States (resolution 3281 (XXIX)) adopted by the General Assembly of the United Nations and with the International Development Strategy for the Third United Nations Development Decade (resolution 35/56) urging developed countries to significantly increase their public aid to support the development of developing countries. In this spirit, new ways of stimulating and channelling voluntary contributions to developing countries could be established. One possible means would be to set up a special "European health development fund"

to assist the development of the health infrastructure in the less developed countries of the Region. If established, such a fund should be operated under the overall guidance of the Regional Committee and be limited to development projects in line with basic health for all policies. However, a special feasibility study would be required before it were decided whether or not to establish such a fund.

Social deprivation is not uncommon even in some of the more developed countries of the European Region; even in the most highly developed countries seven years less life expectancy and two and a half times as much infant mortality have been found among the lowest social class compared with the highest. By the mid-1970s in the countries belonging to the European Economic Community alone, there were still some 30 million people living in poverty. People in other parts of the Region are also living below the recognized social minimum. Their ranks have been swelled by the "new poor", many of them women with dependent children who are reliant either on low wages or on state benefits. Similar differences can also be found in other subgroups within countries, e.g. old people, ethnic minorities and people living in specific geographical areas. A major task in any national health for all programme must therefore be to establish a consistent and long-term policy capable of radically reducing the present social inequity in income, housing, etc.

Satisfaction of basic needs

If there is to be a significant move towards genuine social equity in the Region, people must have the opportunity to satisfy their basic needs in the way of decent food, basic education, safe drinking-water, adequate housing and a useful occupation providing an adequate income.

Food

Obtaining enough of the right kind of food is still an important problem in various parts of the Region. Among children, inadequate food lowers resistance to disease and leads to impaired physical and mental development. Figures for infant deaths and

low birth weight show that there is serious undernutrition and malnutrition in parts of the Region. Furthermore, the deficient diet of many elderly people, particularly those living alone, is of special concern in many countries.

Basic foods should be priced within everyone's means. Well planned and integrated national food and nutrition policies and programmes are needed to improve the production and distribution of food at affordable prices among deprived groups and in deprived areas.

The elimination of hunger and malnutrition is a fundamental objective of the International Development Strategy for the Third United Nations Development Decade mentioned above, and could be achieved by ensuring *inter alia* that all human beings have access to the basic food they need at prices within their means.

Basic education

Education is the foundation for developing individual potential and for ensuring useful participation in society. It is also a basis for understanding health, for making informed choices about lifestyles, and for looking after personal and family health. Member States, by endorsing the Constitution of the United Nations Educational, Scientific and Cultural Organization (UNESCO) have recognized the need for full and equal opportunities for education for all.

The level of education of the people of this Region is among the highest in the world. Dramatic differences nevertheless persist. In some countries, it has been estimated that in 1980 half the people aged 15 years and over were illiterate, and in women in the same countries illiteracy may be as high as 80%. Even in well developed countries, significant percentages of the population are now functionally illiterate.

The United Nations General Assembly recently adopted resolution 37/178 on the right to education, stressing the urgency of eradicating illiteracy, and invited all States to adopt appropriate measures to ensure full implementation of this right through free and compulsory primary education, universal and gradually free-of-charge secondary education, and equal access to all educational

facilities. Particular attention should be paid to groups that have not had the same opportunities of obtaining an adequate basic education. The resolution requested UNESCO to work on the implementation of this right and invited all specialized agencies to work with UNESCO towards this end.

Water and sanitation

Water and sanitation are essential for the protection of human health. In some countries, however, many rural people and even some people in towns lack the most basic facilities. It has been estimated that well over 100 million people in the Region are without an acceptable water supply and 250 million without proper sanitation. The importance of the problem is shown by the fact that in some countries many infants are still dying from enteric and diarrhoeal diseases.

The target of the International Drinking Water Supply and Sanitation Decade requires that by 1990 all people should already be provided with a continuous supply of safe drinking-water and appropriate means of sanitation. Chapter 5 sets targets in these respects.

Decent housing

Decent housing is an important contributing factor in building up and maintaining family life and social interaction. The level of hygiene in human dwellings is a very significant environmental health factor, especially for those who spend most of their time indoors, such as infants, young children, the elderly and the handicapped. Housing conditions thus affect for better or for worse everybody's physical, mental and social wellbeing.

Many millions of people in Europe live in grossly substandard housing. While this is particularly true of the developing countries, a serious problem also exists in the more developed ones. Thus, several million people live in decaying city centres or recently built substandard apartments. In many countries of the Region there is also a lack of reasonably priced dwellings. Young couples especially may have to wait for years before they have an opportunity to occupy their own dwelling, while low-income groups such as the elderly may never be able to afford one. Owing to the housing

shortage or excessive prices, more than one family may have to share the same apartment or members of the same family may be obliged to live apart.

Thus it is clear that this sector represents a major problem for the European Region as a whole, and Chapter 5 sets a health-related target in this respect.

Secure work and a useful role in society

Secure work and a useful role in society have always been fundamental human needs. Unemployment and underemployment therefore take a human and social toll on individuals, their families and communities, that is also damaging to health.

The long-term economic prospect is uncertain. It would be extremely rash to plan on the assumption that there will be a return, even in the 1990s, to the rapid growth rates of the 1950s and 1960s. The older industries of the Region are facing powerful competition from Third World countries, and new technology is making it possible for both industry and many services to produce more with the same or even less manpower. Unemployment in the Region has reached persistently high levels unknown for two generations. Any realistic plan for health must therefore be based on the assumption that the average annual rate of economic growth in the Region up to the year 2000 will be modest.

The bleaker overall economic prospect does not necessarily mean, however, that continued high levels of poverty and unemployment must be passively accepted. The health and social care services are, and will remain, labour-intensive, partly because they rely on personal relationships and personal services. Expansion of the health sector can provide satisfying and useful jobs, paid or unpaid, and thus offers a way of reducing unemployment if there is the political will to do so.

In response to economic difficulties, education and training for young people have been provided mainly in the economic sector, but among the jobs for which young people need to be prepared is the provision of social care. An important factor in this context is that in the past, educational systems have not done much to combat the sexual division of social roles. One consequence of that

policy is that women tend to end up with skills suited only to poorly paid jobs. This is of special importance in the case of family breakdown, which often leads to the establishment of low-income families consisting of a divorced mother and her children.

Employment policies, including responses to the economic crisis in the training of young people, should provide people with an opportunity for choosing satisfying social and economic activities, while maintaining living standards and fulfilling social and family roles. Serious attempts should be made to provide the disabled and the elderly with useful occupations that make the best of their talents. Research efforts should be devoted to finding new ways of redistributing work and work opportunities as economic and industrial patterns change. The political challenge is to find acceptable means of promoting this development.

This is in line with the aims and purposes of the International Labour Organisation to further the achievement of full employment in occupations that provide people with the satisfaction of giving the fullest measure of their skill and attainments, a basic income to all in need of such protection and conditions of work that ensure to all a just share of the fruits of progress.

Political will and public support

Given the magnitude of the task of attaining health for all, strong political will and the mobilization of public support are fundamental prerequisites for launching the necessary action. The ministries of health or other authorities responsible for promoting and sustaining health policies should take a strong line in ensuring the clear commitment of the country as a whole to the objective of health for all. This is in conformity with resolution 34/58 of the United Nations General Assembly and World Health Assembly resolution WHA30.43, calling on countries to develop their national strategies for health for all and take the necessary steps to ensure their implementation. The process of mobilizing support should preferably be set in motion by political decisions taken at the highest level and confirmed in all sectors throughout the country. This should result in all sectors with an impact on health

acknowledging that safeguarding the people's health is an overriding concern in their own particular field as well.

The way people are mobilized depends on the cultural and social patterns and the political system in the country concerned. Efforts should be made to ensure the strong support of religious and civic leaders and other public figures, trade unions and influential nongovernmental organizations. Such popular support could be mobilized by setting up special associations in countries solely to promote the goal of health for all and its attainment. Means must be found to make the health professions and other groups in society, and particularly community organizations, active collaborators in a countrywide movement for health for all, and extensive and sustained mass campaigns should be undertaken to ensure wide and active support among the general public.

In the European Region, the strong, collective political commitment of Member States must be maintained in order to provide the impetus for the collective action required. It was the adoption of the goal of health for all by the World Health Assembly in 1977 that provided the first stimulus, later reinforced by the endorsement of the regional strategy for health for all by the Regional Committee in 1980. It was further strengthened by the adoption by the Regional Committee in 1984 of specific regional targets in support of the regional strategy, to be reached by the year 2000 (resolution EUR/RC34/R5) (see Annex 1). Equally important as an expression of the political will for effective change is the decision, already mentioned, by Member States to establish the machinery for monitoring and evaluating progress towards health for all in each country. The adoption by the thirty-fourth session of the Regional Committee of a list of indicators and a health for all plan of action, both of which are currently only provisional, have further strengthened this commitment. Although the Regional Committee in 1980 did not pursue the matter at that time, the process could even culminate eventually in the adoption by all Member States of a Regional Health Charter, as a means of further heightening the feeling of shared responsibility for trying to fulfil certain basic human aspirations and thus further intensifying efforts for peaceful cooperation.

3

Health for all in Europe by the year 2000

If health for all is to be reached in Europe by the year 2000, two basic issues must be tackled. The first is to reduce health inequalities among countries and among groups within countries. All the people of the Region should be assured an equal opportunity to develop, maintain and use their health. Particular efforts should therefore be made to provide such an opportunity for those countries, groups and individuals who lack it most. The second issue is to strengthen health, as much as to reduce disease and its consequences. Thus, health for all in Europe has four dimensions as regards health outcomes, involving action to:

- *ensure equity in health,* by reducing the present gap in health status between countries and groups within countries;

- *add life to years,* by ensuring the full development and use of people's integral or residual physical and mental capacity to derive full benefit from and to cope with life in a healthy way;

- *add health to life,* by reducing disease and disability;

- *add years to life,* by reducing premature deaths, and thereby increasing life expectancy.

Health for all will be achieved in Europe to the extent that the Region is able to come to grips with the two basic issues: they must thus be seen as the key to the attainment of the goal.

The targets in this chapter deal first with the concern to reduce inequity in health and to promote individual capabilities with regard to health. They then draw attention to the possibilities open to us for eliminating specific diseases and decreasing disabilities and, finally, make suggestions on ways to reduce infant and maternal mortality, and premature death from diseases of the circulatory system, cancer, accidents and suicide. In formulating the targets, care was taken to propose levels of achievement that are known to be realistic, either because they have already been reached by at least some of the countries in the Region or because the necessary technology exists.

Equity in health

Target 1 ☞
Reducing the differences

By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups.

This target could be achieved if the basic prerequisites for health were provided for all; if the risks related to lifestyles were reduced; if the health aspects of living and working conditions were improved; and if good primary health care were made accessible to all.

Problem statement

Health status can be measured by a large number of indicators, but only mortality can be used with a reasonable degree of reliability for intercountry comparisons owing to deficiencies in health statistics in many countries (target 35 refers to the need to improve this situation). Around 1980, life expectancy at birth in countries of the Region ranged from 73 to 55 years in men and from 80 to 57 years in

women, compared with the 1960 figures of 71 to 47 in men and 76 to 47 in women. Infant mortality ranged from well over 100 to less than 7 deaths per 1000 live births. Marked differences in mortality occurred in all age groups, in respect not only of total mortality but also of mortality from specific diseases, particularly the most "preventable" ones such as pneumonia or other infectious and parasitic diseases. Although adequate data do not exist for systematic intercountry comparisons, it seems very likely that similar marked differences also exist with regard to morbidity and disability.

There are also marked differences in health status between the more and the less privileged groups within countries. Irrespective of the means by which socioeconomic groups are distinguished, it has always been shown that there are seriously disadvantaged groups with regard to health status, as measured by classical mortality indicators, with the widest gaps concerning the preventable causes of ill health such as infections or behaviour-related conditions.

The differences between socioeconomic groups are frequently very large and may amount to several years in life expectancy. Several studies have shown more than a twofold difference in infant mortality and mortality from accidents, poisoning and violence, lung cancer and myocardial infarction, as well as more than a threefold one for mortality from cirrhosis of the liver. Likewise, the mean age of retirement due to sickness or disability has been found to differ by 2–5 years between blue- and white-collar workers. Similar variations have been found in morbidity and disability studies.

While men experience higher mortality than women at all ages, the greatest differences occur in young adults. In a number of countries, the male death rate in the age group 15–34 years is three times higher than that of females. However, marked differences persist in older age groups, especially in mortality related to lifestyle, i.e. from accidents, poisoning and other violent deaths, smoking-related cancers and certain respiratory diseases, ischaemic heart disease and cirrhosis of the liver. It is therefore clear that much of the current excess mortality in males is preventable.

Suggested solutions

The reduction of inequalities in health will require first and foremost the general availability of the basic prerequisites for health and the reduction of risks related to lifestyles. Most of the present differences in health status are determined by living and working conditions. The disadvantaged nations and groups are not only more exposed to environmental hazards but also to the pressures that encourage the adoption of health-damaging habits. The prosperous ones are not only more protected from environmental threats but also more likely to benefit from health promotion. It is clear that if the present trend continues, the actual gaps will widen.

The target on health inequalities presents a challenge: to change the trend by improving the health opportunities of disadvantaged nations and groups so as to enable them to catch up with their more privileged counterparts. Within individual countries, this implies above all a need for willingness in recognizing the problem, for initiative in actively seeking information on the real extent of the phenomenon, and for political will in designing social policies that go to the roots of social group formation, in terms of guaranteed minimum income, assurance of the right to work, active outreach services to assist the groups in need, etc. The latter requirement for outreach services has important repercussions for the health care system. It is particularly necessary to ensure that these services are provided at such times and in such a way that they are acceptable to the groups in need.

The aim of diminishing the differences among Member States not only represents a task for the least developed; it also presents a real challenge to the more developed to help them through more efficient cooperation in the financial and technical aspects of building up the health care system, including its components of infrastructure and manpower.

It is recognized that reducing differences as described above will not be an easy undertaking in view of the existing international and national constraints unless the political will and commitment is backed by broad international cooperation and a reallocation of resources.

Adding life to years

Target 2
Developing health potential

By the year 2000, people should have the basic opportunity to develop and use their health potential to live socially and economically fulfilling lives.

This target could be achieved if health policies in Member States gave a framework for developing, implementing and monitoring programmes that provide the environmental conditions, social support and services required to develop and use each person's health potential.

Problem statement

The WHO concept of health as a state of physical, mental and social wellbeing, and not only the absence of disease and disability, views health as a positive condition involving the whole person in the context of his/her situation. The implication of this positive and relative concept of health is that all people, whatever their present circumstances or age, can achieve wellbeing by making full use of their existing functional capacities.

Most health programmes have focused on disease as a biological deviation from the norm, rather than on the full range of health and relative health as a positive value. Health for all thus requires the creation of mechanisms that promote the health capabilities of all people and the removal of any barriers that may prevent use of the available potential. It also requires the enhancement of people's awareness of health as an important resource for leading satisfying lives and the development of attitudes and skills to enable them to make full use of their health capabilities, whether whole or residual, to cope with life.

It is important to recognize that certain population groups may sometimes be denied viable opportunities to use their capabilities, so that handicaps or functional limitations may actually result from the lack of such opportunities. This is a situation often faced by old people in many communities. Although reduced functional

capacity is correlated to advancing age, it is not clear what percentage of the reduced function is due to preventable loss of fitness and/or of social contacts. Most aging people do not show symptoms of mental and physical decline; on the contrary, they tend to enjoy a level of health that permits them to continue to lead socially and economically active lives. Most aging people are indeed able, and would prefer, to remain in a productive occupation, but national retirement policies usually discard these experienced and skilled human resources that no society should leave untapped. Other decisions affecting the elderly are also made without consulting them, even though they usually know best what their needs are and how they should be provided for. A sometimes serious problem arises from the fact that an increasing proportion of old people are living alone and in isolation. The current proportion is particularly high for women, with around 50% of those aged 60–64 years in many countries being on their own. In many cases, these people need to have their capacities stimulated as well as being given opportunities to use them.

It is, however, not only in old age that many people face serious obstacles to the promotion and maintenance of their health. Single parents with young children, especially young mothers, often do not have the opportunity or resources for relaxation, social interaction and balanced physical activities. People who work in jobs that involve shift or night work may also find it difficult to develop their health capabilities. Ethnic minorities and migrant workers may find themselves excluded from normal social interaction in many communities. In view of the growing body of evidence regarding the importance of social interaction and social support for health and wellbeing, particular attention should be paid to this question in relation to healthy aging. Finally, it should be remembered that in some cases, it is a lack of awareness of the factors that promote and preserve health, or an absence of the necessary attitude and skills, that inhibit people from developing their health potential.

Suggested solutions

A great improvement in the health of the people in the European Region could be achieved through the implementation, within the

framework of the regional health for all targets, of policies and programmes that would give people the prerequisites for health, promote healthy lifestyles and provide a social and physical environment conducive to them and, in general, encourage the maintenance of physical and mental fitness.

The concept of health that is imparted in school curricula and presented in the mass media should stress the need to develop and use one's own physical, mental and emotional capabilities. For this purpose, barriers to health-enhancing behaviour must be removed and life made conducive to the achievement of the goal. Individuals in turn must assume responsibility for developing and preserving their capacities.

All human rights and privileges must be reaffirmed in respect of aging people who have an evident claim to a fair share of the benefits flowing from the development to which they have contributed.

Social policies for the aging should be geared towards guaranteeing their economic independence, their right to make decisions in personal matters and their right to be active contributors to the society within which they live. Such policies need to be adapted to the cultural patterns in particular societies and should be of wide scope. Housing should be designed to promote self-reliance in coping with daily life while allowing flexibility for independent living and providing opportunities for social contact, including sexual contact and meaningful personal relationships. Social insurance schemes should ensure economic security and independence. There should be greater flexibility in the fixing of the age of retirement and in the distribution of work over the lifespan, and stimulating leisure facilities or part-time work should give people an incentive to lead a purposeful life after retirement.

Societies should explore to the full the possibilities of mobilizing and deriving benefit from the intellectual and cultural resources of the old. Policies should therefore be directed at promoting cohesion between generations. Not only should the young be encouraged to participate in the care of the elderly, but aging people should be encouraged to become involved with and help the young.

Efforts to develop indicators of positive health show how difficult it is to capture the essence of the term "health" and measure it precisely. Each person is best placed to assess his/her own health in the context of his/her situation. Measurements of perceived health status have been shown to predict health outcomes, including mortality, more accurately than many other indicators of health status. Therefore, Member States should systematically collect data regarding individual perceptions of health, both to evaluate progress towards health for all and to gain a better understanding of the population's own assessment of such progress.

Target 3 ☞
Better opportunities for the disabled

By the year 2000, disabled persons should have the physical, social and economic opportunities that allow at least for a socially and economically fulfilling and mentally creative life.

This target could be achieved if societies developed positive attitudes towards the disabled and set up programmes aimed at providing appropriate physical, social and economic opportunities for them to develop their capacities to lead a healthy life.

Problem statement

Despite all possible preventive and rehabilitative efforts, there will always be some people with permanent functional impairments and disabilities, but they need not be socially handicapped. It is mainly the physical and social environment that determines the effect of an impairment or a disability on a person's ability to lead a satisfying and productive life.

People are handicapped only when they are denied the opportunities generally available in their community to enjoy family life, education, employment, housing, access to public facilities, freedom of movement and the accepted standard of living.

The integration of disabled people in their community is far from satisfactory in most countries. Nowhere have all obstacles been overcome, despite the important steps taken by some countries to eliminate or reduce barriers to the full participation of disabled people. In many cases, disabled children and adults are

still excluded from school because of their limited mobility or because those responsible for them are not sufficiently aware of their abilities and potential. Children with disabilities are too often confined to life in institutions that are more custodial than educational. Disabled people are often denied employment or given menial and poorly paid jobs, even though it can be shown that with proper assessment, training and placement, most can satisfy the prevailing work norms. Finally, the disabled are often denied the right to self-determination in their life and future development, as well as their chance to take part in the social life of their community. This deprivation is a result of physical, social and economic barriers that have often been caused by ignorance, fear or indifference. This socially inflicted deprivation is especially acute with regard to the mentally disabled.

Suggested solutions

A major effort is needed to change the basic attitude of society towards the disabled. This will involve extensive campaigns, aimed at all age groups, and designed to make people concious of the human being within the disabled body. Special programmes should be arranged to help disabled people to develop their skills in daily living, in sport and in social interaction. Strict building and town planning codes should ensure easy access and open up functional possibilities for different types of disabled person. High priority should be given to the design of improved technical aids for the disabled. Public funding should cover the extra cost for the disabled of specially designed housing, transport and tools for daily life, work and leisure. The disabled should be assured paid occupations commensurate with their residual functional capacity. All disabled people, whether in institutions or in their own homes, should be guaranteed all the basic human rights, including the right to self-determination in their own lives, to a reasonable degree of privacy, to sexual relations, and to participation in community life. However, most important of all will be the need to ensure that the disabled themselves exercise a decisive influence on the design of such policies and programmes, at both national and, particularly, local levels.

Adding health to life

Adding health to life by reducing disease and disability can be achieved by a two-pronged strategy:

(*a*) reducing the incidence and consequences of accidents and of diseases for which partially effective prevention and/or treatment methods are available (target 4);

(*b*) eliminating completely from the Region diseases for which there exists reliable control technology that can be applied with a reasonable effort (target 5).

Target 4 ☞
Reducing disease and disability

By the year 2000, the average number of years that people live free from major disease and disability should be increased by at least 10%.

This target could be achieved if, for instance, comprehensive programmes aimed at primary prevention of accidents and violence, cardiovascular disease, lifestyle-related cancers, occupational diseases, psychiatric disorders, alcoholism and drug abuse were developed, and adequate curative and rehabilitative services provided to all; if current knowledge regarding infectious diseases prevention were systematically applied; if genetic counselling services were made more generally available; if research were intensified with regard to disabling neurological and musculoskeletal disorders; and if preventive measures in oral health were effectively implemented.

Problem statement

It is estimated that about 20% of disability is due to noncommunicable somatic diseases, 15% to accidents (about half of them road traffic accidents), 15% to psychiatric disorders, alcoholism and drug abuse, 10% to congenital anomalies including hereditary defects, and 7% to mental retardation.

The volume of disability as measured by its prevalence shows a definite age gradient in that only about 1–2% of young people are physically disabled, but the figure increases to over 30% among those aged 75 years and more. The proportion of people having difficulties in coping with their day-to-day lives increases from about 50% among those aged 60–64 years to over 70% among those aged 85 years and more. Thus, the aging of the population in itself affects the number of potentially disabled people.

The causes of disease and disability also vary with age. Genetic factors that intervene before birth include chromosome aberrations, simple gene defects and more complex and variable genetic predispositions to disease or to congenital anomalies due to known and unknown teratogens. Birth traumas and certain perinatal conditions are also of importance. During childhood and young adulthood, the main contributors to disability are traffic, home and occupational accidents. In adulthood and old age, while traumatism still plays an important role, new disabling conditions start to prevail: mental disorders, cardiovascular diseases, chronic respiratory diseases, diseases of the musculoskeletal system and connective tissues, and certain types of cancer.

Great progress has been achieved in infectious disease control. However, many of these diseases, although fully amenable to effective control, still occur throughout the Region. Immunization and surveillance programmes are far from complete in many countries. Because of the contamination of food and drinking-water, diarrhoeal diseases still cause high mortality and morbidity in the developing parts of the Region, while salmonellosis is on the increase in the industrial countries. Acute respiratory infections are a significant burden on primary health care services, a major factor in child mortality and morbidity, and the most important medical cause of absenteeism. The continuing prevalence of hepatitis A and the upsurge of hepatitis B, as well as some other viral and hospital infections and venereal diseases, pose problems. Although the prevalence of tuberculosis has been drastically reduced in most Member States, further action is still needed in a number of countries.

Dental caries and periodontal disorders continue to show a high prevalence. Although the average number of decayed, missing and filled teeth per person (DMFT index) at 12 years of age has declined drastically in several countries following fluoridation campaigns, it is still in the range of two to well above seven in the European Region. The prevalence and severity of periodontal diseases are high in almost all countries of the Region.

The social impact of diseases and disability depends on the degree of dependency resulting from them and their duration. Severe handicaps originating early in life are of particular importance, but later disablement also hampers the welfare of the individual and family unless compensated by support from society. The reverse is equally true: morbidity and disability are associated with worsening socioeconomic conditions. Episodes of illness, the length of illness and the occurrence of disability almost always affect the socioeconomically disadvantaged groups more frequently.

Suggested solutions

The reduction of disease and disability will require comprehensive programmes in all the areas concerned, and many of the targets in this book are of relevance for this purpose.

The highest priority should be given to primary prevention of the most common disabling conditions, such as cardiovascular diseases (target 9), accidents (target 11), violence (target 17), selected cancers (target 10) and occupational diseases (target 25). Since these conditions are covered by specific detailed targets, only some of the other major groups will be mentioned here.

With regard to genetic conditions and congenital anomalies, the rational approach is to increase public awareness, to provide diagnosis and advice, and to make suitable technical interventions available. However, extremely important and difficult ethical issues are involved, and technical means should therefore be used only on the basis of the individuals concerned being offered an extensive, informed choice. Possible actions range from genetic counselling, early treatment or a protective alteration in lifestyle to the selective abortion of a severely affected foetus.

Vigorous research is still needed to find effective ways of preventing rheumatic conditions. As long as such prevention is not possible, the main emphasis in such conditions should be put on the provision of appropriate pain-relieving treatment and better rehabilitation services if there is no breakthrough in the treatment methods.

As yet, much too little is known about the causes of mental illness. However, although intensified research is still needed on biological factors (genetics, brain biochemistry) and external factors (whether related to the social or to the physical environment) enough knowledge already exists to warrant attempts to improve environmental conditions. Attainment of the targets specified in Chapter 4 on lifestyles, especially those relating to social interaction, would certainly lead to considerable improvement. Much can also be achieved through improved primary health care, and particularly by training personnel to tackle mental health problems in the community, making full use of the potential of the community itself, and restoring self-respect in the patients.

Reducing the incidence and prevalence of infectious diseases calls for improvements in many areas mentioned elsewhere in this book and covered by specific targets. Some are of a general nature, such as safe water supply (target 20), sanitation and housing (target 24) or nutrition (target 16). Others can be eliminated by immunization and comprehensive eradication programmes (target 5). Improved epidemiological surveillance and control systems are needed for the rapid detection of new cases of certain infectious and parasitic diseases and determination of the type of environmental "vehicle" involved. Specific measures are required to protect highly exposed groups and neutralize potential sources of pollution. Finally, the role of individual behaviour in the prevention of communicable diseases should be taken into account in health education programmes.

Dental caries and periodontal diseases are primarily lifestyle-dependent, since the risks are linked to excessive intake of fermentable carbohydrates, lack of appropriate oral hygiene and insufficient dietary intake of fluorides. The reinforcement and expansion of the population coverage of oral disease prevention

programmes, with emphasis on the need to reduce the risk factors and to ensure a regular intake of the necessary amount of fluorides, are of paramount importance. Fluoridation of drinking-water is still considered to be the safest, cheapest and most effective caries prevention measure, but where this method is not feasible or acceptable, other techniques have also been shown to be very effective. In this way, it could well be possible by the year 2000 to achieve a situation where in no country or group within a country do 12-year-old children have more than four decayed, missing or filled teeth.

Preventive action by other sectors will play a crucial role in lowering the present level of occurrence of diseases and disabilities. However, the contribution that the health system itself can make will be no less important. Reduction of risks, early detection whenever appropriate technologies exist, effective treatment and rehabilitation will substantially reduce the burden of ill health and disability. Ensuring that all patients have easy access to good quality health care is therefore an essential requirement in reaching this target.

Target 5 ☞
Elimination of specific diseases

By the year 2000, there should be no indigenous measles, poliomyelitis, neonatal tetanus, congenital rubella, diphtheria, congenital syphilis or indigenous malaria in the Region.

This target could be achieved through a well organized primary health care system ensuring effective epidemiological surveillance, vaccination coverage, malaria control measures, education on the risks of syphilis, screening and, when necessary, treatment of expectant mothers.

Problem statement

Although reporting of these diseases is not complete, the available data give some idea of the problem they pose in the Region. In particular, in the period 1976–1980, more than 100 cases of measles

per 100 000 population, with approximately 800 deaths, as well as over 900 cases of diphtheria and 700 cases of poliomyelitis were reported annually. In the last five years, more than 4500 deaths from tetanus were reported, including about 15% in the first year of life. Finally, malaria notifications decreased from over 115 000 in 1977 to about 35 000 in 1980, but the number rose again in 1982 to over 50 000.

Suggested solutions

Today, satisfactory technology is available to establish systematic and effective surveillance and vaccination programmes based on primary health care that would make it possible to eliminate measles, poliomyelitis, neonatal tetanus, diphtheria and congenital rubella. Such action should include vaccinations against those diseases under the Expanded Programme on Immunization, for which the quality of the currently available vaccines is not yet sufficiently good for complete eradication (tuberculosis, pertussis). Furthermore, the action should be seen as part of a broader vaccination programme also dealing with issues such as the use of hepatitis B vaccine for selected groups. An important requirement in this respect will be to undertake vigorous research (using new laboratory techniques involving recombinant DNA, etc.) in order to develop effective vaccines that are also better, safer, cheaper and easier to handle.

Indigenous malaria could be eliminated through a vigorous programme comprising a wide range of control methods applied within a well organized primary health care system. This programme should combine sound epidemiological surveillance with environmental measures to reduce larval breeding sites, insecticide spraying against adult mosquitos, and the use of drugs to prevent and cure infections. The current intensive search for a malaria vaccine may also produce new and simpler approaches to the problem. Congenital syphilis could be eliminated through systematic education, and early diagnosis and treatment of expectant mothers, carried out within a well organized primary health care system.

Adding years to life

This section deals first with a general issue, life expectancy, which is a composite expression of all the other mortalities. It then sets out targets for the reduction of six major forms of mortality: one age-specific (infant mortality) and five etiological (maternal mortality and deaths from diseases of the cardiovascular system, cancer, accidents and suicides).

Target 6
Life expectancy at birth

By the year 2000, life expectancy at birth in the Region should be at least 75 years.

This target could be achieved if, by the year 2000, no country or group within a country had a life expectancy of less than 65years; if countries that reached this level in 1980 had a life expectancy of more than 75 years; and if all countries had reduced by at least 25% the differences in life expectancy among geographical areas and socioeconomic groups and between the sexes.

Problem statement

Compared to the global figures for life expectancy at birth, the levels in the European Region are high. The mean was over 70 years around 1980, with figures for men and women of 67 and 74 years respectively. As shown on p. 24, however, there are important inequalities among countries of the Region, varying from 73 to 55 years in men and from 80 to 57 in women.

From 1960 to 1980, the expectation of life at birth rose by three years in the European Region. There were great variations among countries in regard to life expectancy at different ages and according to sex. In women, an increase of varying magnitude occurred in all the countries and at all ages. However, in men, there was a decrease at age 15 in eight countries, and at ages 45 and 65 in ten. This was due to the higher mortality in men from accidents and lifestyle-related causes.

According to United Nations demographic projections, the present trend in life expectancy at birth will continue in the Region,

reaching 72 years in 1995–2000 and 75 in 2020–2025. Thus, target 6 clearly sets out to improve the situation beyond present trends.

Suggested solutions

Life expectancy should be regarded as an indirect expression of the mortality of a given population. Therefore, the extension of life expectancy as specified by the target represents a broad measurement of reduction of mortality. In this perspective, all the targets in the book should be viewed as potential contributors to the achievement of the target on life expectancy. Accordingly, all the proposed solutions, from measures to provide the prerequisites for health such as social equity, food and sanitation, to action to promote healthy lifestyles and environment, adequate care, support and research will play their part in extending life expectancy.

Nevertheless, special attention will be given to measures to reduce the above-mentioned six major forms of mortality, as described in targets 8–12.

The greatest possible improvement with regard to lifestyle-related mortality would be achieved through the reduction of deaths from cardiovascular diseases, diseases of the respiratory system, cancer and accidents, and this would be of particular importance for extension of the life expectancy for men. The sex differences are greatest in respect of this group of causes of death and genetic factors can at best explain only part of the phenomenon. Even the elimination of a single behavioural factor, such as smoking, would result in a marked increase in life expectancy.

Target 7
Infant mortality

By the year 2000, infant mortality in the Region should be less than 20 per 1000 live births.

This target could be achieved if, by the year 2000, no country or group within a country had an infant mortality rate of more than 40 per 1000 live births; if countries with a rate below this level in 1980 had a rate below 15 per 1000; and if all countries attempted to reduce significantly the differences among geographical areas and socioeconomic groups.

Problem statement

In the European Region around 1980, over 500 000 infants died during the first year of life, giving an overall regional rate of just under 40 deaths per 1000 live births, with the rates for individual countries ranging from over 130 to less than 7 per 1000.

By comparison with the situation in 1960, infant mortality in the Region as a whole declined by 20%. However, the level of reduction of infant deaths varied according to countries, and the difference between the highest and lowest rate increased from 12-fold to 19-fold.

In all countries, the decline in perinatal mortality was almost parallel to the downward trend of the overall infant mortality from 1950–1954 to 1975–1979. Deaths due to diseases of the respiratory and digestive systems have shown a marked decline, but there has not been much change in the level of mortality from congenital anomalies. Mortality from infectious and parasitic diseases, after an initial fall in the 1960s in a number of countries, has shown an increasing trend. Although precise information on cause-specific infant mortality for developing countries is lacking, a recent survey in one of them showed that over 80% of deaths in infants 1–11 months old were due to infectious or respiratory diseases and that within this total over 50% of the deaths were due to diarrhoeal diseases alone. Deaths from external causes have been declining in some countries, while tending to increase in a number of others.

While in some countries post-neonatal mortality still represents a large component of infant mortality, in most countries of the Region attention has focused on perinatal mortality. It is difficult to make a proper comparison of the effectiveness of individual country programmes in this field. However, one programme initiated in 1970 with a target of 18 perinatal deaths per 1000 by 1980 brought the rate down to 13 per 1000, while according to previous trends, without intervention, it was expected to reach 23 per 1000.

Suggested solutions

Priority should be given to preventing infant deaths due to respiratory, diarrhoeal and other infectious and parasitic diseases. For this purpose, the provision of safe drinking-water and safe food,

the use of oral rehydration salt and the delivery of other appropriate medical care at the primary level are essential. Pregnant women should be encouraged to plan to breastfeed. Family planning advice and opportunities should be made widely available to help prevent undesired pregnancies, in particular among the very young. Better education of parents and children and measures to ensure a safer environment would reduce infant deaths, such as those due to accidents. Finally, more emphasis should be put on the prevention of low birthweight by improved nutrition and the elimination of smoking and the use of alcohol during pregnancy.

In all these measures, particular attention should be paid to socially disadvantaged groups and immigrant communities.

Programmes should be developed to ensure proper preparation for parenthood and adequate prenatal, obstetric and follow-up preventive care. They should also provide for support services and activities to give equal social, cultural and economic opportunities. Systematic monitoring and evaluation showing variations in infant mortality among countries as well as among population groups, classified by social class and other characteristics such as occupation, income, education or geographical location, would be necessary to indicate the degree of success and failure of the programmes.

Target 8
Maternal mortality

By the year 2000, maternal mortality in the Region should be less than 15 per 100 000 live births.

This target could be achieved if, by the year 2000, no country or group within a country had a maternal mortality rate of more than 25 per 100 000 live births; if countries with a rate already below 25 in 1980 had a rate below 10; and if all countries had reduced significant differences among geographical areas and socioeconomic groups.

Problem statement

Around 1980, there were 1500 maternal deaths per year in 28 countries of the Region for which data are available, giving a rate of 22 per 100 000 live births for the Region as a whole. However, 25 countries had lower rates, and 6 have already brought their rate to below 10.

During the last decade there has been a decline in maternal mortality rates. However, the magnitude of the decline varied among the countries and there were marked fluctuations of the rates from one year to another. In some countries, the overall rate decreased by more than 90%, and the same level of reduction was observed in deaths due to toxaemia in pregnancy, haemorrhage and abortion. While further improvement in countries with low levels would be difficult, in others much remains to be done.

Even at rather low levels of maternal mortality, large numbers of maternal deaths are reported to be preventable and many of the factors involved have been identified. Confidential inquiries into maternal deaths conducted in one country since 1952 proved to be a useful tool in analysing the causes of such deaths and providing guidance on prevention and maternal care. The last (1982) report, covering the period 1976–1978, showed that the considerable improvements recorded in 1973–1975 compared with 1970–1972 had been maintained. However, the percentage of potentially preventable deaths was more or less unchanged: in more than a half of true obstetric deaths, one or more avoidable factors were involved. A study in another country also showed that about half of the maternal deaths could probably have been avoided.

Suggested solutions

In spite of the impressive reduction in maternal mortality during the last three decades, a large proportion is still due to factors that are considered avoidable. The causes of maternal mortality do, of course, vary from country to country, and therefore special inquiries may provide crucial information on the circumstances under which mothers die and on the causes that can be eliminated by appropriate preventive programmes. Direct or indirect contributory factors may intervene during pregnancy, delivery or the puerperium. Where such factors are avoidable, the responsibility for their occurrence is divided between the patient and the health service. Thus, the preventive programme should start with good family planning to avoid unwanted pregnancies, continue with preparation for motherhood and be completed by appropriate care during the antenatal period, delivery and the puerperium.

Target 9
Diseases of the circulation

By the year 2000, mortality in the Region from diseases of the circulatory system in people under 65 should be reduced by at least 15%.

This target could be achieved by a combination of preventive and treatment methods that would reverse the trend in countries where ischaemic heart disease mortality is increasing or stable, and accelerate it in countries where the mortality is decreasing, thereby contributing to the current decline in cerebrovascular mortality in all countries.

Problem statement

In Europe, diseases of the circulatory system are the main killers of the population as well as being an important cause of disability. They account for about half of all deaths in the Region, and a far higher proportion in the age group over 65. Cardiovascular mortality shows a very wide variation among countries. In the age group 35–64, the range of standardized rates extends from 572 to 207 per 100 000 in men and from 246 to 68 in women.

Ischaemic heart disease is the single largest cause of cardiovascular mortality, being responsible for 30–60% of the deaths. Around 1980, the age-adjusted rates at 35–64 years ranged from 455 to 96 per 100 000 in men and from 123 to 18 in women. According to the WHO international collaborative study on the subject, which was coordinated by the Regional Office and conducted in 19 communities, the annual attack rate of acute myocardial infarction for all communities in the age group 20–64 was 3.4 per 1000 in men and 0.9 per 1000 in women. The variation in the attack rates among the communities studied corresponded closely to the variation in mortality from ischaemic heart disease in the countries.

During the last two decades in most of the countries, age-adjusted mortality rates from ischaemic heart disease at 35–64 years increased in men and decreased in women. However, current trends in the age/sex-specific rates point to a recent decline in mortality among younger men in a number of countries.

Around 1980, age-adjusted mortality from cerebrovascular diseases ranged from 132 to 20 in men and from 81 to 14 in women at 35–64 years. In a morbidity study conducted under WHO sponsorship in 17 communities, including 7 in the European Region, it was found that in this Region the age-adjusted annual rates for stroke per 1000 persons of all ages ranged from 8.3 to 3.9 in men and from 6.5 to 2.2 in women. In the last two decades, mortality from cerebrovascular disease decreased in most countries of the Region. However, the decline was more pronounced in women than in men.

Suggested solutions

Numerous studies conducted in the last 30 years have substantially increased knowledge of the possible causes of ischaemic heart and cerebrovascular diseases and of means for their prevention. Several intervention studies, including some community-based trials, have confirmed the feasibility of preventing ischaemic heart disease. A WHO Expert Committee recently summarized the available scientific evidence and developed guidelines for preventive strategies. In particular, it was noted that prevention should aim at altering the characteristics of lifestyle and the environment that underlie the occurrence of the diseases, preventing risks, identifying and helping individuals in need of special protection, and avoiding the recurrence and progression of the diseases.

The extent of the risk of the above diseases is significantly influenced by a number of personal and population characteristics acting separately or in combination. In turn, these characteristics are largely determined by sociocultural factors and are therefore modifiable. They include elevated blood pressure and blood cholesterol, associated eating and activity patterns, and smoking. Even a small lowering of the average blood pressure of the population could bring about a large reduction in disease.

The role of habitual diet and blood cholesterol-lipoprotein levels is well established and is judged to be causal. In high-incidence countries, a lowering of the population distribution of blood cholesterol levels is recommended through progressive changes in eating patterns.

Smoking, especially of cigarettes, contributes significantly to the occurrence of coronary heart disease, and high alcohol intake is associated with an increased risk of the disease as well as high blood pressure.

Lack of physical activity is associated with higher levels of the major risk factors, primarily because of the increased prevalence of obesity; regular exercise may help to reduce high blood pressure and blood cholesterol.

The underlying atherosclerotic process begins in youth, along with the appearance of its major risk characteristics of elevated blood pressure and blood cholesterol and associated risk behaviour, including smoking. Preventive measures should be introduced in childhood in order to prevent the risks from arising.

The achievement of the target on cardiovascular disease calls for countrywide community-based programmes aimed at promoting healthy lifestyles and supported by appropriate social policy; it also calls for a preventive orientation of health services, especially at the primary health care level.

However, while preventive measures will reduce the occurrence of the disease, complementary programmes are required to prevent deaths as well as the progression and recurrence of acute myocardial infarction and stroke, and to rehabilitate victims. But the demand that this will make on the health services may be too great for the developing countries of the Region before the year 2000, and they may well have to adopt a somewhat later deadline.

Target 10
Cancer

By the year 2000, mortality in the Region from cancer in people under 65 should be reduced by at least 15%.

This target could be achieved if tobacco-related cancers were reduced as a result of a major decrease in smoking and cervical cancer following the establishment of screening programmes; and if current methods in early diagnosis, treatment and rehabilitation were applied in an appropriate way to all cancer patients.

Problem statement

Malignant neoplasms form the second group of major causes of mortality, being responsible for some 30% of all deaths in men and about 40% in women in the age group 35–64. In this group, the age-adjusted mortality rates per 100 000 persons in the last year for which statistics are available ranged from 308 to 113 in men and from 229 to 114 in women. During the last two decades, overall mortality from malignant neoplasms in men aged 35–64 increased in most countries. In some, however, a moderate decline was recorded. In women of the same age group, the changes were much smaller and half the countries experienced a decline.

Cancer of the trachea, bronchus and lung is the most frequent form of the disease among men, accounting for 33% of cancer deaths in the age group 35–64. Around 1980, age-adjusted mortality rates for lung cancer ranged from 114 to 16 per 100 000 men of this age. The corresponding range in women was 41 to 6.

Lung cancer is the largest single contributor to total cancer, and most of the cases are due to smoking, especially of cigarettes; smoking is also linked to the development of some other cancers. Already at least a quarter of all cancer deaths in the Region are due to tobacco, and this proportion is growing, chiefly as a result of the delayed effects on health of large increases in smoking during previous decades.

A viral origin has been postulated for several types of cancer, but firm evidence is lacking.

The relative changes in lung cancer mortality over the last two decades showed a marked variation among countries. In most, the age-adjusted rates increased in adults of both sexes; however, a decrease was noted in a few.

The other most important types of cancer are those of the stomach and intestines. There have been widespread rapid decreases in mortality from cancer of the stomach and moderate increases in mortality from cancer of the intestines, but the underlying reasons for them are not well understood.

In women aged 35–64, breast cancer is the leading form of the disease, accounting for 24% of all cancer deaths. The trend shows an overall increase as well as a shift towards younger age groups,

highlighting the need for further intensive research with regard to prevention, early detection and treatment. Around 1980, age-adjusted rates of mortality from malignant neoplasm of the cervix ranged from 21 to 2 per 100 000 women aged 35–64 and, although they are decreasing in most of the countries, by far the greatest decline was noted in those with intensive screening programmes.

Suggested solutions

The reduction in smoking, as envisaged in target 16, is the most important contributor to the prevention of cancer morbidity and mortality. Although there are indications that the modification of nutritional, reproductive or infective factors may substantially alter cancer risks, there is as yet no firm evidence, and multidisciplinary research on such risk factors should be encouraged. Finally, small but worthwhile gains may be achieved by limiting certain occupational exposures, especially to asbestos or to air pollution from smoke and other factors; by limiting the iatrogenic use of X-rays and certain drugs; and by decreasing individual exposures to sunlight. Collectively, however, these factors are of less importance than tobacco.

There is evidence that mortality from cancer of the cervix, which accounts for about 2% of all cancer deaths in the European Region, could probably be approximately halved by regular screening. Women should, therefore, be encouraged to participate in well designed cervical screening programmes based on a primary health care approach.

Intensive efforts should be made to develop appropriate methods for early detection of other types of cancer, which could be applied at the primary care level; at present, breast cancer screening methods are under careful scrutiny.

Finally, it is hoped that the progress made in the last decades in the treatment of malignant tumours will be enhanced through research.

Meanwhile, it is very important that the effective diagnostic and treatment technologies now known should be rapidly available to all in need — a situation that at present does not obtain in most countries. It must also be recognized that it will be extremely

difficult for the developing countries of the Region to reach the proposed levels of screening, diagnosis and treatment by the year 2000, and they may well have to settle for a somewhat later deadline.

Target 11 ☞
Accidents

By the year 2000, deaths from accidents in the Region should be reduced by at least 25% through an intensified effort to reduce traffic, home and occupational accidents.

This target could be achieved if, by the year 2000, no country had a mortality rate from road traffic accidents of more than 20 per 100 000; if countries below that level reduced it to less than 15; if all countries reduced the differences between the sexes, and age and socioeconomic groups; furthermore, if the occupational accident mortality in the Region were lowered by at least 50%; and if the mortality from home accidents were significantly reduced.

Problem statement

Accidents constitute the third leading cause of death in the Region, with a mortality rate of about 50 per 100 000. About 50% of accidental deaths occur in the age group 15–64, and they account for 50% of all deaths in men aged 15–24.

The number of accidental deaths varies considerably among countries of the Region. Among those for which data are available, the death rates range from 30 to 65 per 100 000 people. There is also a considerable variation within countries. In fact, accidents are one of the causes of death for which the difference between socioeconomic groups is most significant.

In developed countries, the number of accidental deaths and injuries has declined over recent years. However, the relative importance of accidents as a cause of death and injury is growing, especially among children, young people and the elderly. In developing countries, the numbers of accidents, accidental deaths and injuries are rising as a consequence of increasing industrialization and greater use of motor vehicles.

Motor vehicle accidents account for about 40% of accidental deaths. Death rates from such accidents in Member States range from 9 to 30 per 100 000 population, although 20 countries have registered an overall reduction of 15% in traffic fatalities since 1974. For every death in a road accident, there are about 15 cases of severe injury and 30 of slight injury. Motor vehicle accidents are thus an important cause of hospitalization and a major factor in permanent disability. They entail the use of complex and costly technology for treatment as well as medical/social services for the care of the disabled.

Accidental poisoning, falls and fires produce a combined death rate of close to 25 per 100 000 and account for about 45% of all accidental deaths. Although the available information does not allow precise identification of the places where accidents occur, those in the home appear to be an important cause of death in the Region.

Accidents at work are still an important cause of disability and death. The available data indicate that in highly industrialized countries the annual rate of reported occupational accidents is about 6 per 100 working people. Accidents on the way to and from work are about one tenth as frequent as those that occur at work. The reported death rate varies from 2 to over 10 per 100 000. As many as 10% of these accidents result in permanent disability, and they are six times more frequent in men than in women.

During the past 10 years, some countries have achieved a sizeable reduction of fatal accidents at work. However, the general trend in Europe has been towards only a limited or no reduction of accident frequency.

Suggested solutions

In the prevention of accidents, multidisciplinary and intersectoral policies and programmes should be developed with a view to determining and then eliminating or reducing hazards, especially in the home, on the roads and at work, and to designing safer goods. In view of the large and increasing trade in motor vehicles, encouragement should be given to the adoption of internationally agreed vehicle design changes that will improve health and safety

and give better protection to occupants. More effective traffic control and safety education for road users, better roads, improvements in the design of machinery, child-proof containers for medicines, building codes, fire codes, protective devices and other forms of occupational hazards control are some of the safety measures that would help to reduce accidents. Legislation and economic incentives should be established to encourage the design and marketing of safer products. Consumer products should be systematically tested from the point of view of health and safety, and the results made widely available to consumers.

The health sector should play an important role in increasing an awareness of risks among politicians, planners, professionals and consumers. Systems for epidemiological surveillance, contingency planning and response to accidents, including man-made and natural disasters, should be developed in all countries, with suitable machinery to deal with major emergencies that might affect more than one Member State.

Consideration should be given to improving the system of information on accidents so as to state the place of occurrence in each case. This would allow better identification of the causes of domestic accidents as well as of those people who are most at risk, and thus give important feedback for the development of intervention programmes.

Target 12 ☞
Suicide

By the year 2000, the current rising trends in suicides and attempted suicides in the Region should be reversed.

This target could be achieved if improvements were made with regard to societal factors that put a strain on the individual, such as unemployment and social isolation; if the individual's ability to cope with life events were strengthened by education and social support; and if the health and social service personnel were better trained to deal with people at high risk.

Problem statement

The reported rates for suicide vary greatly among the countries of the Region for which data are available; they range from 3 to 45 deaths per 100 000 and are below 10 in eight countries and above 20 in seven (two cases reporting above 26). In countries with low suicide rates, religion and social beliefs may be the factors involved; on the other hand, they may also be responsible for considerable under-reporting of suicide. The trend in the last 20 years has been for suicide to increase in most European countries, particularly in the younger age group of 15–34 and in women. Suicide rates are higher in the older age groups and in men.

A large proportion of suicides are associated with a recognizable mental disorder — probably a treatable depressive illness in at least half of the cases. Alcoholism is the next most common condition predisposing people to suicide.

Another matter of great concern is that of *attempted* suicides. The rates have doubled and in some countries even tripled over the past 20 years. The average rate is now estimated at around 200 per 100 000 in men and 350 per 100 000 in women. Almost two thirds of the cases occur before the age of 30. Although the majority of suicide attempts are not intended to be lethal, 10–20% of people who have made a previous unsuccessful attempt commit suicide at a later stage in their lives.

The people most likely to attempt to commit suicide are youngsters from families that are disrupted or have a history of suicide, drug and alcohol addicts, failures in school, the unemployed and people suffering from depression. The fact that both the suicide and suicide attempt rates are increasing most among the younger age groups can be attributed to the greater vulnerability of young people to the social conditions that accompany economic and cultural instability.

Suggested solutions

In the light of the facts presented above, it is evident that there is considerable scope for prevention in at least three main areas.

First, making improvements with regard to the underlying societal factors that seem to put a strain on the individual, such as unemployment, the social isolation of elderly people living on their

own, and failure at school, would be an important means of intervention. Although our present knowledge of the intricate web of contributory factors involved is insufficient and greater research in this field is necessary, enough is already known to warrant positive action as from now.

Second, ways of strengthening the individual's general ability to cope with the events of life must be a key concern. The targets related to developing that ability (target 15) and providing a better network of social support (target 14) are particularly important for this purpose.

Finally, since most people who commit or attempt suicide are seen shortly before by general practitioners or other health professionals, there is an opportunity for preventive action. There is evidence, however, that owing to a lack of training in diagnostic and treatment methods and of necessary skills, health professionals are often not adequately equipped to deal with suicidal patients. The same applies to the staff of emergency and intensive care wards of general hospitals to which attempted suicide cases are referred. Finally, public knowledge of the signs and circumstances of suicide risk is still relatively sparse.

Both health personnel and the community should be involved in the detection, assessment and care of those at risk. The training of health professionals should include information on the social and clinical characteristics and management of the individuals most at risk, and on effective approaches to aftercare and supervision in the community. There is also a need for the education of the public, and especially young people through schools, on the causes and means of preventing suicidal behaviour and the mismanagement of life events that often leads to it. Since rates of suicide and attempted suicide are important indicators of the health status of a community, steps should be taken to improve the registration of cases.

4

Lifestyles conducive to health

Lifestyles are intimately bound up with the values, priorities and practical opportunities or constraints of specific cultural, social and economic situations. A person's particular way of life is shaped by patterns of interpersonal interaction and social learning that interrelate with and depend upon the social environment. Thus, lifestyles, shaped by experience and environmental factors, are not simply individual decisions to avoid or accept certain health risks. There are limits to the choices open to individuals — limits imposed by their physical, social and cultural environment and by their financial means.

A great deal of knowledge is needed to understand the relationships between health and the components of particular lifestyles. Many lifestyles enhance health, develop physical and mental well-being, and protect the individual from the effects of stress. Other lifestyles include behaviour that may damage health. Harmful practices, such as smoking or excessive alcohol consumption, are sometimes ascribed to personal stress, but they often become routine habits used by a majority of people to cope with life and ease social contact. They can also symbolize certain stages in human development, such as growing up. Cultural patterns of social interaction, symbolic behaviour and tension reduction are learned in childhood and reinforced throughout life. Thus, they reflect ways that members of a given society or group organize their daily lives.

Lifestyle practices are increasingly influenced by public and corporate policies that control the production of goods and promote products that may damage health. Opportunities and incentives to select healthy lifestyles thus depend heavily upon public policies that shape the economic and social conditions under which people live. To be effective, therefore, health programmes concerned with lifestyles must deal with structural influences on behaviour as well as its specific individual components. There are ethical issues to be considered when lifestyle policies and programmes are being devised. This means that a delicate balance must be achieved between respect for individual rights of free choice and the duty of society to promote the health of the population.

One of the major factors shaping individual lifestyles is inequality between countries and within countries. Socially and economically privileged people have a wider range of options in seeking a healthy lifestyle, while the disadvantaged are still grappling with the basic problems of existence. Ill health and poverty are closely related to each other and to lifestyles. Programmes for enhancing health through changes in lifestyle must not only widen personal choice, but also be supported by a resolve on the part of society to improve the status and standard of living of the poor. Other factors, such as rapid urban and industrial development, can also negatively influence health by uprooting large numbers of people and destroying cultural patterns and social ties; the negative impact of unemployment on health has already been mentioned.

People may not have the necessary knowledge to make an informed choice of lifestyle or they may be inhibited by traditional attitudes. However, even when knowledge and motivation are present, they are not always sufficient to induce change once a type of behaviour has become part and parcel of daily life. Every opportunity should therefore be taken to provide incentives that make health-enhancing behaviour easier to choose and maintain, in the awareness that people's behaviour is largely determined by the necessities of everyday life and by what they perceive as pleasant and rewarding.

A strategy to promote healthy lifestyles would thus include:

- making the physical, social, cultural and economic environment conducive to healthy lifestyles;
- strengthening the individual's basic capacity to make choices and to cope with stressful situations without recourse to types of behaviour that may damage health;
- improving individual knowledge on lifestyles and health issues;
- strengthening the social support system (families, self-help groups, etc.) that assists individuals and vulnerable groups to cope;
- drawing up specially designed programmes to deal with certain aspects of behaviour that affect health.

Many additional targets could have been included in this chapter, i.e. ones focusing on specific practices such as smoking or alcohol abuse. Since, however, it is important to emphasize both the variety of factors that shape and maintain lifestyles and the multiple causes of disease, the targets are concerned with the essential components of a strategy to promote healthy lifestyles rather than with individual habits and suggest supportive policies to make healthy lifestyles more readily attainable for all. To this end, the following targets are grouped in three major categories, those aiming at providing general opportunities and strengthening capacities for living life in a healthy way, those promoting healthy behaviour, and those preventing health-damaging behaviour.

Better opportunities and improved capacities

Individuals and groups have to function within a particular physical, social, cultural and economic environment. The characteristics of that environment and the policies that determine its development are therefore basic factors affecting lifestyles and health.

Target 13 ⇨
Healthy public policy

By 1990, national policies in all Member States should ensure that legislative, administrative and economic mechanisms provide broad intersectoral support and resources for the promotion of healthy lifestyles and ensure effective participation of the people at all levels of such policy-making.

The attainment of this target could be significantly supported by strategic health planning at cabinet level, to cover broad intersectoral issues that affect lifestyle and health, the periodic assessment of existing policies in their relationship to health, and the establishment of effective machinery for public involvement in policy planning and development.

Problem statement

The ways in which public policies influence lifestyle choices are manifold, and only a few examples will be given here.

In many countries, some industries are subsidized even though their products are harmful to health and harmful products are freely advertised. National economies may finance health promotion programmes and at the same time depend heavily on revenues from taxing unhealthy goods. Health-damaging products are exported to and promoted in developing countries, compounding their already serious health problems. Gross inequality in income distribution may create poverty groups with such limited financial means that choosing a healthy lifestyle is precluded. In some countries over the past 10–20 years, alcohol has become steadily cheaper in relation to the general cost of living, thereby stimulating greater consumption. Products that will improve health, even absolutely necessary ones such as foods needed by diabetics, are allowed to increase in price sometimes to luxury levels.

If communities, industries and governments are to become aware of the influence of environmental conditions on the adoption and maintenance of lifestyles and take effective steps to ensure broad environmental conditions that are conducive to healthy

lifestyles, the general public must be involved in policy and programme development, taking into account the prevailing conditions in each Member State. People will be both less able and less inclined to choose health-promoting types of behaviour if they have no influence on decisions by the private and public sectors that affect their own lives.

As declared in Alma-Ata in 1978, the key to health for all is primary health care with active public participation. In most countries of the Region, however, there is still a gross imbalance between the influence on health policy of powerful interest groups (such as the tobacco or food industry and professional groups) and the public at large. Many Member States have not yet established ways to ensure public involvement in policy development.

Suggested solutions

In every country, a scrutiny of policies and programmes that may affect health should be made an obligatory step in the public planning process and a systematic review of major areas of existing policy should be carried out in order to:

- determine their influence on health choices, e.g. the effects of tax policies on the consumption of harmful substances;
- recast existing policies so as to reduce health inequalities;
- eliminate subsidies to industries that manufacture harmful products and subsidize those that are good for health;
- ensure consumer protection;
- avoid the dissemination of dangerous products and practices to other countries;
- ensure a coordinated effort in health legislation, especially by restricting the advertising of harmful products and making easily understood and comprehensive labelling practices obligatory;
- improve urban and rural planning in order to promote health.

Already in several Member States, national intersectoral committees or councils have been established. In others, regional and local plans for health promotion are being implemented that aim at broad intersectoral cooperation. Two types of action are of particular relevance at the local level:

- the intensification of cultural and educational activities so that people can be more easily involved in worthwhile leisure pursuits;

- the provision of opportunities for the easier and safer use of healthy means of locomotion, e.g. walking, cycling.

The general public should be systematically informed regarding health-related problems and developments, and care should be taken to provide such information in a way that is easy to grasp, will arouse interest and will enhance commitment.

The participation of the public will vary according to national and local political, administrative and cultural patterns. However, representative community participation should be the rule in all official bodies (local, regional and national health councils, socio-economic planning councils, etc.) that deal with developmental issues that may have implications for lifestyles and health. Care should be taken to include representatives both from vulnerable groups and from groups that have shown particular interest and initiative in improving the health of communities.

Target 14 ☞
Social support systems

By 1990, all Member States should have specific programmes which enhance the major roles of the family and other social groups in developing and supporting healthy lifestyles.

The attainment of this target could be significantly supported by establishing close intersectoral links between health and social welfare programmes, primarily at the local level, and by securing funds for projects that enhance joint community action.

The skills that enable people to control and direct their lives, and thus to live in a healthy way, include the capacity to formulate problems, find solutions, make decisions and then act on those decisions, resolve conflicts, communicate effectively, and question and intervene actively on their own behalf when necessary. These skills are most easily learned in childhood and youth. It is more difficult to change to a healthy lifestyle later in life once unhealthy habits have become ingrained.

Routine health habits of daily living as well as practices acquired to cope with special problems and strains are part of a lifelong learning process and are not easily changed. Once established, certain patterns of behaviour may be used as a way of coping with the chronic stresses of everyday life. Some people smoke more when under stress; others automatically take a drink after work. Different forms of behaviour with an impact on health may have similar origins, the pattern chosen being related to the style in which a specific group copes. In some societies, it is more or less acceptable for a man to take a drink "to forget his problems". Women are more often prescribed tranquillizers to try to help them cope with their lives.

The early socialization and learning that take place in the family are major determinants of decision-making and coping skills. The patterns of problem-solving and conflict-resolution in which small children participate as their personalities are developing will influence both the health practices they adopt and their readiness and ability to modify or change their behaviour. Recent research has shown, for example, that a sense of personal worth and self-esteem growing out of acceptance and encouragement during development is associated with more effective patterns of coping and more frequent preventive health practices.

Another major aspect of the social environment important for the preservation of health is satisfying social support and social contact. The lack of these has been found to be connected with higher rates of tuberculosis incidence, hypertension, heart disease, multiple accidents, complications in pregnancy, various categories of mental disorder and reported episodes of illness of all

types. Degrees of social contact, integration and/or support have been found to have a bearing on death from suicide and stroke, and in a few studies on mortality rates from all causes.

As can be seen, it is not only the learning but also the support and caring functions of families that protect health and promote health-enhancing behaviour. At the same time, the structure and function of family units are changing rapidly. The composition of households in the Region ranges from multiple generations of relatives living together to individuals living alone. The number of single parents, usually young women, living alone with small children, has increased rapidly. So has the number of single elderly women. New forms of family unit are developing in the Region. Endeavours to provide opportunities and strengthen capacities for selecting healthy lifestyles, to be effective, must take account of the varying context and composition of social groups and environments and their changes over time.

As children grow older, peer groups have a progressively more important influence on their behaviour, until in adolescence peer influence becomes dominant. Therefore, the school and friendship group experiences of children help to shape and maintain forms of behaviour that may have a positive or negative influence on health. Potentially health-damaging practices that may become imprinted on lifestyles during adolescence include smoking, the use of habit-forming drugs, eating disorders and unsafe driving behaviour. Not enough attention has been given to the reinforcement of positive health behaviour through peer groups.

Suggested solutions

Policies and programmes that enhance the problem-solving, supportive and care-giving capacities of families and extended social networks perhaps offer the greatest potential for health promotion and for facilitating health-enhancing lifestyles.

There should be support services in the community to help families according to their particular situation. Sometimes families may need help with patterns of conflict resolution or to overcome the generation gap. Other family situations may require community services for child care or to complement the family

care of an ill or disabled member. Even where there are opportunities for social contact and/or community involvement, elderly people, especially those living alone, may need help to find and use them.

Special attention should be given to programmes in kindergartens, nurseries, play groups, schools and youth groups, and they should be carefully designed to cover active choice and decision-making. School health education should encourage children to look after their own health, to evaluate symptoms and to decide whether they can deal with them themselves or should seek professional care. Programmes designed for workplaces, educational institutions and health facilities or broadcast by the media should contain elements of problem-solving in difficult situations and decision-making in health care settings. Research should be encouraged to develop new and more effective approaches, for example, to preschool and school education, that promote in children and adolescents the ability to make decisions and think independently.

Unhealthy behaviour sometimes arises from problems such as loneliness, work stress or bereavement. Action designed to prevent such behaviour must be related to its causes. Since individuals are rarely able to solve such problems on their own, social programmes are needed that encourage individuals' families and wider community networks to solve their problems cooperatively. The establishment of integrated and informed social networks and problem-solving groups in local communities should be actively promoted, particular attention being paid to the needs of vulnerable groups, such as the elderly, the disabled, migrants and unmarried young mothers.

For example, the social network available to individuals, such as the newly widowed or parents alone with small children, may be insufficient to satisfy the need for social support and social contact. New forms of contact must then be found. Groups of people with common problems who meet to provide each other with support (mutual aid or self-help groups) have become a satisfying option for many people.

Target 15 ☞
Knowledge and motivation for healthy behaviour

By 1990, educational programmes in all Member States should enhance the knowledge, motivation and skills of people to acquire and maintain health.

The attainment of this target could be significantly supported by ensuring an adequate and effective infrastructure and funding for health education programmes at all levels.

Problem statement

People may do things that damage their health because they know nothing of the risks or of healthier alternatives, or because their values do not give them sufficient motivation to change their behaviour in response to what they know.

Information regarding the health implications of particular forms of behaviour, however, is not enough. Smokers, for instance, often know that smoking is bad for their health. This is also true of children and teenagers, but many of them still start smoking. As discussed above, complex factors shape potentially damaging practices. Many people need help to change habits that have become routine.

Being bombarded with advertising or with indirect sales promotion, which associate potentially harmful practices such as drinking and smoking with attractive and desirable lifestyles, may increase or reinforce unhealthy behaviour. In the developing parts of the Region, many people are captivated by corporate campaigns presenting smoking and drinking alcohol as symbols of modernity and wealth. In industrialized countries, advertising campaigns using the themes of "maturity and independence" are aimed particularly at young people and women. An especially insidious influence on the behaviour of young people is the sponsorship of sporting events by companies that produce health-damaging products. It is therefore important that people be provided with information through a wide range of effective educational methods of presentation to counteract these negative health messages.

Another area in which there is a rapidly growing need for education of the public is the appropriate use of professional services and the use of self-care.

Not all Member States have yet set up an adequate organizational structure for health education at all levels. There is little or no coordination in preparing health education messages between government agencies and nongovernmental groups and organizations. In some countries, various industries are rapidly moving into the health education field and — particularly using new types of technology — developing programmes covering a wide range of health issues.

Suggested solutions

Successful health education programmes must be based on local social and cultural patterns and be intimately linked with the formation of individuals' value systems. Consequently, they must start very early in life (e.g. traffic safety programmes should begin when the child is very young) and be reinforced at those periods in life (e.g. start of kindergarten, school, puberty, parenthood, retirement) when changes in value systems are most likely to occur.

Health education efforts must cover a very wide range of activities: teaching children in kindergartens and primary schools about the role and function of their bodies and how behaviour affects health; incorporating mental health information in all health education programmes; and providing easy and free access to the most recent facts about health by using major social institutions such as schools, trade unions and the media for distributing the information. Nongovernmental organizations have a major role to play in developing education programmes. Information on when to use, and when not to use, professional services and which type of professional to contact for a given problem is an important aspect of health education. Consistent updated health information must permeate public policy and professional education, as well as being supplied to lay people.

The powerful influence exerted by peer groups and wider social pressures that today so often strongly encourage unhealthy behaviour can be diverted to enhance healthy lifestyles. This has

already begun in some countries where nonsmoking is becoming a valued norm. Celebrities and personalities can popularize healthy behaviour. Similarly, self-help groups, such as those for people wishing to stop smoking, control their weight or stop drinking, provide an effective means of combining information and support for people working to change their potentially damaging habits.

Finally, there must be planned, systematic monitoring and evaluation of the public acceptability and relative success of health education programmes to provide feedback to increase their relevance and effectiveness. Accordingly, health education must also be adequately integrated into academic structures.

Promoting healthy behaviour

Target 16 ☞
Positive health behaviour

By 1995, in all Member States, there should be significant increases in positive health behaviour, such as balanced nutrition, nonsmoking, appropriate physical activity and good stress management.

This could be achieved if clear targets in these areas were set in each Member State, e.g. a minimum of 80% of the population as nonsmokers and a 50% reduction in national tobacco consumption, and if steps were taken by WHO and other international organizations to promote cooperation in health promotion activities throughout the Region in order to make a wider impact on basic health values.

Problem statement

Positive health behaviour constitutes a conscious effort by individuals to actively maintain their health and that of others. Research indicates that practices such as eating a balanced diet, taking regular physical exercise, ensuring rest and relaxation and engaging in rewarding social and sexual relationships help to increase an individual sense of wellbeing and act as a buffer against illness.

Most research hitherto has focused on health-damaging rather than health-enhancing forms of behaviour, but the interest in developing positive health indicators is growing. In a number of

Member States, health education programmes have begun to promote health as an important cultural value. In some countries, a new interest in health is manifest among the general public. Physical activity, sports, health foods, stress relief, meditation and non-smoking are not only gaining individual attention but also constitute part of a value change promoted by groups of environmentalists and ecologists within the Region.

Positive health behaviour is by far the most challenging field for a health promotion policy. It opens up important fields of research, since more knowledge is needed of what constitutes positive health behaviour and how individuals can be induced to take more responsibility for their own health and for that of others.

Nutrition Health-damaging problems include insufficient nutrition, unbalanced nutrition, overnutrition and self-imposed undernutrition. The problem of insufficient nutrition is related to social equity and sufficient basic resources, problems that have been discussed as prerequisites to health. Unbalanced nutrition may be due to lack of knowledge, but is closely related to food advertising, packaging, etc., as well as to the choice of menus in fast-food outlets, cafeterias and restaurants. The food processing industry is in some countries the largest manufacturing industry — much bigger than the alcohol or tobacco industries. The development of food processing technology has influenced agricultural production and the availability, distribution and consumption of foods more than any conscious nutrition education campaign. There is commonly too little fibre, too much fat and too much sugar in diets in many European countries, and there may be deficiencies in important micronutrients. Overeating of energy-rich foods leads to obesity — an important problem in many countries — which in turn is linked with cardiovascular diseases, diabetes, etc.

Other problems are more complex, arising from the interaction of learned eating habits, psychological conflicts and cultural values and stereotypes. Adolescent girls are particularly vulnerable to eating problems arising from the contradictory pressures of body-image stereotypes and the association of eating with happiness and

gratification during a time of considerable psychological conflict and development.

Smoking This is the form of risk behaviour related to health that has been most studied. It has been estimated that up to 10 million people in the European Region are at risk of death from illnesses related to smoking between 1980 and the year 2000. Smoking-related diseases include lung cancer and some other cancers, ischaemic heart disease, chronic bronchitis, emphysema and certain chronic arterial diseases of the leg. Furthermore, the effects on the foetus of smoking by pregnant women are causing increasing concern.

Over the past 30 years, the general pattern of smoking has changed considerably within the Region. There are indications that it may be levelling off in the Region as a whole, but there are still considerable differences among countries and among different subgroups within countries. In some countries, many people, especially members of high-status groups, have stopped smoking. In general, women and young children constitute groups whose risks are increasing. It is for this reason that the focus of smoking programmes within the Region has moved towards active non-smoking as a positive form of health behaviour.

Despite the high long-term social and economic costs to society, tax policies have often made the sale of tobacco of short-term economic benefit to many governments. This fact, along with the powerful business interests involved, often counteracts directly or indirectly attempts by the health sector to reduce smoking. Little attention has been given to programmes of crop substitution or to the fundamental ethical question of whether it is right to produce a clearly pathogenic substance, even in countries with a state tobacco monopoly. These problems are further complicated by the cross-national promotion and distribution of tobacco and other products that affect health.

Stress Both the subjects just discussed are examples of behaviour that may be part of negative patterns of stress management. A growing body of research evidence demonstrates the consequences of stress-producing situations on both physical and

mental health. Coping behaviour, then, has both direct (the frequency of stress reactions in the body) and indirect (tendency to use health-damaging forms of behaviour in attempts to feel better) effects on the preservation of health. Balanced physical activity, relaxation and social interaction, all of which promote health, are important components of effective coping. Unfortunately, the lives of many people do not allow the balanced lifestyle most conducive to health.

Physical activity Participation in healthy physical activity can be a very joyful experience and thus be an important factor in improving the quality of life. Physical fitness, acquired in youth and maintained throughout life, seems to be essential for the body to function healthily and at its best. Evidence suggests that improved fitness through regular physical activity helps in prevention and rehabilitation. It is especially important for elderly people to maintain patterns of regular physical activity in order to preserve their functional capacity in old age.

Over the past decades, there has been a basic change in the way in which societies regard physical activity. Its contribution, not only to people's health but also to their general wellbeing, has been acknowledged.

Suggested solutions

Since advertising, the sale of consumer goods, television shows, films, etc., are increasingly influencing basic values across national borders, efforts should be made to see how Member States, with the cooperation of WHO and other organizations, can coordinate their individual campaigns so as to enhance the effectiveness of their health promotion policies and programmes. Action must be taken with regard to programming as well, to ensure that programmes designed to promote healthy lifestyles recognize the importance of balance, satisfaction and support in the situations of life and respond to the special needs of the many people who are attempting to alter their health-damaging habits.

Nonsmoking In relation to smoking, strong, persistent nationally and internationally coordinated efforts are needed to change basic social attitudes and practices so that nonsmoking is

established as the positive social norm, and considerable attention should be given to creating closer cooperation among Member States in this respect in the years ahead. Legislative steps, such as reducing the availability of tobacco to children, labelling all packages with a health warning, controlling the advertising of tobacco products, and restricting smoking in public places, schools and workplaces, also play a very important role; duty-free sales of alcohol and tobacco should be abolished.

Since for some countries the growing of tobacco and the manufacture of cigarettes and other tobacco products are of short-term economic importance, initiatives should be taken in each Member State and at the international level, to plan and gradually develop substitute crops and industries.

Balanced diet In relation to nutrition, it will be necessary to develop ways of ensuring the production and sale of healthy food products so that those most commonly eaten provide a well balanced diet. A positive image of healthy eating should be developed with the cooperation of the media and popular public figures in school health education and with the support of industry and nongovernmental organizations, taking into account the cultural values and pressures linked to eating behaviour. Increased information about and support for mutual aid groups, such as those helping people cope with eating disorders, are needed.

Stress management Thus, health promotion programmes should not only provide information regarding health-enhancing behaviour but should also help individuals to obtain active support for their endeavours to lead a healthier life. Health professionals must develop an interest in health promotion and be ready to study the effectiveness of new approaches, e.g. in stress management. It is not enough to help people to overcome health-damaging ways of responding to stress. Active health-enhancing methods of stress management must be devised and promoted, including methods of problem-solving, keeping a proper balance between work and leisure and relaxing in stressful situations.

Physical activity Sports and physical activity programmes should be promoted and made more accessible to people in all

social and age groups. Physical activities combined with recreation that strengthen social and family ties should be enjoyable and inexpensive. This requires town planning that protects nature areas and parks for walking, relaxing and socializing and provides opportunities for swimming, cycling, etc., while at the same time guaranteeing access for the disabled. Imaginative health promotion campaigns can stimulate interest and awareness in activities that combine social involvement with physical activity.

It is clear from this discussion that only multisectoral cooperation can achieve this target. Ideally, healthy behaviour patterns, learned in childhood and supported by social conditions, opportunities and resources for maintaining them, offer the most certain long-term strategy for promoting health in the population. It is important to note, though, that group approaches, e.g. within adult education, have yielded promising results and opened up prospects for adult behaviour to change in a positive direction.

Target 17
Health-damaging behaviour

By 1995, in all Member States, there should be significant decreases in health-damaging behaviour, such as overuse of alcohol and pharmaceutical products; use of illicit drugs and dangerous chemical substances; and dangerous driving and violent social behaviour.

The attainment of this target could be significantly supported by developing integrated programmes aimed at reducing the consumption of alcohol and other harmful substances by at least 25% by the year 2000.

Problem statement

There is no doubt that the way many people live in industrial societies is hazardous to their health. This is not necessarily due to the willingness of people to risk their health, since many are, in fact, not always able to choose a healthier lifestyle. Health-damaging

practices should not be thought of as discrete forms of behaviour, but rather as aspects of a cultural life, often one of several interacting problems.

Risk behaviour can be a way in which people try to resolve conflicts within themselves and between themselves and society. In such situations, risks, if calculated at all, may be calculated more in terms of immediate benefit and social acceptability than in relation to their health consequences. Unfortunately, risk behaviour is self-reinforcing; it may not only allow people to cope with the current conflict, but give them a sense of strength to face the same conflicts again.

Feelings of powerlessness may also contribute to risk-taking behaviour. Furthermore, many people feel or associate pleasure or a sense of control with forms of behaviour that may damage their health. These feelings will be felt more intensely when the behaviour is reinforced by peer group pressure and has become part and parcel of daily life. Such motive forces are particularly strong during adolescence, when they interact with a great deal of experimentation and uncertainty.

Behaviour involving short-term or long-term health risks is often highly acceptable in some cultures and is promoted by traditions, the mass media or advertising. Such phrases as, "You need a drink!", "Take a pill and calm down!", "Have a cigarette!", are a common part of everyday life.

Alcohol abuse As regards alcohol-related problems, there is extensive evidence that alcohol consumption is one of the most important factors contributing to social and health problems. The catalogue of alcohol-related problems includes cirrhosis of the liver, road traffic and other accidents, several types of cancer, mental health problems and social problems, such as financial difficulties within families, absenteeism, wife-beating, child abuse and divorce.

The extent of alcohol-related problems is statistically closely related to annual per capita consumption of alcohol, and it is therefore a matter of great concern that the alcohol consumption per head in the Region has shown a drastic and very disturbing

increase over the past 30 years. During that period, all but one of the 21 countries for which data are available have disclosed increases in their per capita consumption of alcohol. In 12 of these countries, the annual consumption of pure alcohol equivalent per person aged 15 years and over has more than doubled, and in four countries it has more than tripled. There is also a trend towards heavier drinking among women and young people.

Other drug abuse Patterns of drug use in European countries are linked to social phenomena, such as changing living conditions, alienation and lack of cultural identity, especially among young people. The insecurity and conflicts arising from such social conditions are exploited by unscrupulous people who promote drugs for profit, including very dangerous addictive drugs such as heroin and cocaine. This situation is exacerbated by the ineffectiveness of national drug control policies, insufficient coordination of drug control programmes nationally and internationally, the ineffectiveness of programmes for prevention, treatment and rehabilitation among drug users and failure to integrate them in the general health services.

Problems related to the use of psychoactive substances are not confined to illicit drugs, as there is substantial misuse and abuse of pharmaceutical products. It has, unfortunately, become a common practice to choose drugs to deal with social and psychological problems. The overprescribing of psychoactive drugs, especially to women and old people, is a serious component of this problem. This is an aspect of appropriate care discussed in Chapter 6. Among children, a dangerous practice involves the use of chemical substances, such as glue, to achieve sensory effects.

Dangerous driving Abuse of alcohol and other mood-altering drugs not only has direct health effects but is also heavily related to the death and disability that result from dangerous driving and violent social behaviour. In traffic accidents, driving behaviour is responsible for extensive death and disability, especially among adolescent males. In this respect, it should also be remembered that some societies have created a dependence on the motor car, which places people at an unavoidable risk. In Europe, the number of cars

in the public, corporate and private sectors is rapidly increasing. Many factors are involved in road traffic accidents, but not using seat belts, careless driving (especially under the influence of alcohol) and speeding are very significant factors. The protective effect of seat belts is highest in children, with belt-restrained children 70–80% less likely to be injured or killed in a car accident. The protective effect of helmets for motorcyclists is also high; a non-helmeted rider is about five times as likely to suffer severe or critical injuries and twice as likely to suffer a minor head injury as a helmeted one.

Violence Violent social behaviour is perhaps the area where the interaction of health-damaging forms of behaviour and their complex relationship with life's situations is most obvious. Child abuse, wife-beating and rape are examples of violent social behaviour that are currently subjects of growing concern in many countries. Violence is associated with high levels of situational stress and/or inability to resolve conflict.

Patterns of adult behaviour that may contribute to the abuse of children include being overwhelmed by life's situations, inability to handle stress, inappropriate expectations of children and low self-esteem. Abuse, in turn, may contribute in the abused children to retarded development, problems in school, a poor self-image, delinquency in adolescence and abuse of children in adulthood.

Sexual abuse is a form of violence against children that has been associated with many serious problems, and recent research indicates that it may be more frequent than was hitherto believed to be the case. Sexually abused children more often suffer from drug addiction, eating disorders, depression and self-mutilation, including suicide. Thus, stress-producing situations, coping and health-damaging behavioural practices are complex, interacting problems and can be self-perpetuating if associated behaviour patterns are not altered.

Suggested solutions

In a recent study of the relationship among alcohol control policies, aggregate levels of consumption and chronic health problems related to drinking, it emerged that controls are not rigid systems of

legal regulations that can easily be changed but rather elaborate networks of cultural, economic and political structures that reflect and at the same time determine the magnitude of the alcohol problem. They involve economics, culture and history, but most of all they involve politics and the state apparatus. The profits, both private and public, to be made from the sale of alcohol often lead to a conflict between economic interests on the one hand and the concern felt by health authorities regarding the possible health and social consequences on the other.

Alcohol and drug abuse These may be influenced by regulations concerning production, by changing advertisement policies regarding alcoholic drinks and reducing their availability, by price policies and by supplying alternatives to the drinking of alcohol. Carefully planned educational campaigns to win acceptance of these policies by the people are necessary. Specific drinking patterns should be tackled not only through changes in the availability of alcohol, but above all by attempts to achieve changes in the lives of those who are particularly vulnerable. In addition, innovative approaches to the treatment of people with established patterns of health-damaging behaviour should be supported.

Better information material and programmes are needed for use in schools, workplaces and the media concerning the influence of cultural beliefs, such as the tendency to use alcohol and drugs as means of coping, and their consequences. More effective mechanisms of social support for groups that are especially vulnerable to acquiring habits of drug abuse should be developed, including a broad range of outreach activities, self-help groups, treatment centres, half-way houses, shelters, etc., so as to improve services for prevention, treatment and rehabilitation in cases of alcohol and drug abuse and social violence. A much stronger research effort is needed to develop innovative approaches to prevention, taking into consideration a broad range of possible measures in different sectors. Similarly, the development of better methods for evaluating treatment programmes and a systematic search for more effective methods of treatment must be given high priority.

Driving As regards dangerous traffic behaviour, while it is the responsibility of public authorities to ensure that roads are safe and that vehicles are designed and built to protect the public, it is no less important to plan and carry out extensive educational campaigns for all road-user categories: drivers, cyclists and pedestrians. Such programmes should start with very young children — not later than in kindergarten — and follow through in subsequent stages of life: children, adolescents, adults and the elderly. In the case of drivers, particular emphasis should be laid on the danger of alcohol or drugs for driving, as well as the creation of values making safe and considerate driving the culturally acceptable norm in all age groups.

Health promotion programmes that aim at modifying driving and other forms of behaviour in young populations should recognize the special importance during adolescence of peer pressure and influence. Young people should be involved in developing the programmes and determining ways of effectively using peer influence to stimulate the study of health problems and promote safe and health-enhancing behaviour.

Violence Special efforts are needed to help victims of social violence, i.e. physical, psychological and sexual abuse. Programmes that aim at reducing the incidence of social violence should include services concerned mainly with problem-solving and conflict resolution in families and other social groups. Information developed for and aimed at vulnerable groups, such as children and old people, should focus on ways of recognizing and exposing abuse and obtaining help. Special arrangements must be available to provide vulnerable people with safe environment when necessary.

There are thus many approaches that can be used in attempts to change individual habits, but clearly it is most important to concentrate on the causes, the structural factors that shape behaviour, and to support people's active and positive participation in their own health.

5

Healthy environment

The environment of the European Region is changing rapidly in terms of demographic structure, human lifestyles, consumer goods, energy sources, modes of industrial and agricultural production, transportation, tourism and migration. All these factors can cause, and can interact to produce, major impacts on health.

An important aspect of preventive health care is to ensure that socioeconomic development is carried out in such a way as to protect, and where possible enhance, human health and wellbeing. In addition to safeguards in relation to new socioeconomic development, there is a need for improvements in the existing human environment, including the upgrading of housing, the reduction of long-standing pollution and the provision of better working conditions.

Such measures involve many aspects of government, at central, regional and local levels, and require well integrated, multisectoral planning and management. Because many of the problems, such as air and water pollution and the transportation of potentially harmful materials, may affect more than one country, there is a need for international collaboration on surveillance and control measures.

The development of new technologies, e.g. in the areas of energy production or chemical manufacture, must be such that it minimizes the potential adverse effects on human health, and this requires the establishment of systematic mechanisms for risk assessment and the study of alternatives.

While rapid socioeconomic development has brought about substantial changes in the European environment, some countries still have major problems of water supply and sanitation, whose solution could lead to a major reduction in the incidence of enteric diseases, particularly those affecting children.

Environmental management should aim not only at safeguarding human health from the potential adverse effects of biological, chemical and physical factors, but also at enhancing the quality of life by, among other things, providing people with clean water and air, pleasant living and working conditions and ample facilities for leisure pursuits. All are factors that can have substantial positive effects on health and wellbeing.

In all countries of the European Region, there is now widespread interest in the quality of the environment and in its influence on human health. Attainment of the targets in this chapter will be facilitated by the provision of information on the issues involved, and by promoting community and individual participation.

Environmental health policies

Target 18 ⇨
Multisectoral policies

By 1990, Member States should have multisectoral policies that effectively protect the environment from health hazards, ensure community awareness and involvement, and support international efforts to curb such hazards affecting more than one country.

The achievement of this target will require the acceptance by all governments that well coordinated multisectoral efforts are needed at central, regional and local levels, to ensure that human health considerations are regarded as essential prerequisites for industrial and other forms of socioeconomic development, including the introduction of new technologies; the introduction of mechanisms to increase community awareness and involvement in environmental issues with potential implications for human health; and the development of international arrangements for effective control of transfrontier environmental health hazards.

Problem statement

Preventive health care involves many matters of concern to governments, within the fields of physical planning, housing, industry, agriculture, transport, energy production and environmental protection. At present there is sometimes a lack of a multisectoral approach towards environmental health management, and an absence of effective coordination to ensure that socioeconomic development is not accompanied by detrimental effects on the health and wellbeing of the population. In addition, in some countries there is an overlap of functions, with two or more ministries or government agencies engaged in closely related work that could be performed more effectively by a single body.

Particularly since the Conference on Man and the Environment in Stockholm in 1972, there has been increasing concern in all countries of the Region about the impact of environmental hazards on human health, but the public are often confused and worried about the nature of such hazards, both in the workplace and in the general environment. In some countries, insufficient efforts have been made to promote community awareness of or involvement in such issues.

Increasingly, potentially hazardous goods and wastes are being transported across national boundaries, and hence air and water pollution may affect states other than the country of origin. Industrial development close to frontiers can pose particular problems. Moreover, continuing trends in the migration of workers and international travel can lead to an increased probability of infections reaching other countries.

Suggested solutions

This target will be achieved only if governments regard environmental health concerns as mandatory elements of socioeconomic development. This means that there should be adequate legislation in all areas affecting the environment, an increased awareness throughout society of possible environmental hazards and how to protect against them, more concern for health factors when planning for new developments, a free flow of information and public involvement in these issues, and more international collaboration on transfrontier problems.

Effective legislation and permanent machinery will need to be established to ensure that all sectors of national, subnational and local government, including those concerned with physical planning, housing, industry, agriculture, energy production and environmental protection, take health considerations fully into account at the planning stage of new developments. Intensive efforts are required to ensure that development takes place in forms that minimize environmental hazards and enhance human health and wellbeing.

The achievement of a significant reduction in health risk due to environmental factors will require increased awareness among all exposed groups, "risk producers", all categories of professionals involved, and the general public, as to the nature and extent of risks and effective means of protection against them.

Greater awareness of environmental hazards will increase the desire for safety and promote more active and enlightened public involvement in the issues. This in turn should lead decision-makers to exercise greater care in ensuring that environmental health considerations are taken fully into account when planning and assessing new developments.

Much attention should therefore be given to producing material that provides information on health concerns and existing risk factors for the general public, particularly at the community level. The community should also be given a decisive voice in decisions affecting its environment. This could be done, for example, through representatives on local health councils with strong mandates.

All countries will need to give support to agreements to control the transfrontier pollution of air and water and the international movement of hazardous goods and wastes. Examples of existing cooperation are the Convention on Long-Range Transboundary Air Pollution and the Convention for the Protection of the Mediterranean Sea against Pollution, in whose implementation the WHO Regional Office for Europe is collaborating closely with Member States and with the other international organizations concerned.

Monitoring, assessment and control

Target 19
Monitoring and control mechanisms

By 1990, all Member States should have adequate machinery for the monitoring, assessment and control of environmental hazards which pose a threat to human health, including potentially toxic chemicals, radiation, harmful consumer goods and biological agents.

The achievement of this target will require the establishment of well coordinated monitoring programmes with clearly defined objectives; the development of methodologies and health criteria for the assessment of data in relation to control procedures; the investment of adequate levels of funding for control measures, and their introduction and maintenance; and the training and utilization of sufficient numbers of competent personnel for all aspects of environmental health protection.

Problem statement

Chemicals The possibility of health hazards arising from chemical, physical and biological factors is a major concern in all countries of the European Region. A total of about 60 000 chemicals are produced commercially, and between 200 and 1000 new compounds are introduced each year. A high proportion have not caused any discernible adverse effects. However, although some toxicity information is available for many of the products, there is very little relating to human health risk assessment. For example, the International Agency for Research on Cancer has evaluated nearly 600 chemicals and industrial processes, and found some 30 to be causally associated with cancer in humans. Furthermore, cancer is only one of a variety of the potential toxic insults from chemicals that can cause acute toxic effects, congenital abnormalities, skin lesions, neurological disorders, behavioural abnormalities, immunological damage, and mutagenic effects.

Ionizing radiation The adverse effects of ionizing radiation on human health, particularly in relation to cancer, have been clearly

demonstrated. Mishaps have occurred only when technical knowledge has been inadequately applied to the design and operation of plant and equipment. It is not always appreciated that the greatest public exposure to ionizing radiation is from medical X-rays, and attention is being paid to the limitations of diagnostic procedures in many countries.

Noise Noise is increasing in urban and industrial areas with an estimated 10–20% of the European population exposed to sound well above acceptable levels. It is forecast that community noise levels in the Region will increase by 30% by the year 2000 unless more stringent controls are imposed.

Biological agents These take a great public health toll, particularly in the Mediterranean area of the Region. Inadequate sanitation has led not only to diarrhoeal diseases, which are the major cause of morbidity and mortality in infants in that area, but also to endemic typhoid and cholera. As regards tropical diseases, there were 116 000 cases of malaria in one country in 1977, schistosomiasis is still a problem and leishmaniasis is returning. In some European countries with good reporting systems, the incidence of food poisoning has shown a sharp increase in the last 10 years, and it is often associated with new methods of production, storage and preparation. Finally, the considerable damage caused by insects and rodents not only as disease carriers but as destroyers of food must be recognized.

Consumer goods An ever-increasing range of consumer goods is available to the public. A small proportion are unsafe, either because they are badly designed or constructed or contain potentially dangerous materials, or because they can readily be misused.

Risk assessment There are widespread uncertainties and misconceptions about the magnitude and probability of different types of risk, and conjecture about impairments to health resulting from exposure to chemicals and radiation and to unsafe consumer products has become a regular feature of the mass media. Public concern often differs markedly in respect of risks that are sustained individually, such as smoking, and those that affect the community, such as occupational conditions or pollution of air and

water. Fears in the latter category frequently result in suspicion of or opposition to certain kinds of technological development, and in the past the lack of effective health safeguards has sometimes justified such negative responses. Decisions have frequently been made in a way that does not allow community involvement.

The risk to health arising from the contamination of water, air, soil and food is often difficult to assess precisely. Specific episodes of high-level pollution, resulting in widespread contamination, have attracted considerable attention, but much less is currently known about the cumulative risk of low-level, long-term contamination, including the combined effects of exposure to a number of different hazards.

Although there have been major efforts in all countries of the Region to monitor and control the adverse health effects of unsatisfactory environmental conditions, such measures have often been incomplete and fragmented, with a lack of anticipatory action which could have prevented the conditions from arising in the first place.

Suggested solutions

To understand the potential impact of environmental hazards on human health, there is a need for carefully designed monitoring strategies, involving as appropriate the measurement of levels of contaminants, the tracing of pathways of contamination in the environment, the estimation of personal exposures and accumulations in tissue, and the performance of epidemiological studies. Assessment of potential health effects will involve the use of the results of investigations together with toxicological information, which is often based on experiments in other species. Use should also be made of internationally developed health criteria in developing limits of exposure.

Control strategies may provide for legislative, economic and technical measures, together with education and training, and they would frequently involve more than one sector of government. Efforts should be directed especially to the development of procedures whereby potential adverse effects on health can be anticipated and prevented at the planning and design stages of new

development. Such measures should be counted as part of the cost of such development, since prevention is almost invariably cheaper than later cure. When control equipment is introduced, e.g. to reduce the levels of harmful emissions, it must be efficiently operated and maintained by appropriately trained personnel.

When possible, technologies with a low impact on human health and the environment should be adopted. So far as possible, waste materials should be recycled and reused.

An important requirement for the satisfactory control of environmental health hazards is the establishment of a well trained corps of inspectors who, with the backing of sound and practical legislation, can not only monitor and seek to remedy harmful conditions, but also give expert advice on both preventive and curative measures.

Because of the international nature of many environmental health problems, there is a clear need for collaboration among countries in relation to both monitoring and control. In addition, because the available human and financial resources are limited, risk assessment for particular hazards, such as new chemicals, can often be best done through international endeavours.

Target 20 ☞
Control of water pollution

By 1990, all people of the Region should have adequate supplies of safe drinking-water, and by the year 1995 pollution of rivers, lakes and seas should no longer pose a threat to human health.

The achievement of this target will require, in the less developed countries of the Region, the investment of higher levels of funding for the construction and maintenance of drinking-water supply facilities, with the appropriate mobilization of international and bilateral assistance to reinforce national endeavours, and with the training and utilization of adequate numbers of competent personnel; and in all countries of the Region, the introduction of effective legislative, administrative and technical measures for the surveillance and control of pollution of surface water and groundwater, in order to comply with criteria to safeguard public health.

Problem statement

The recognition that safe water and sanitation are essential for the protection of human health led to the adoption by the United Nations General Assembly of resolution 35/18 on the International Drinking Water Supply and Sanitation Decade. Water-related diseases are an important public health problem and a major cause of death of young children in developing countries. It is estimated that over 100 million people in the Region are without an acceptable water supply and 250 million without adequate sanitation. Even in the most advanced Mediterranean countries, some 10% of all children's admissions to hospital are due to diarrhoeal disease. Water-related vectorborne diseases (malaria, schistosomiasis) are on the increase in some areas of the Region. Population growth and the sudden influx of tourism in the warmer countries have added to the demand for safe water supplies.

Even in the more developed parts of the Region, there are still serious deficiencies in water supply and sanitation, particularly in rural areas, and it is estimated that about 35 million people lack safe water and 100 million adequate sewerage. Any defective supply system, whether the shortcoming is in the form of leakage or discontinuity of service or poor operation and maintenance, is a potential danger to health. Every effort should therefore be made to ensure that all systems remain in continuous and effective operation, and disinfection will play a key role in this respect.

Owing to increased demands on limited water resources, an ever greater proportion of public supplies is being drawn from lowland rivers and groundwaters that are subject to pollution by a growing range of potentially toxic substances from domestic, industrial and agricultural sources. Groundwater is particularly difficult to rehabilitate once contamination has occurred. Natural occurrences of substances such as arsenic and excessive concentrations of fluorides may pose a public health problem, and the degree of softness of the water is even considered to be a factor in cardiovascular disease. In older communities with plumbing systems in lead, appreciable concentrations of this element can occur in the water. Some forms of treatment of public water supplies can result in the production of potentially harmful substances.

Control of pollution of major water resources is not always the responsibility of a single nation. When rivers cross or constitute international borders, or where large aquifers are shared by countries, international collaboration becomes essential.

The contamination of rivers, lakes and coastal waters may represent a hazard when they are used for water supply, bathing or aquaculture. Enteric diseases and hepatitis have been associated with swimming in polluted Mediterranean waters, and the consumption of seafood harvested from contaminated areas has resulted in many cases of infection. On the other hand, unpolluted waters can represent an important, health-enhancing recreational resource.

Suggested solutions

This target could be achieved if all countries ensured that the whole population was served by supplies conforming to the WHO guidelines for drinking-water quality and that effective steps were taken to protect both fresh and marine waters from pollution.

Specific measures to reach this target would include the investment of sufficient funds to provide adequate supplies of safe drinking-water for the population, and the effective management or maintenance of collection, treatment and distribution systems. It will be necessary to draw up countrywide strategies on the protection of water resources as part of overall water management, and to entrust their implementation to effective pollution control authorities. Particular stress should be laid on preventing groundwater pollution and the leakage of potentially toxic materials from non-point sources and from hazardous waste dumping sites. Physical planning and land-use management may also have an important influence on water quality. Finally, agricultural practices that can be detrimental to water quality need to be controlled.

Achievement of the targets would be facilitated by the adoption of internationally binding agreements on the development and implementation by all coastal countries of measures to protect the quality of seawater, particularly in areas where there are bathing beaches or where seafood is harvested. Protocols and agreements on pollution control, between countries sharing water resources, are also an important requirement.

By 1995, all people of the Region should be effectively protected against recognized health risks from air pollution.

The achievement of this target will require the introduction of effective legislative, administrative and technical measures for the surveillance and control of both outdoor and indoor air pollution, in order to comply with criteria to safeguard human health.

Target 21

Control of air pollution

Problem statement

In extreme instances, acute episodes of air pollution have been shown to cause serious illness and loss of life. Less is known about the consequences of long-term exposure to low concentrations of contaminants, although the adverse health effects of sulfur oxides and particulates, nitrogen oxides and oxidants and hydrocarbons, for example, are recognized. Greater use of fossil fuels, particularly coal, and oil for energy production and transportation has led to considerable increases in the discharge of sulfur and nitrogen oxides. Vehicular traffic in European countries has increased by at least 30% in the last 10 years, producing harmful emissions with both a direct and an indirect impact on human health. The transboundary migration of sulfur and nitrogen oxides, together with other pollutants and acid rain, are causing increasing concern in northern and central Europe.

Long-term climatic changes resulting from air pollution may ultimately have an influence on human health and wellbeing, particularly in terms of the direct effects of increased carbon dioxide emissions on atmospheric temperature and the possible effect of the reduction of the ozone layer due to aerosol propellants on the incidence of skin cancers.

Indoor air pollution by substances originating outdoors, emitted by building materials or generated by man and his indoor activities is a problem that is becoming more acute as new materials are introduced and ventilation is reduced to save energy.

Suggested solutions

The attainment of this target would require the strengthening of measures in Member States for control of emissions from industry,

domestic premises and motor vehicles, and a substantial reduction in indoor air pollutants. Legislative, economic and technical measures based on internationally accepted criteria will be needed for this purpose. In some cases, air pollution would be substantially reduced by the use of alternative raw materials or technologies or the modification of production processes. More effective international agreements would progressively enable adequate control of long-range air pollutants, such as sulfur and nitrogen oxides. More systematic investigations, *inter alia* in the form of epidemiological surveillance, should be carried out in accordance with internationally agreed protocols in order to determine the long-term health effects of air pollutants.

Target 22 ☞
Food safety

By 1990, all Member States should have significantly reduced health risks from food contamination and implemented measures to protect consumers from harmful additives.

The achievement of this target will require the introduction of effective legislative, administrative and technical measures for the surveillance and control of food contamination at all stages of production, distribution, storage, sale and use; and the implementation of measures to control the use of harmful food additives.

Problem statement

The reporting of foodborne infections is inadequate, and it is estimated that no more than 5% of acute incidents are notified in most countries. The relationship between such diseases and the availability of safe drinking-water and sanitation is well established.

Chemicals, whether from natural, industrial or agricultural sources, can adversely affect food safety. The possible effects range from acute poisoning to carcinogenicity or reproductive damage in the longer term. Although knowledge of the effects of the ingestion of low concentrations of potentially harmful chemicals is limited, it is clear that technological development is resulting in a steady

increase in the number and range of chemicals to which the population is exposed. For example, recent programmes for monitoring cadmium in food have shown European levels to be close to the weekly permissible dose. In addition, several hundred chemicals are used as food additives to improve the quality and appearance of prepared foods and, hence, toxicological evaluation and systematic surveillance are of paramount importance.

Changing social habits, tourism and the entry of a large proportion of the female population into the workforce have led to dramatic changes in the pattern of food consumption. In some countries, the majority of meals are now produced outside the home, and thus mass catering has replaced home cooking, leading to new problems related to changing methods of food production, storage and preparation.

Suggested solutions

The attainment of this target would involve the design and strict enforcement of properly coordinated control systems covering the production, distribution, storage, sale and use of food, and the employment of well trained and effective food inspectors and food surveillance teams. Furthermore, it will be necessary to change public attitudes by means of information and education and to include food hygiene in all primary school curricula. In view of the rapidly growing international trade in food products, food safety regulations in countries should be based on those agreed internationally.

Target 23
Control of hazardous wastes

By 1995, all Member States should have eliminated major known health risks associated with the disposal of hazardous wastes.

The achievement of this target will require the introduction of effective legislative, administrative and technical measures for the surveillance and control of hazardous wastes; and the introduction of effective measures to eliminate health risks due to previously dumped wastes.

Problem statement

Very large quantities of waste are generated within the European Region. In the member countries of the European Community, for example, 2000 million tons are produced annually, including about 30 million tons that are considered to be hazardous. The chemical industry has expanded continuously for more than a century and the manufacture of some of the most important substances has increased by 30% within the last 10 years; inevitably this has been accompanied by a greatly increased production of waste, some of which could pose a threat to health unless effective disposal measures are adopted.

A number of major incidents have occurred during recent years, resulting in gross contamination of soil and groundwater. At the same time, there have been many less dramatic cases where unsatisfactory methods of disposal have led to long-standing pollution as well as health hazards on some occasions. Clandestine disposal to rivers and public sewers sometimes occurs, and in the 90% of cases where hazardous wastes are dumped, the contents and even the location of disposal are unknown to the authorities.

In some countries, pesticides are frequently handled without proper care, and partly filled containers may be left to rot. Facilities are not always available for the collection and safe disposal of hazardous consumer products such as waste oil and household chemicals. Potentially toxic materials are often transported and stored without clear labelling and without adequate precautions to prevent spills or seepage. In some countries, there are no arrangements for educating the users as to potential dangers.

Suggested solutions

This target could be achieved if all countries adopted comprehensive legislative, administrative, technical and educational measures for the safe handling, transportation and disposal of hazardous wastes, including effective international agreements relating to transfrontier shipment. In some cases, technical measures will include the recycling of wastes, the manufacture of useful by-products, alternative methods of production or the selection of alternative raw materials. In some places, measures will be needed to eliminate risks due to wastes dumped (sometimes many years) previously.

Improving environmental conditions

Inadequate living and working conditions expose people to physical, chemical and biological pollution, and to various adverse psychological and social factors, perhaps especially in the large population centres. In spite of the major construction programmes in the European Region during recent years, millions still live in dwellings that do not meet basic criteria for healthy living, suffering from overcrowding, damp, and inadequate heating, and having no reasonable sanitary facilities. Health and safety in the workplace is of major concern to most countries in the Region, although small groups of workers do not always have the same protection as those in large industrial units. It is the responsibility of the health sector to initiate and participate in multisectoral efforts to improve health conditions in the home and workplace.

Target 24
Human settlements and housing

By the year 2000, all people of the Region should have a better opportunity of living in houses and settlements which provide a healthy and safe environment.

The achievement of this target will require the acceleration of programmes of housing construction and improvement; the development of international health criteria for housing, space, heating, lighting, disposal of wastes, noise control and safety, while taking into account the special needs of groups such as young families, the elderly and the disabled; legislative, administrative and technical measures to comply with such criteria; the improvement of community planning in order to enhance health and wellbeing by improving traffic safety, providing open spaces and recreational areas, and facilitating human interaction, etc.; and the equipment of all dwellings with proper sanitation facilities and the provision of sewers and an adequate public cleansing and wastes collection and disposal system in all human settlements of sufficient size.

Problem statement

The environment of human settlements is a basic factor governing the physical and mental health, the social wellbeing and, generally, the quality of life of the people who live in them. Despite much improvement during the last few decades, environmental health conditions in many cities, towns and villages in the European Region, and in particular housing conditions, are often totally inadequate. Some large settlements are still not fully sewered or do not have an efficient service for public cleansing or for liquid and/or solid wastes collection and disposal.

The level of hygiene in human dwellings is a very important environmental health factor especially for those who spend most of their time indoors, such as infants, young children, the elderly and the handicapped. For better or for worse, housing conditions affect everybody's physical and mental health and wellbeing; yet today, many millions of people in Europe still live in dwellings that are grossly substandard. It has been estimated that 34% of the population have less than 8 m^2 of floor space, 42% of dwellings are inadequately heated, and 27% are without basic sanitation. In some countries, a majority of the population do not have a flush toilet, and in some parts of the Region millions live in shanty towns.

The population growth rate of the Region as a whole is projected at 0.5–0.7% up to the year 2000. However, in some areas, especially around the Mediterranean, the rate is much higher. At the same time, there is a steady movement of people from rural to urban areas, thus increasing the pressure on housing in towns and cities. The incidence of respiratory diseases is considered to be related to such housing features as air quality and density of occupation. In Mediterranean countries, there is a significant link between poor housing and both tuberculosis and enteric diseases.

In some cases, social trends have led to the decay of inner city areas, with its consequences of overcrowding, inadequate hygiene, noise pollution, traffic hazards and a total lack of facilities for health promotion. Migration patterns have placed an increased burden on housing in some places. Areas in the vicinity of poor housing are often derelict and open to infestation by stray animals, rodents and insects.

The mentally depressing effects of living in dirty, drab and monotonous environments are difficult to quantify but are clearly important in relation to human health and wellbeing.

In developed countries, the advent of air conditioning and energy conservation measures have been accompanied by growing problems of indoor air quality. Potentially harmful levels of nitrogen oxides, tobacco smoke, formaldehyde and radon can be found in homes. Some pollutants arise from insulation products, some from kerosene heaters, and others from modern housing materials. As many Europeans spend up to 90% of their lives in buildings, the health effects of the indoor climate are significant.

In all parts of the Region, there is an unacceptably high incidence of accidents in the home leading to considerable mortality and disability.

Suggested solutions

The situation could be substantially improved if all countries took effective measures to reduce overcrowding in houses, to ensure the provision of adequate means of heating, lighting, cooking and hygienic disposal of wastes, and to reduce community noise to acceptable levels.

Effective and enlightened community planning could have a major impact on the creation of a healthy environment, by such measures as traffic safety, adequate collection and disposal of solid and liquid wastes, the provision of recreational areas and the facilitation of human contact and interaction. In many countries, the health sector should be more directly involved in housing and settlement planning. Minimum standards should be set in relation to the health aspects of housing, including provisions on hygiene, safety, space, lighting and both noise and thermal insulation. Criteria for indoor air quality should also be established. In accordance with the goals of the International Drinking Water Supply and Sanitation Decade, all dwellings should not only have a supply of safe water but also adequate means for the hygienic disposal of wastes.

A special effort should be made to ensure that building designs meet the needs of the disabled and the elderly and the requirements

of harmonious family life. Comprehensive measures, including specifications for the safe design and construction of buildings, furniture, fittings and domestic equipment, together with continuing education programmes, should be introduced with a view to substantially reducing the incidence of home accidents.

Target 25 ☞
Working environment

By 1995, people of the Region should be effectively protected against work-related health risks.

The achievement of this target will require the introduction of appropriate occupational health services to cover the needs of all workers; the development of health criteria for the protection of workers against biological, chemical and physical hazards; the implementation of technical and educational measures to reduce work-related risk factors; and the safeguarding of specially vulnerable groups of workers.

Problem statement

Satisfying work in a safe and pleasant environment is a source of health and wellbeing. Yet, the physical and psychological working environment is all too often responsible for diseases and injuries.

Many workers are exposed to toxic chemicals, harmful dusts and fibres, noise, and the hazards of fatal or disabling accidents. In some European countries over the last 10 years, there has been little reduction in the incidence of accidents at the workplace. In certain industries, such as mining, quarrying or construction, there are remarkable variations among the countries of the Region with regard to the frequency of accidents per number of hours worked, apparently due mainly to differences in the effectiveness of regulations and safety education of workers. The self-employed and workers such as those on farms, on construction sites and in small manufacturing plants are often at most risk.

The total incidence of occupational disease in the Region is unrecorded, although information is available on the effects of particular substances, such as lead, arsenic, asbestos and vinyl

chloride, and of processes such as coal mining, stone quarrying and furniture making. Deaths from occupational diseases such as asbestosis, silicosis, pneumoconiosis and byssinosis are recorded in some countries. Individual behaviour such as smoking can greatly increase the risk of health damage due to occupational exposure.

As a result of the increasing employment of women who currently represent 30–40% of the civilian workforce in Europe, there is now an interest in identifying and controlling the potential effects of chemicals on reproductive processes, both male and female. Mental disorders, hypertensive diseases and myocardial infarction have sometimes been linked to psychological and social stress associated with certain working conditions, changes in those conditions and unemployment. Noise levels can have a disturbing effect on workers and result in severe physical impairment.

In most countries of the Region, occupational health records are inadequate, and it is not possible to establish clear links between them and the overall morbidity and mortality statistics. Coordination between occupational health services and the rest of the health care system is often unsatisfactory.

Suggested solutions

This target could be achieved by ensuring that occupational health services cover the needs of all workers, with reporting systems that faciliate identification of hazards, assessment of risk and evaluation of the effectiveness of control measures.

Occupational health services should cover all places of work, including the home. In some countries, it will be necessary to introduce or intensify training programmes for the various categories of personnel required. It is important that workers, employers and the general public should be involved in developing and should receive guidance on ways to improve working conditions and prevent occupational risks, including reference to the association between such risks and personal behaviour such as smoking.

Legislation, economic incentives and improved employer/employee cooperation should facilitate health promotion and risk prevention. In particular, the registration of workers and the

recording of workplace exposure to potentially harmful processes and materials should make it easier to take preventive action. Special attention will have to be paid to high-risk vulnerable groups. Measures to reduce risks should include the introduction of safer procedures and in some cases the replacement or strict control of chemicals known to be dangerous, especially those having carcinogenic, teratogenic or mutagenic effects.

Methods and procedures for monitoring chemicals, dusts, fibres and radiation in the workplace will need to be strengthened. Internationally developed health criteria concerning all potential hazards should provide the basis for the assessment of risks and the establishment of control strategies. Epidemiological studies and surveillance of workers' health will need to be expanded in many countries of the Region.

Efforts are needed to improve the linkage between occupational health services and the overall health care system at all levels, from the highest government authorities to primary health care units.

6

Appropriate care

Earlier chapters have discussed the relationship between wellbeing and the social, economic, political and environmental situations in which we live and work. Better nutrition, housing, education and living standards in the Region as a whole have increased life expectancy and reduced many health risks, but urbanization and industrialization, in their turn, have contributed to the development of new risks and new patterns of disease. Among other things, the number of people with chronic disabilities has increased, patterns of work and leisure are changing, and the structure of the family and society is very different from what it was two generations ago.

Over the past 20 years, there has been a massive increase in the resources allocated to health services in the European Region as a whole, and technological developments in medicine have been unprecedented. New equipment and new types of therapy have expanded the possibilities of accurate diagnosis and effective treatment, and a whole variety of drugs has been added to the pharmacopoeia. As a result the quality of life for many patients with specific physical conditions or mental illnesses has improved significantly.

Despite these real achievements, however, the health of people in Europe has not progressed as rapidly as might have been expected. Two main factors appear to have played a crucial role in causing this state of affairs: the relative speed of development of the various components of health systems and the balance between the different types of care provided. The most important trend in recent decades has been a rapid increase in the hospital sector with regard to both overall capacity and the degree of specialization. Most countries of the Region now spend between 6% and 10% of GNP on health care. In many of them, money spent on hospital care already consumes three quarters of the health budget, and that share is increasing.

Advances in health technology have allowed the safe and efficient ambulatory treatment of certain conditions, at home or in hospitals. However, these same developments have also contributed to the increasing numbers of diseases, with serious and permanent sequelae, with which people can now live. Support facilities to allow patients with residual or reduced capacities to function as normally as possible are therefore increasingly needed, and there is a great demand for rehabilitation and continuous care at home and in the community. The need for terminal care has grown, and it is becoming increasingly necessary to consider such issues as the quality of life of the seriously ill and how to let people die with dignity.

Clearly, we are faced with the dilemma of what to do in an increasingly complex situation characterized by the emergence of new health "problems" and challenges, changing expectations, developing capabilities both within and outside the health sector, and finite resources. Thus, linkages between all levels of the health care sector need to be improved. In this context, therefore, primary health care is increasingly relevant. Because of the way our health care systems have evolved during the last few decades the philosophy of primary health care needs to be reiterated. It is not well understood, either by the public or by the professional health workers, both of whom nevertheless stand to gain much if it is put into practice.

Because of this, an increasing responsibility lies with the public to participate so far as possible under prevailing constitutional provisions with politicians, health planners and providers in decisions regarding financing, organizing, managing and evaluating all aspects of health care. The purpose of the Conference on Primary Health Care in Industrialized Countries, held in Bordeaux, France in 1983, was to assess the progress that industrialized countries have made in implementing the concepts put forth at Alma-Ata. While it was evident that much has been achieved since 1978, a great deal of work remains to be done, even for the most developed parts of the European Region of the World Health Organization.

The primary health care concept has not always been readily accepted in industrialized countries. In Europe, primary health care is often defined in a somewhat restricted way, being taken to signify only physicians' services sought by, and rendered to, people at their first contact with the health system. Although such care is a crucial component of primary health care, it ignores the role of other categories of health personnel, such as nurses, midwives, dentists and pharmacists, traditional sources of health care and self-care. Legislation for health, and the orientation and organization of the health care system, is often such that home care services, nursing homes and other support programmes have been undersupported, underfunded and slow to develop.

Furthermore, what sectors other than health, for example, education, transport and industry, can do to improve or worsen the health of communities is also an important aspect of primary health care.

It is commonly recognized that if the full spectrum of disease — acute and chronic diseases, minor and major ailments — is considered, only part of all personal health care is actually provided by health professionals. The majority of care is self-care or care provided by family members and friends. Unfortunately, there is too little official recognition of this fact by health professionals, planners and politicians. As a consequence, individuals and families are often not given sufficient information to make well

informed choices or to participate on an equal basis with health professionals in decision-making concerning their own health. All in all, therefore, people and their communities are gradually becoming less and less involved in a very important aspect of their overall care.

As a result, many countries have health systems that are not as sensitive to the needs of individuals and families as they should be. In turn, because individuals and families belong to various working, social, recreational, etc., groups, attention must be paid to the feelings of helplessness, anger, dependency and isolation that are often caused when patients are neither given the opportunity to participate in decision-making nor well enough informed to participate effectively. The philosophy of health for all calls for a significant reorientation of the health system, giving more emphasis to integration and coordination at all levels of the health care system; a multisectoral approach to health promotion, prevention, rehabilitation and care; and formal recognition of the greater role that individuals, families and communities can play, wish to play and should have the opportunity to play in health-related matters. In so doing, due account should be taken of the specific characteristics of each country.

In dealing with this wide range of issues, this chapter outlines targets in three major areas:

- first, there are two targets that clarify the overall design of the health care system, the need for health care resources to be allocated according to people's needs and other aspects of the rational use of resources;

- second, three targets outline the essential elements of primary health care: the content, the coordination of human resources and the intersectoral aspects;

- finally, one target specifies the need to ensure quality of care.

Priorities of a health care system

Target 26
A system based on primary health care

By 1990, all Member States, through effective community representation, should have developed health care systems that are based on primary health care and supported by secondary and tertiary care as outlined at the Alma-Ata Conference.

This could be achieved by clear statements from the highest national authorities and political leaders of all levels of authority in the health field, backed by effective legislation, regulations and plans, making primary health care the hub of the health care system, with secondary and tertiary levels in a supporting role and only carrying out those diagnostic and therapeutic functions that are too specialized to be carried out at the primary health care level; the establishment of effective ways and means of bringing consumer needs and interests to bear on the planning and delivery of primary health care; and free discussion with all groups of health personnel, supported by appropriate modifications of health manpower policies and programmes, to obtain their full commitment and support for carrying out this policy in their daily work. Such developments should take due account of the constitutional provisions of each Member State.

Problem statement

Although there are considerable differences among and within countries of the Region, a "centralized" notion of the role of the hospital has characterized the health care system in almost every country during the last 40–50 years. The hospital was considered to form the basis of the system, providing leadership, controlling other levels and generally exercising the main responsibility for the entire range of care.

In many countries, the concept of primary health care has not yet received much attention, and there has been little research concerned with assessing needs or resources. In others, a great deal of thought has been given to defining the functions and responsibilities

of the health care sector, but often less attention has been paid to implementing the changes called for and to integrating the activities of primary, secondary and tertiary levels into a coherent whole. Many countries see the decentralization of health matters as the best approach to achieving this goal and satisfying the criteria of primary health care first described at Alma-Ata. This is probably most readily achieved within the context of a general decentralization of all sectors in the overall national administrative apparatus, but no matter how a system is organized, criteria have to be established and met if concrete goals are to be achieved.

The organization of primary health care varies very much within the Region. In some countries, well coordinated teams of primary health care physicians, nurses and/or midwives form the established and recognized first point of contact with the official health system. In others, access to health care may be through general practitioners, specialists or nurses, all working alone. In many countries, people belonging to special social groups or living in special geographical areas are still without good access to primary health care services, while in other instances only curative services are available, preventive, health-promotive, rehabilitative and care services being lacking.

The organization of secondary and tertiary care also varies. In many places, secondary-level district and local hospitals are part of a regionalized structure, cooperating with primary health care and tertiary units. In other countries, less organized systems are found, based in many cases on the services of individual specialists working alone in the community, and with the responsibilities of individual hospitals poorly defined. A few Member States too small to provide the full range of tertiary services meet their needs through cooperation with other countries. In the great majority, however, tertiary services are found at the national level, and in most at the intermediate level as well.

A fundamental principle of the health for all philosophy is that participation in planning and decision-making is an important process by which individuals and families can contribute to their own development and that of the various communities in which

they live, work, socialize, etc. The form community participation takes will depend on each country's political, social and economic system. At present, it may in some cases be little more than an opportunity to air grievances and complaints, but in many other instances, community participation enables people to become active partners in change instead of passive recipients of someone else's decisions and perceptions.

Suggested solutions

Since the health for all movement started, there has been a shift in orientation. All countries participating in the 1978 International Conference on Primary Health Care at Alma-Ata formally endorsed the concept that primary health care should ensure integrated health care for individuals, families and communities and that it should become the foundation of countries' health care systems. Secondary and tertiary care services should be seen in a supporting role, only fulfilling those diagnostic and therapeutic functions that are too specialized or too costly to be implemented by the primary health care services. Furthermore, the crucial importance of actively involving individuals and the whole community in the planning and delivery of primary health care was stressed.

Building trust and confidence in primary health care among the general public and prestige for it among health professionals is perhaps the most crucial issue and one that requires a long-term, consistent policy. If a reorientation of the health care system is to be achieved, it is clear that new approaches to the training of health professionals, especially physicians and nurses, are needed. Clear statements from political leaders that primary health care is to be considered the true basis of the health care system must be followed through by effective measures that increase the prestige of primary health care and primary health care personnel. The potential of continuing education for influencing the perceptions of practising professionals in this regard and reinforcing the precepts of primary health care learned as students must be acknowledged. The granting of "specialist's rights" to general practitioners, the institution of professorships and the creation of research institutes for primary

health care, the launching of special medical journals for professional discussions on primary health care issues, the creation of "model primary health care areas" where new concepts can be demonstrated and given wide publicity, the preferential allocation of research funds to primary-health-care-oriented research under the auspices of research councils, and the broadcasting of carefully planned mass media programmes on primary health care, are only some of the many actions that must be forcefully and consistently undertaken if there is to be a basic change in public and professional opinion. In particular, there must be extensive exchanges of opinion with professional organizations — medical, nursing, sociological, etc. — to obtain their active support for such a change.

No less important is the development of a clear concept of what the content of primary health care should be, what the essential services to be delivered should be, what kind of personnel should be involved, what roles they should play, and how they should cooperate with individuals, groups and communities. These issues are dealt with at greater length in the text relative to targets 28 and 29.

With those basic concepts in mind, and taking into account the specific conditions in each Member State, a systematic planning exercise, covering all communities in the country and involving local communities and health professional groups, should be undertaken in order to develop a concrete plan as to how the theoretical principles should be turned into practical realities in every community. Needless to say, such planning exercises will have to be organized quite differently in different countries, taking into account their political and administrative systems. Subsequently, systematic changes need to be ensured in the extent of the resources allocated to the primary health care sector, so that it is given preferential treatment with regard to new investments and running costs.

Last but not least, in most countries, extensive changes will have to be undertaken in the present system of educating health personnel, but this topic is dealt with in detail in Chapter 8.

Target 27

Rational and preferential distribution of resources

By 1990, in all Member States, the infrastructures of the delivery systems should be organized so that resources are distributed according to need, and that services ensure physical and economic accessibility and cultural acceptability to the population.

This could be achieved by a combination of planned development and a wide range of carefully designed incentives to direct the necessary health care resources to the primary health care services, in order to ensure that the distribution of the services and the care they provide correspond to the needs of the population; and by similarly gradually readjusting hospital resources, wherever necessary, to form a system whereby secondary and tertiary care resources are distributed in a regionalized system according to needs.

Problem statement

The great difference in socioeconomic development, political systems and administrative traditions among Member States of the Region has resulted in widely varied patterns of distribution and organization of institutions and personnel for health care. In some countries, a well developed system of health centres exists that makes primary health care readily available, while in other countries such services are organized in quite a different fashion. In some countries, hospital services are "regionalized", hospitals of different degrees of specialization being distributed in a country-wide network in such a way as to meet the needs of the population, while in others there is little coordination. Some countries have too few doctors; others have too many in urban areas and too few in remote regions. Similarly, a number of countries have a shortage of nurses or a maldistribution of their services and need more nutritionists, dentists, physiotherapists, social workers, home helps, etc., trained to work in the primary sector.

This problem is often compounded by a maldistribution of available personnel and other resources. Urban areas are generally better served than rural ones. There are also inequities within cities, where poor areas often bear the brunt of the shortages.

Accessibility to health centres, doctors' premises, vaccination clinics or hospitals may be hampered by long distances, poor or costly transportation or by the inconvenient hours during which health services are available. There may be economic, cultural and organizational factors that limit the accessibility and acceptability of health services. For example, although social security entitlements have been steadily increasing throughout the Region, not all countries have comprehensive coverage of the whole population.

Shifts in the financing of health care from the public to the private sector raise very important questions of equity and equality. Language or cultural factors can also have an effect on the use of services, especially when health personnel do not make extra efforts to communicate or understand. Because of religious or cultural beliefs and traditions, some services may be unacceptable to, or deemed unnecessary by, certain groups. Conversely, services that would be useful may not be available. The way in which they are organized or the times at which they are offered may make it difficult to use them as efficiently or effectively as possible.

Suggested solutions

The question of organizing health care resources according to need is currently a major problem in many countries, and decisions to redress the situation will necessitate some painful choices in many instances. Careful attention should therefore be given to what *kind* of changes are needed, and *how* to make them. Three main issues are involved: overall balance in resource allocation, the organization of resources and the acceptability of the services.

First, in almost every country of the Region, hospitals receive the largest — and continuously increasing — share of health care resources. Consequently, many countries have serious shortages of primary health care resources, such as nursing homes, home care services, and suitable care for the mentally retarded, for alcoholics and for drug addicts. Many people who should have been cared for by the primary health care sector now fill hospital beds.

In most countries, therefore, a hard policy decision is needed that gives clear preference in the allocation of resources to primary health care services, thereby cutting down the sums assigned to the

hospital sector. However, it is vital to study such shifts very carefully, so that there can be a gradual change that can alleviate practical local problems that may arise, e.g. in connection with the employment of health personnel in the local communities involved.

Second, there are often problems in the rational utilization of existing resources. At present, the distribution of hospital resources in many countries is badly coordinated, resulting in duplications, underserved areas and groups and/or a waste of expensive resources. Much can be done in many countries in trying to define a more rational organization of the hospital system, where individual units have clearly defined roles and serve well defined populations. Practice has shown that, in many countries, a systematic review of the situation with such principles in mind can release substantial resources. Such institutional resources can often be reallocated to primary health care, reducing the overall cost of the health care system compared with what otherwise would have been the case. The means used in making such changes will depend on the political and administrative system in the country concerned.

Third, although the distribution of existing primary health care resources — in particular, the number of physicians and nurses working in primary health care services — is very uneven in different communities in many countries, experience has shown that ways acceptable both to the public authorities and to the medical profession can be found of ensuring a more even distribution of health personnel based on needs.

In view of the overall economic development in European countries, where this has not already been done, it would seem necessary to undertake some basic revisions of the present system of distributing health care. The overall goal should be improving the quality of services without substantially increasing the overall resources allocated to the health system. Countries without fully comprehensive health insurance plans should undertake to improve coverage, not only for diagnosis and treatment but also for health promotion and rehabilitation services. Much more attention needs to be paid to improving equity of access to health care and health care resources, which in many cases may require

tackling the issues of public versus private funding and the overall control of national resources in their totality.

Characteristics of primary health care

Target 28
Content of primary health care

By 1990, the primary health care system of all Member States should provide a wide range of health-promotive, curative, rehabilitative and supportive services to meet the basic health needs of the population and give special attention to high-risk, vulnerable and underserved individuals and groups.

This could be achieved by establishing clear policies in all Member States with a description of the full range of services that the primary health care system should provide, based on the principle that most preventive, diagnostic, therapeutic and care services and activities could be provided outside hospitals and other institutional settings; modifying basic and continuing education programmes for health personnel to ensure their active support for this development; and reviewing planning, referral and incentive systems to ensure that they support these policies.

Problem statement

A wide range of services and personnel is needed to make comprehensive health care services available to individuals, families and communities. In the developing countries of the Region, variations in the range of equipment, supplies and essential drugs that primary health care personnel have at their disposal result in large differences in the levels of diagnostic, treatment and rehabilitative services available to the population. In the more developed countries of the Region, the situation is somewhat better, although maldistribution and problems of accessibility often exist.

The availability of special types of care, such as home help, half-way houses, day centres or apartments for the handicapped, varies greatly both among and within countries. In many countries,

the shortage of nurses and the lack of well organized nursing services at the primary health care level significantly reduces the possibility of working with individuals and getting to understand their problems in the wider context of their families, their communities and their own lives. This lack of nursing services also limits the range of services that can be brought to the patient's home.

In many instances, people who are no longer capable of caring for themselves could stay at home with the help of home care services or they could live in apartments or nursing homes adapted to their functional needs. These new arrangements should be integrated into the community in which the individual lives, be designed to include a wide range of services, and ensure the maximum possible degree of independence and self-determination commensurate with the individual's functional capacity.

In many countries, rehabilitative services are not well developed. As a result, the period of functional incapacity following illness, especially for the elderly and disabled, is prolonged. People are denied the opportunity to return to familiar surroundings as soon as possible.

Satisfactory genetic counselling services are still lacking in a number of countries. While prenatal and perinatal services exist everywhere, their quality differs, and what is appropriate technology in the care of women before, during and after birth is intensely debated in many countries. In many countries, family planning services and information on, and methods of, contraception are not uniformly available, in particular for young people, migrant workers or immigrants. There is an underestimation of the problems arising from restrictive abortion laws. Information on, and access to, contraception for both men and women may be lacking. Couples unable to conceive may not have access to fertility clinics and people with other sexual problems frequently lack access to appropriate counselling and treatment services. When termination of pregnancy is necessary or desirable, services or personnel may not be available. Where needed, more opportunities to discuss the social, ethical and religious aspects of these questions must be made available, both to health professionals and to the lay public.

Better outreach services are required so that the elderly, single parents, the physically or emotionally handicapped or drug addicts and alcoholics can be helped to cope with their lives. Measures are also needed to determine the geographically, socially or linguistically isolated, the neglected or abused, and the mentally and physically ill who are without adequate access to health care and other social resources.

As regards immunizations important gaps in coverage still exist in many countries of the Region. In some areas, for example, measles and rubella vaccines have not yet come into routine use, and some children still acquire poliomyelitis or die of neonatal tetanus.

The availability of occupational health services varies, and even in countries with better systems, programmes tend to be less developed for small groups of workers, the self-employed and agricultural workers.

Suggested solutions

It is of crucial importance to establish clear policies, outlining what should be the desired situation as regards services to be delivered by the primary health care system. This is also important in countries with less planned systems, which may have to use a more indirect, incentive approach to influence the development.

In the basic shift towards greater emphasis on primary health care, a revision of present concepts is essential, such as what situations pose potential health problems and what should be done at primary, secondary and tertiary levels. While there will be wide agreement that, for example, vaccination is a primary health care task and heart surgery is a highly specialized hospital task, serious doubts can be raised about a part of today's hospital patients and whether they would not be equally well or better served in a well organized primary health care service. In most countries, an answer to the question could be based on a systematic analysis of each patient's needs. Such an analysis should make a realistic assessment of the patient's essential diagnostic, therapeutic, rehabilitative and care needs, seeing the patient as a whole, and of the importance of his or her condition in relation to the home and work environments.

Most preventive and many diagnostic, therapeutic and support services can be offered outside hospitals. For example, minor surgery, physiotherapy, screening and laboratory tests, as well as counselling for health promotion, mental health problems, alcoholism, drug abuse, sexual problems, genetic problems, and family planning services can be provided in various contexts, such as at home and in health centres.

Countries should lay much more emphasis on multidisciplinary evaluative research on these aspects of health care delivery; in such research, effective means of ascertaining users' opinions should be utilized.

Countries will have to determine their own needs and resources and establish their own priorities, but the critical element is the need to offer integrated services. It is the responsibility of countries in accordance with prevailing conditions to define the structure and functions of primary health care units and to take more effective steps to stimulate their development, no matter whether the approach to planning and delivery of health care is more centralized or more decentralized.

Support must be given to primary health care programmes that provide a comprehensive, continuous and well integrated array of health-promotive, diagnostic, therapeutic and rehabilitative services for individuals, families and communities. Special consideration should be given to the elderly, the disabled and the chronically ill, to alcoholics and drug addicts, to minority ethnic groups, and to migrant workers, nomads and travellers. In some cases, certain adaptations of health services will be necessary to meet the needs of religious or minority groups.

Programmes should aim at encouraging and supporting independence and self-determination among individuals, families and self-help groups using these services. For example, legislative or financial support could encourage and foster the development of integrated health and social policies providing chronic care or rehabilitation facilities as well as community support (sheltered housing, home help, etc.) in the community as an alternative to using acute hospital beds for such functions. There will also be a

need for a careful review of planning, referral and incentives systems to ensure that they support rather than contradict (which now is often the case) such a development.

However, the most important step will be to develop basic and continuing education programmes for all categories of health personnel, so as to provide them with the insight, motivation and skill to provide such services in a primary health care setting.

Target 29 ⇨
Providers of primary health care

By 1990, in all Member States, primary health care systems should be based on cooperation and teamwork between health care personnel, individuals, families and community groups.

This could be achieved by policies in the countries that clearly define the role that different categories of health and social personnel should play in health care; basic, specialist and continuing education programmes for health personnel that provide insight, motivation and skill in interprofessional teamwork and in cooperation with individual families, groups and communities; and health education programmes that provide a realistic picture of what services can be expected from health professionals and give help in developing lay care skills.

Problem statement

In most countries, in past decades, health care has generally come to be seen as the prerogative of professionals, and little attention has been paid to studying what people, families and communities do, or could do, for themselves. However, people do, in fact, cope with a wide range of health problems in their daily lives. It is apparent that the majority of minor ailments and many major conditions, including care of the disabled and elderly, are often handled within the family. Although such tasks often place heavy demands on the caring family member or members, such involvement should not, in most cases, be considered only as a burden or a matter of necessity. Self-care is attractive to people because it

involves personal choice, lets people have control of their own bodies and be directly involved in certain aspects of decision-making. As health care systems are usually organized, it may be difficult or impossible for people to participate in major decision-making processes and care is too often felt to be dehumanizing. Since lay people frequently do not have the necessary information to make certain choices, professionals and politicians may make choices on their behalf without always being really aware of what is needed, wanted, acceptable or useful. Improved communication between everyone would contribute to resolving some of these problems. However, politicians, planners and health professionals must recognize how much is being done by individuals and how effective it often is. While not everyone has the training that health professionals have had, this does not mean that lay people lack an understanding of their own problems and how to cope with them. Many health professionals must be educated to a better awareness of the value of patients' contributions and must encourage the participation that this awareness implies.

Major problems are also found in many countries as regards the way that health personnel cooperate — or, rather, do not cooperate — with each other and with other closely related personnel groups, e.g. sociologists, psychologists and educators. In a number of countries, there are still individual physicians who work without a regular exchange of views with primary health care colleagues, who have no personal contacts with physicians in the local hospitals to whom they send patients, and who do not have any systematic collaboration with nurses, social workers or physiotherapists working in the community. Similarly, home nursing organizations, physiotherapists, and so on may likewise work as isolated units without much cooperation with other health personnel groups.

On the other hand, there are also many instances of the opposite, where major groups of health personnel work harmoniously together in teams, supplementing each other's knowledge and skills and making a wider contribution to the solution of

complex problems facing individuals, families and communities. Countries vary perhaps more in this respect than in any other.

Although the situation varies greatly among Member States, there is also a considerable range of types of health care provided outside the official health sector. Some countries find these types of care attractive, while others do not feel that they are necessary or should be acknowledged. However, the fairly widespread acceptance and use of the until recently ignored technique of acupuncture shows the willingness of many countries to adopt new approaches. An important factor contributing to the widespread scepticism among health professionals with regard to such forms of care is the fact that they have rarely been the subject of strict evaluative studies. It should therefore be a basic principle that they should be subject to systematic evaluation and be recognized only when effective, in the same way as the forms of care offered by the established health care system.

Of particular interest has been the growth of self-help groups organized around specific health issues: groups of women with breast cancer, diabetic patients, haemophiliacs' family organizations, etc. Various groups have sprung up around other issues, such as women's groups (concentrating on women's health problems) and environmental protection groups (fighting pollution). Some groups of long standing, dealing with particularly difficult health problems such as alcoholism (e.g. Alcoholics Anonymous), drug addiction and overweight, have developed methods of treatment in a group setting that have proved successful.

Suggested solutions

Two major issues are at stake: how to cooperate well with other health and social workers and how to communicate better with individuals, families, groups and communities.

A major shift is needed in many countries as regards physicians' attitudes and methods in working with other professionals. Educational systems in many countries need to give more emphasis to training medical students in settings that give them a broader understanding of the need patients have for the services provided by nurses, physiotherapists, social workers, etc. Medical students

must be given broader concepts of patients' health and health needs, as well as a better knowledge of the contribution other personnel can make in this respect. As a precondition for such improved understanding, senior personnel in professions such as nursing and sociology must be allowed to have a more direct say in the education of medical students, who also need to be given practical training in teamwork during their studies.

Similar principles also need to be applied to the training of other categories of health personnel.

As for the need for more active cooperation between health personnel and the community they serve, it is important to stress during training how to communicate with lay people, how to recognize what resources exist in the community and how to make more effective use of them. In many countries, health personnel are not sufficiently aware of the extent and type of health care given in family settings or community groups. The need to support individuals, families or groups carrying out particular functions should be considered.

A number of issues must be given closer attention, e.g. how to achieve a symbiosis between the skills and self-help efforts of individuals, families and communities, and the activities of health providers. In most societies, there is a certain tendency to "medicalize" problems and to treat specific symptoms rather than attempt to discover the underlying factors in the social environment and find solutions for them.

Since health professionals are not alone in having this propensity, politicians, professionals from other sectors and lay people must learn to accept that some situations cannot be either quickly or simply dealt with. This will need a change in attitude, a new approach to education and a new understanding of what health and medical services can and should do. Topics for lay people might include ways of handling common diseases and health problems, preventive measures, the early recognition of dangerous symptoms on which professional health advice must be sought, the management of simple ailments and the functioning and appropriate use of the official health system.

Target 30 ☞
Coordination of community resources

By 1990, all Member States should have mechanisms by which the services provided by all sectors relating to health are coordinated at the community level in a primary health care system.

This could be achieved by recognizing the responsibility of the primary health care sector to determine what matters require special attention, change and reorientation, and to coordinate efforts in those directions; and establishing a permanent structure, e.g. a health council, in each local community, where representatives of the community itself, and health and other sectors can make joint analyses of local health plans and determine what contributions each sector should make to improving the health of the community. Such mechanisms should, of course, be developed with due regard to the various constitutional provisions of each Member State.

Problem statement

Consideration of the factors involved in maintaining and improving health makes it clear that the health sector *per se* has only limited influence. This underlies the concept of primary health care that must involve other sectors and community participation, as set forth in the Alma-Ata Declaration.

School health programmes and preschool health and health education activities, which have existed in most industrialized countries for many years, are well known examples of successful collaboration between two sectors. In occupational health and environmental programmes, legislation and statutory provisions have been instrumental in bringing activities closer to those of other sectors. In mass media involvement in education or health advertising, there is some variation in the willingness or ability to coordinate efforts.

However, equally important are other sectors' contributions to health, e.g. the activities of the housing, transport and social service sectors. The problem is not always a shortage of health institutions, emergency transport, facilities or personnel, but a

shortage of other alternatives. Elderly people may become ill with malnutrition or pneumonia because they cannot negotiate the stairs in their apartments to get to the shops or cannot afford to pay for proper food or heating. Physically and emotionally frail or handicapped people could live close to their families in their own communities if support services were available to them or if they had financial assistance.

The proper planning of human settlements could have avoided the unhealthy exposure to industrial pollution, local traffic, noise, etc. that is so prevalent today, and turned neighbourhoods into healthy areas conducive to social contacts, varied physical activity and community cohesiveness.

Suggested solutions

Achievement of this target involves a recognition of the fact that health is not the prerogative of the health sector alone. The changes necessary will vary from country to country according to their present situation and their political system and administrative structure, but health concerns must be systematically reflected in the development plans of all sectors — water, transport, housing, social services, etc. — not only at the national level but in particular at the local level. The basic strategy should be to develop well integrated, community-based programmes combining all aspects of primary health care, with the support of appropriate advisory bodies, such as community health councils, in which representatives of the community, the health sector and other sectors can work together. In so doing, account must be taken of the specific characteristics of each country.

The health sector has an important role to play in coordinating these efforts, in helping to single out the major problems, in suggesting possible preventive strategies and solutions, in proposing shifts in priority and changes in resource allocation, in encouraging other sectors, including the government, to take positive action, in devising methods for measuring the impact on health of resource reallocations and developments in other sectors, and in participating in advisory committees responsible for the necessary assessments.

Quality of services

Target 31 ☞
Ensuring quality of care

By 1990, all Member States should have built effective mechanisms for ensuring quality of patient care within their health care systems.

This could be achieved by establishing methods and procedures for systematically monitoring the quality of care given to patients and making assessment and regulation a permanent component of health professionals' regular activities; and providing all health personnel with training in quality assurance.

Problem statement

The approaches to assessing the quality of health care vary from country to country and even within countries. Often, the level of technical development is used as an indicator of quality, because it is relatively easy to measure the mechanical components of care. But this approach does not allow for any consideration of such issues as overtreatment, iatrogenic disease, the alienation of patients and their families, the unwanted prolongation of life or emotional and financial costs. It sidesteps ethical issues and fosters the belief that only expensive and complex types of treatment and support measures are effective.

Clearly, assessing the quality of health care involves more than measuring the level of technical development or expert skills. It must also measure the effectiveness, safety, efficiency and adequacy of care methods for the needs of the population. The acceptability of services to those for whom they are provided and some assessment of consumer participation, patient satisfaction and the contribution of primary health care to overall socioeconomic development are also vital components of measuring quality. Thus, approaches are needed that will assess not only the technological aspects of health services but also the extent to which the services of a country, community, particular health establishment or individual practitioner meet a variety of needs in an integrated way.

In recent years, there has been a rapid increase both in medical knowledge and in the availability of technical resources, such as drugs and equipment, for health care. In addition to the difficult problems of choosing among several different possibilities for the diagnosis and treatment of a given clinical condition, physicians are under increasing pressure from patients, industry, the mass media and the profession itself to always perform a test, undertake a procedure or prescribe a drug. An increased awareness and acceptance that quality care does not always need highly sophisticated or expensive equipment or medicine is urgently needed.

A large amount of research is currently being conducted in all countries on the question of the evaluation of new methods in clinical medicine. Some of the work is coordinated internationally and some nationally, but too often data are not comparable, thus making the exchange of information difficult and necessitating the repetition of studies. In the vast majority of cases, studies are performed on an ad hoc basis.

In a number of countries and in the case of a few diseases and conditions, "model health care programmes" for the treatment of such common conditions as hypertension or urinary tract infection are being developed as one approach to improving the quality of care. Criteria for treatment are drawn up that try to reflect an awareness of the multiplicity of factors that influence the provision of care: the availability of equipment, personnel, facilities and drugs; the cost of training personnel and providing services; the long-term emotional and physical costs and benefits to patients, health professionals, families and society; ethical implications; future developments; and patient involvement, satisfaction and wishes. In some countries, undergraduate, postgraduate and continuing education programmes include elements of this approach in their curricula, thereby fostering an awareness of the importance of these factors among health professionals.

Suggested solutions

Where needed, and allowing for their particular situations, countries should draw up clear policies on quality assurance in health care. Such policies should state what procedures are to be

assessed, how the assessment should be organized, how health providers, politicians and consumers should coordinate their efforts in this respect and what the expectations and practical consequences of quality assessment will be. Policies will have to be formulated very carefully to ensure the involvement and cooperation of provider groups, researchers, public health authorities and consumers. It should be made clear to everyone that the purposes of quality assessment are not only to evaluate the technical aspects of providing care, but also to ensure that it is a responsibility that all must share. Equally important, quality assessment and quality assurance must be a continuous process and must consider technical, economic, social and ethical factors from the viewpoints of the provider and the consumer. Individuals, families and communities should receive the best possible and most appropriate preventive, health-promotive, diagnostic, therapeutic, rehabilitative and supportive care in a manner that is acceptable to them.

The ways and means used for systematically assessing the quality of care should aim primarily at giving information to individual care providers and units regarding their own performance, as a means towards constant self-improvement.

An important concern should be not only to make sure that each patient receives the level of care required, but also to protect against the unnecessary use of expensive, unpleasant, invasive and potentially hazardous procedures or pharmaceuticals. Furthermore, health care practices should ensure that patients are able to make informed decisions about undergoing procedures by being given sufficient information about the methods proposed to be used, including the effects and risks associated with them and the possible alternatives. Better information of the public in general, better counselling of individual patients in particular, and changes in the attitudes of health professionals will be required to put this principle into effect.

The education and training of health personnel will need to give more emphasis to the question of the quality of services, including their acceptability to patients and their relatives. More attention

will have to be paid to the humanization of services, especially when attending the most important events: birth and death. Satisfying conditions of delivery that avoid unnecessary "technicalization" should be offered to pregnant women, and people must be given the opportunity of dying with dignity. In this respect, particular attention must be paid to cultural and religious requirements.

By intensifying their efforts to achieve the systematic evaluation of different types of care and by making the results of such evaluations widely known, countries would take a very significant step towards ensuring greater equality in patient care.

7

Research for health for all

The previous chapters of this book have reported serious gaps in the knowledge needed to attain many of the targets. It is because those gaps must be filled that stress is laid on the vital importance of research as a support for the development of health for all.

In this chapter, research is discussed in relation to health for all, i.e. as a process of obtaining the knowledge needed to attain the targets set forth in this book and of understanding how that knowledge can be applied. This concept has several implications for the orientation of health research.

First, a key element in any successful strategy designed to meet the challenge of attaining health for all by the year 2000 must, in view of the short period remaining, be the application of the knowledge that already exists. It is probably safe to say that if the knowledge already available were put to good use throughout the Region, the goal of health for all would not be so far away. Thus, the first priority of a research strategy in support of health for all is to understand the reasons why this knowledge is not applied and find ways of overcoming them. However, the acquisition of new knowledge in all areas influencing health is of crucial importance and must continue. It will help to bring us even closer to our goal and provide a basis for further improving the health of the population even beyond the year 2000.

Second, one of the most important aims discussed in this book is the promotion and maintenance of health and the prevention of disease. While it is vitally important to increase knowledge that will

make it easier to intervene in already established diseases, what is immediately needed is research that will provide a better understanding of the factors that contribute to health so that the onset of disease can be prevented and people can make better use of their own capacities for health. Another crucial problem dealt with in this book is how to reduce health inequalities, and one of the major research challenges is therefore to find ways to improve the health of those currently most disadvantaged.

Third, given the great extent of the knowledge needed, efforts should be directed towards drawing full benefit from the vast amount, quality and variety of expert knowledge and experience available inside and outside the health sector. Thus, a research strategy in support of health for all should also concern itself with ways and means of using to the fullest extent possible the knowledge obtained in the course of scientific investigations, professional practice and people's experience in all areas related to health.

Target 32
Research strategies

Before 1990, all Member States should have formulated research strategies to stimulate investigations which improve the application and expansion of knowledge needed to support their health for all developments.

This target can be achieved if Member States establish machinery to ensure the effective application of new knowledge in the development of health policies and programmes; determine what gaps there are in the knowledge needed to support the strategy of health for all and set research priorities accordingly; ensure a balanced representation of all academic disciplines relevant to health and of providers and users of health services as well as health policy makers, in the planning and coordinating of research for health for all and make the research community an active contributor to the development of health for all; stimulate relevant multidisciplinary research; and allocate sufficient resources to conduct the research needed, giving preference to aspects that have not received the support they deserve.

Problem statement

Six broad areas of study will provide the knowledge needed to implement health for all strategies:

- a description of the health of the population in all its facets;
- ascertainment of the biological factors that determine health;
- determination of the role of lifestyles in maintaining health;
- determination of the ways in which the physical, psychological and social environment, including the prerequisites for health, influence the health of individuals and of populations;
- the devising of effective and efficient ways of providing people with appropriate care;
- improvement in policy-making procedures, planning and management in regard to health for all.

Research is needed to provide a more comprehensive picture of the health problems facing countries and groups within countries and the health risks to which they are exposed. Mortality data have been extensively used to describe people's health, but knowledge is needed on the course of morbidity and disability, especially in relation to those population groups whose health deteriorates more rapidly than others. A great deal of research is needed to test existing and develop new methods in order to obtain valid and reliable information on all aspects of health. Member States would then be better able to set priorities, plan activities, monitor progress and evaluate results.

Knowledge is also needed on patterns of consumption of goods and services, lifestyle practices and exposure to environmental risks. In order to obtain this knowledge, data collection systems are needed that will improve understanding of the relationships between these different phenomena and of their separate and combined effects on health.

More knowledge of the biological characteristics of the human body is needed. A major priority is to determine the ways in which

the human organism reacts to external factors and thus to find out why there is a variation in the individual response (neoplastic growth, the arteriosclerotic process, immunodeficiency, etc.) to various pathogenic, toxic and other agents.

Improved understanding of the reproductive, growth, defensive and repair processes could lead to new health-promoting and preventive measures as well as to better methods of diagnosis, treatment and rehabilitation — not least in ways that can reduce disability. Recent developments in molecular biology and immunology have provided new tools and hypotheses, and they may lead to a better understanding of various autoimmune diseases as well as the immunodeficiencies that sometimes develop in later life. Recent biomedical research has opened up new prospects of finding ways of dealing with certain disabling neurological disorders. The investigation of inflammatory processes has advanced significantly and the results could be important, especially in regard to degenerative diseases of the joints, one of the major causes of disability in the elderly. Biomedical research is increasingly profiting from advances in other scientific disciplines, such as genetics, chemistry, cell biology, computer science and fibre optics, which increase the likelihood of significant contributions from research to the development of health for all in the years ahead. The further development of genetic engineering may lead to the mass production of low-cost vaccines against malaria, viral hepatitis and influenza, as well as to the improvement of several already existing vaccines against other infections.

A better understanding is needed of the influence of lifestyles on health. Investigations should be undertaken to determine the separate and combined effects of specific types of behaviour on health and to understand what factors determine each type. As examples, studies are needed to determine the effect of early learning, peer pressure, patterns of coping, social support and environmental conditions on lifestyles and on the capacity to change behaviour. An important question for research is why people, in spite of knowing the consequences, behave in a way that is hazardous to their health, e.g. by overconsumption of alcohol, smoking

and dangerous driving. In this connection, research is also needed regarding effective methods of providing the public with information. Questions that require investigation are how both the content and the presentation of information can be improved so as to increase public comprehension of and involvement in health promotion and the protection of the environment.

The interrelationships between the psychological, socioeconomic, cultural and physical characteristics of people's environment and health and disease are also in dire need of scientific investigation. Studies in which variables in the social environment have been examined have resulted in a realization of the importance of situational stress, especially in family life and at work. Intensified research is needed to reach a better understanding of the effect of unsatisfactory and stressful conditions and situations. Progress in this respect will help clarify aspects of mental illness, social violence and suicide, regarding which current methods of obtaining information are far from satisfactory.

Special attention should be given to the effect of underemployment, overemployment or unemployment on health. Research is needed to disentangle the complex relationship between human settlements and housing design on the one hand and social and family life on the other. With regard to the physical environment, more research is needed on the cumulative risk of low-level, long-term exposure to dangerous substances, including the combined effects of exposure to a number of different physical, chemical and biological agents, whether at work, in the home or outside. Studies are also required to develop better methods for analysing, monitoring and assessing the various environmental health hazards.

Further research on the organizational aspects of health services is needed to increase the efficiency and effectiveness of the services as well as the satisfaction of the consumers. Research projects are needed to determine how best to focus the health system on health promotion and primary health care, and what organizational arrangements will produce the best mix of services for effectively meeting the needs of the population.

Studies are needed to evaluate the effectiveness and efficiency of health services, procedures and products. In this connection, priority should be given to examining present ways of looking at health and present methods of promoting health, and preventing and treating disease. Special importance should be attached to effective methods of testing claims as to the benefits that will accrue from new types of health intervention. This includes assessing the cost-effectiveness of technology at all levels. Particular attention should be given to assessing new technology from the patient's point of view, so as to determine the truth or otherwise of the criticism increasingly heard that many modern health techniques do not pay attention to the human factor. Investigations should also be undertaken to unravel the intricate skein of factors responsible for the escalation of health care costs and to find ways of using resources more effectively. Controlled trials should be encouraged to develop alternative ways of meeting health care needs, ways that are less costly but just as effective or acceptable.

Finally, research is needed to find more effective methods of planning the changes suggested in this book; such methods should be fully adapted to the differing sociopolitical conditions in the various countries of the Region. Better knowledge is required to make the training of health personnel more compatible with the functions of primary health care and effective work in multidisciplinary teams. Research is also needed to find the best ways and means of ensuring effective community participation and multisectoral collaboration at all levels in the health system.

In each of these major areas, a great deal of knowledge awaits application. As already mentioned, the reasons why available knowledge is often not translated into action are not fully understood. There might sometimes be a failure to communicate the knowledge to those who can act upon it, but there could also be a lack of awareness of the benefit to be obtained from applying it or there may not have been sufficient practical experience collected to substantiate the claims that have been made. Even in areas where awareness and proof do exist, there are often important political, social, economic or organizational constraints on the application

of the available knowledge. Existing laws and regulations may impede the application of recently obtained knowledge. Vested interest groups may gain social, political and economic benefits from the status quo and may lobby against the application of the new knowledge. All these constraints need to be better understood if ways and means of effectively overcoming them are to be found. These are questions for research.

As shown, there are gaps in knowledge of the way health is built up and of how different factors interact to develop, maintain and restore it. The methods at present used in treating individuals and solving community health problems also require further study with a view to their improvement.

At the moment, however, research efforts are concentrated on the basic biomedical sciences, while in most countries much less research is being done on lifestyles and health, environmental risk factor control and health services research, fields in which it is urgently needed. In many countries, not enough is yet being done to set clear priorities for health and health-related research based on the most important problems that come to light in the national health planning and evaluation process. There is still, in many countries, very little *systematic* review by policy-makers of new knowledge arising from research projects — knowledge that could influence health policies and programmes. This lack of coordination is often the result of weak organizational links between the research community and health policy-makers, both within and among countries. In fact, major decisions about health priorities, policy and programmes need an adequate scientific basis that should be provided by appropriate research that is often lacking.

To carry out the research required, studies are needed in a wide range of subjects. The research potential of the various branches of scientific study and of projects to which several of them make a contribution is often underexploited. Moreover, there has been no systematic attempt to make efficient use of the contribution that could be made both by the health care providers and by the broader public in defining research questions and analysing the implications of applying new-found knowledge.

Research themes have often been too narrowly defined. In many cases, it is essential to move beyond simple models based on correlations between individual risk factors and negative impacts on health to models that represent the complex reality of multiple causation. Perhaps even more important in this respect is collaboration among researchers in interdisciplinary projects. This kind of collaboration is often weak or nonexistent, thus reducing the possibility of exchanging and developing ideas, approaches and methods that will produce a better and more comprehensive knowledge of health and its determinants.

In some instances, not enough consideration has been given to the ethical, social, environmental or economic consequences of advances in knowledge.

Finally, most countries of the Region have a fairly extensive health and health-related research programme, and their support for research has increased significantly in the past two decades. Attainment of the targets will be made significantly easier by an increase in the resources devoted to research. Many of the areas in which new knowledge is required to support developments for health for all have generally been neglected or have received low priority and thus insufficient funding. In most countries, research funds need to be reapportioned to give more weight to the new priorities. To what extent this will lead to a reduction, a maintenance or an increase of funds for *present* research areas will depend on the overall limits of research funding for the health sector.

Suggested solutions

A prerequisite for the important first step of drawing up research strategies to support health for all is the existence of clear strategies for health for all. It is the responsibility of government bodies to develop both the general and the research strategies for health for all. The research strategies should define the major areas where knowledge is needed, how the research to obtain it should be developed and what institutions should be involved, how the knowledge obtained should be put to practical use, what resources should be used, and what arrangement should be made for evaluation and quality control. How this is done in practice will vary

from country to country, depending on the particular features of each. However, as a general principle, systems should be established (e.g. in the form of a council with working parties) through which researchers, health care providers, user groups and public health administrators can all contribute to the development of research strategies for health for all.

It is of the utmost importance that scientists and health policy-makers should regularly review new knowledge emerging from research projects that could be of use in drawing up health policies and conducting health care programmes. It would be easier to carry out such joint reviews if an appropriate body were set up, but what is needed, above all, is a better understanding on the part of policy-makers and researchers of their respective role and needs. Policy-makers need the time and adequately trained advisers to fully understand and foresee the practical implications of new knowledge coming from research, while researchers must be better aware of the need to demonstrate the practical value of their research results and to develop the ability to do so effectively. The research community would then become an *active* partner with health officials, not only in the planning of research but also in contributing to health development policies.

Ways must be found to encourage researchers to play a full part in the drive towards health for all and to take up questions related to countries' priorities for health for all. If full benefit is to be obtained from the vast amount of research capacity available, research establishments must be actively involved in discussions on health for all, including the regional strategy, its targets and the research needed to attain them. All media of communication must be used to the utmost for this purpose. Constant efforts will have to be made to ensure that the scientific community is fully aware of the importance of expanding knowledge on matters of importance for health for all.

Ways and means must be found to stimulate research on health for all issues involving different disciplines and professions within and outside the health sector. Universities and other research establishments may wish to review their present arrangements so as

to allow for and stimulate research activities involving several faculties and different institutions. If they are to play an effective part in influencing the society around them, the establishments must find ways of bringing their various capacities and resources to bear jointly on the problems facing that society. Health research councils or similar bodies should be multidisciplinary in composition, so as to possess the range of expert knowledge needed to assess the quality of health research and be aware of the merits and limits of the approaches and methods used in the various types of health and health-related research.

Methods should be devised to ensure that the research carried out is of high quality. Of crucial importance is the basic training, further training and career structure available for research workers. Here again, universities and other teaching institutes have a vital role to play.

Last but certainly not least, there must be ways and means to monitor research and development in the field of health from the viewpoint of ethical standards and social, economic and environmental consequences. The development of standards of "what should be" and "what should not be" requires constructive coordination among various sectors of the community and should involve different disciplines and different sets of values. It is not the primary task of the scientific community to develop ethical standards for the conduct and utilization of research in the health field, but it is its responsibility to point out possible ethical and social consequences and to consider and propose rules and mechanisms that will ensure that, whatever research is performed and whatever results are obtained, they do not infringe on recognized international ethical standards.

It is clear that the public sector will have to make a substantial contribution to the financing of this research. Behavioural and health policy research are more dependent in most countries on public funding for their development, and countries should give them due priority in public research allocations. Financial incentives and opportunities should be provided to enable researchers on these subjects to carry out their work. A major effort

should be made to inform research funding agencies about the countries' strategies for health for all and the research needs that arise from them with a view to obtaining their financial support.

At the regional level, steps should be taken to establish closer links between the European Advisory Committee on Medical Research (EACMR) and countries' health research bodies. The EACMR is to produce before the end of 1985 a broad analysis of research priorities related to the regional targets for health for all for submission to the Regional Committee. This regional research plan for health for all will be widely disseminated among the European research community and will form the basis for discussions between the EACMR and academies of science or health research councils on their research plans, and for drawing up regional research programmes and projects in support of the regional strategy for health for all.

An effort should be made to increase the resources available for stimulating priority research in support of health for all in the Region. A feasibility study is being conducted to see whether a European health research fund should be established for this purpose or whether alternative ways of improving funding should be found.

The European Region has a great tradition of obtaining important new knowledge through research. Planned concentration of the resources of the Region on problems of health for all will go a long way towards attaining the ambitious targets outlined in earlier chapters of this book.

8

Health development support

The attainment of the targets set out in the preceding chapters will require a fundamental change of attitudes and working practices among politicians, health authorities, health personnel, people in other sectors and, above all, the general public.

However, change will not occur by itself. It requires strong political commitment and legislative support, ways and means of bringing it about that are adapted to the characteristics of the country, a good information base, health personnel capable of playing their part in the process, personnel in other sectors willing and able to cooperate, and an array of good health care techniques and methods as tools. This chapter deals with the individual targets set in each of these areas. How to ensure the most important asset of all — an educated and cooperative public — has already been dealt with in Chapter 4, in target 15 in particular.

All the targets in this section will have to be reached much earlier than those dealt with in the previous chapters, as the support measures with which they are concerned are all prerequisites for a successful health for all development process. The degree of change to be introduced in these domains will depend on the present stage of development and on the constitutional provisions in the individual country concerned. However, no Member State could at any moment say in all good conscience that its system does not require substantial improvements.

Health policy formulation

Target 33 ☞
Policies for health for all

Before 1990, all Member States should ensure that their health policies and strategies are in line with health for all principles and that their legislation and regulations make their implementation effective in all sectors of society.

This could be achieved if all countries were to make a systematic review of their health policies and health legislation in the light of the regional health for all strategy and targets, and to develop health for all strategies and targets and amend or extend their health legislation accordingly, taking due account of the specific legal, political and structural conditions in each Member State.

Problem statement

Given the magnitude of the change needed, it is vital to mobilize political commitment to and support of the health for all goal and all that it implies in all groups and organizations concerned.

The 1983 report from Member States of the European Region on monitoring national progress towards health for all indicated that, while no country had yet drawn up specific countrywide health for all strategies covering all the main items dealt with in the regional strategy adopted by the Regional Committee at its thirtieth session in 1980, some governments had recently instituted the systematic planning process required to produce such health for all strategies. Nevertheless, it is clear that even in those countries the fundamental change that the drive for health for all entails will require the launching of a broad campaign, in a form appropriate to each country on the basis of political decisions taken by the government as a whole and which apply to all sectors, at all levels, national, regional and local. One of the first steps must be to enlist the support of political, social and community leaders, health organizations, the professions and the mass media.

A problem already mentioned in this regard is that too often health tends to be seen as essentially the responsibility of health

professionals and not primarily that of the people themselves, their families and their communities. Furthermore, the importance of the prerequisites for health, of individual and collective lifestyles and of specific environmental conditions is also often severely underestimated.

Many governments do not have all the legislative powers they need to attain all the targets mentioned, and in many instances existing laws may even hamper progress if they have been built up on the basis of uncoordinated and ad hoc decisions. Some may be difficult to enforce because they are too complex, because they have failed to gain professional endorsement or because the necessary logistic support is lacking, while others are so specific that they hinder the coordination that is so essential among ministerial departments responsible for health and health-related regulations.

Suggested solutions

The ministry of health or other authorities responsible for promoting and sustaining the development of health policies should take the initial steps to ensure that, if it has not already done so, the government commits itself unequivocally to the objective of health for all, thus making health a key concern for all sectors of society. The commitment could take the form of a statement by the head of state or parliament, perhaps even of an amendment to the constitution, or of other legislative measures. This should be followed by the adoption of strategies for health for all. In countries with less centralized or federal systems of government, the full mobilization and participation of subnational and local authorities is essential for the development and implementation of the strategy.

In all countries, efforts should be made to enlist the support of political parties, religious and civic leaders and other public figures, trade unions and influential nongovernmental organizations. Such popular support could be mobilized by setting up special associations solely to promote the goal of health for all and its realization. Health professions, other social groups and, in particular, community organizations should also be encouraged to give strong support, and extensive and sustained mass campaigns should be undertaken to ensure wide and active support among the public.

Governments, as part of their important function of mobilizing professional and public support for and participation in the development and control of the new health policies, may find it useful to establish or strengthen national, regional and local advisory health councils. Such councils could be particularly valuable in ensuring that the development of health systems forms an integral part of overall social and economic development. They might be composed of personalities representing a wide range of interests in health and in political, economic and social affairs, as well as members of the public. In this context, the whole range of policy questions affecting health and socioeconomic development could be explored jointly, thus making health leaders more aware of social and economic realities and social and economic interest groups more aware of health realities. In the process, they will gain a better appreciation of the difficulties and opportunities facing individuals, families and communities.

In most Member States, health legislation needs to be strengthened and decisive action taken to harmonize legislation with the new policies of health for all collectively endorsed by Member States and adopted nationally. Legislation would in this way become a true expression of their health policies.

In ensuring that legislation is implemented, political will and community acceptance are essential, but legislation can also be used to strengthen such will and acceptance. This should be borne in mind when drafting health legislation.

In the European Region of WHO, the strong collective political commitment of Member States is essential to provide a stimulus for the collective action that is required. The Regional Committee has a fundamental role to play in leading the health for all movement. The adoption of the worldwide goal of health for all by the World Health Assembly in 1977 provided the first stimulus, later reinforced by the endorsement of the first regional health policy — the regional strategy for health for all — by the Regional Committee in 1980. This regional health policy was further strengthened when, at its thirty-fourth session in 1984, the Regional Committee adopted the regional targets for health for all.

Managerial process

Target 34
Planning and resource allocation

Before 1990, Member States should have managerial processes for health development geared to the attainment of health for all, actively involving communities and all sectors relevant to health and, accordingly, ensuring preferential allocation of resources to health development priorities.

Such a process should cover the systematic planning, monitoring and evaluation of health for all activities, with due regard to the specific legal, political and structural characteristics of each country.

Problem statement

Management in many countries is still concerned mainly with the functioning of the health care system more than with determining where the health system should be going and whether it is going where it should. When such questions are raised, it is often mainly in terms of the resources needed to provide health services, in particular hospital care. Far too rarely are they formulated in terms of the levels of health to be achieved and the basic health problems to be solved. Managerial processes for health development at various administrative levels are usually concerned with the short-term task of solving problems that have already occurred rather than with long-term considerations. Finally, in many countries, there is a lack of adequate coordination with other sectors or local communities and of efforts to involve them in the process.

Often, present management systems do not bring resource allocation in line with sound planning principles. Furthermore, budgeting systems may have to be adapted so that budgets are based on priority programmes and services, not merely on health institutions.

As of 1983 countries started to monitor systematically their progress towards health for all, and regional and global indicators have been developed for this purpose. In resolution WHA37.17 the

World Health Assembly urged Member States to "accord the highest priority to and assume full responsibility for the continuing monitoring and evaluation of their strategies". The results of this evaluation will be reported to WHO at six-year intervals, starting in 1985.

Suggested solutions

To help formulate, implement and evaluate strategies for health for all, countries will have to develop or strengthen their current managerial processes for health development. The European Conference on Planning and Management for Health, held in The Hague in August 1984, formulated specific recommendations to Member States in this respect. Managerial processes for health development should comprise all approaches aiming at promoting health, improving equity, and increasing the effectiveness, efficiency and quality of health systems, whether such approaches take the form of a comprehensive, systematic health plan or consist of less structured rules, regulations and incentives. Managerial processes should be outcome-oriented in terms of reducing health hazards and improving of health status, and be capable of selecting long-term solutions that favour health promotion and the prevention of health problems. They should also be amenable to cost-effectiveness analysis. An appropriate managerial process ought to reconcile long-term outcome and strategic thinking with short-term objectives and day-to-day problem-solving. A multisectoral approach to planning and management for health is considered essential, as is the necessity of ensuring effective mechanisms for the participation of users and providers in the health development processes.

Recognizing that all health systems have varying degrees of centralization and decentralization of their decision-making process, the Conference stressed the need for flexibility, so that countries should strive towards an optimum balance, given their own legal, political and structural systems. Whatever balance is designed, countries should ensure the assignment of clearly defined functions and responsibilities at every level, together with the necessary authority and supporting information services.

Whatever the precise nature of its health development and the administrative level concerned, each country should thus define

objectives and targets to reach health for all. It should indicate the main types of activity to be undertaken in the health sector and other sectors of relevance to health and the authorities responsible for carrying them out. It should set forth the measures required to develop or strengthen a health system based on primary health care and to link the different levels within it. Priorities in the allocation of resources for the strategies and the way in which its implementation and results should be monitored and assessed should be clearly indicated, so as to improve the effectiveness of any changes found necessary and increase the efficiency of the methods used to bring them about.

To ensure better management practice, ministries or departments of health may wish to use a network of experts and institutions to help in developing and applying appropriate managerial processes for health development and to give adequate training to all those who will be actively involved, nationally, regionally and locally, in the process of change. To ensure that national policies and/or policies at lower levels are in line with local community needs, health authorities may reconsider, in accordance with the country's political and administrative setting, delegating certain responsibilities to intermediate and community administrative bodies. By doing so the cooperation between sectors could be eased and local authorities would be encouraged to develop their own initiatives. The managerial processes should not ossify into a rigid bureaucratic system, but should make full use of formal and informal channels and encourage the broad participation and cooperation of providers and consumers of health services. Such managerial processes need to be compatible with and part of the existing administrative system of each country. The community should play an active part in decision-making and assume a bigger responsibility for implementation and evaluation.

Irrespective of the type of approach a country considers appropriate, emphasis should be laid on continuous and thorough evaluation and, wherever necessary, reprogramming should be undertaken according to the agreement now reached among all Member States.

Resources for socioeconomic development should actively support health and health-related measures. This does not necessarily mean an increase in expenditure: more resources could be allocated to health-related activities within each sector concerned and efficiency could be improved. Within the health sector, resources should be preferentially allocated to the local communities to develop or strengthen primary health care, especially promotive, preventive and rehabilitative services and possibly support to families and self-help groups. The attainment of the targets will help curb the increase in health care costs, and thus enable countries to keep them more in line with the general increase in national resources.

The developing countries of the Region are an exception, however, and will quite clearly need substantial additional resources.

To back up efforts by countries to develop and strengthen their managerial processes, WHO should continue its efforts to support them on request and encourage the international exchange of information and expert knowledge. Regionally coordinated research should be conducted to develop more effective management techniques for solving conflicts among institutions, organizations and sectors, and to find better ways of achieving community participation. A regional network of national institutions will be used by WHO for developmental and educational activities in support of the managerial process.

Target 35 ⇨
Health information system

Before 1990, Member States should have health information systems capable of supporting their national strategies for health for all.

Such information systems should provide support for the planning, monitoring and evaluation of health development and services, the assessment of national, regional and global progress towards health for all and the dissemination of relevant scientific information; and steps should be taken to make health information easily accessible to the public.

Problem statement

Health information systems range in complexity from general practitioners' book-keeping to highly sophisticated computer-supported hospital information systems. However, health information systems in the countries are often based on the collection, analysis and publication of statistics that are not very well adapted to management needs. Even in the case of the epidemiological surveillance of diseases, the responsibilities are often divided among different institutions with insufficient coordination. Information systems for hospitals and primary health care, where they exist, are sometimes incompatible.

Moreover, the main premises of the strategies for health for all make new types of information necessary, e.g. information related to lifestyles, preventable risks, services provided outside the official health care system, patterns of service use, cost-effectiveness, and the functional ability of patients, which are not routinely available. This also applies to material on health promotion and health-related issues from other sectors.

Communication with the public is essential if there is to be more awareness of the problems and more political support. The public not only needs greater access to health information but also needs that information in a form it can use.

The health sector will have to adapt to the rapidly increasing automation of information and to the advent of the microcomputer. Long before the year 2000, the home computer will have become almost as common as the telephone in many countries of the Region, and individuals and communities may expect to obtain their health and health-related information direct from data bases.

Suggested solutions

All countries should make an extensive review of their health information systems and adapt them to the needs of their strategies for health for all. Such systems should be so integrated — or at least coordinated — as to meet the requirements for planning, management and evaluation, support the epidemiological surveillance of diseases and risk factors, and be a source of open information easily accessible for the scientific community, the professions and

the public at large. Only through this sharing of knowledge can these different groups become active and informed participants in a joint partnership for health development.

The existing information should be made more accurate and useful by the development of methods of collection, analysis and presentation as well as the promotion of research on health indicators. WHO should initiate collaborative research projects in these fields.

As stressed in Chapter 7, more knowledge is required of the effects on health of many factors and of their possible combinations in the physical and social environment. Research must also be developed with regard to the measurement of health status and health resources and their utilization, with a view to devising better indicators of morbidity, disability, positive aspects of health, perceived health status, and the quality, accessibility and adequacy of services. In all cases where routine data collection cannot satisfy information needs, the use of censuses and random surveys must be encouraged. To avoid unnecessary expenditure, relevant data should be extracted as far as possible from the findings of existing population-based surveys in the health and other sectors. In some cases, it could be useful to organize comparative intercountry surveys with the support of WHO, every country using the same methods.

For monitoring and evaluating progress in national, regional and global strategies, Member States will have to give priority to the collection and analysis of information related to the targets and indicators adopted. They must realize that this effort will be subject to technical, economic and sometimes political difficulties. It is, however, essential that all Member States unite their efforts and exchange their experience so that they can agree on the minimum common set of indicators to be used for monitoring and evaluating the regional strategy. The regional exchange and dissemination of information should be further strengthened on the basis of existing national institutions that specialize in the collection and analysis of information in the relevant fields.

Public information methods should be reviewed and improved and more use made of modern ways of communication by the

promotion of direct access to information bases and the more effective involvement of the media.

Human resource development

Human resources will play a key role in achieving health for all by the year 2000, and governments, while avoiding wasteful overproduction, will have to take vigorous but carefully planned action to ensure that there will be enough health personnel of the appropriate types to implement their strategies. Likewise, steps are needed to ensure that key personnel in sectors other than health are encouraged to apply the principles of health for all effectively in their own sectors.

Target 36
Planning, education and use of health personnel

Before 1990, in all Member States, the planning, training and use of health personnel should be in accordance with health for all policies, with emphasis on the primary health care approach.

This can be achieved if all countries analyse their needs for the different categories of health manpower required to implement their policies of health for all, adopt suitable health manpower policies, and decide on the numbers and educational qualifications required for each category of personnel.

Problem statement

The main problem of the health manpower development system in many countries of the Region is that planning does not always fully reflect needs. There may be wide divergences between academic training goals on the one hand and service requirements, consumer expectations and the general socioeconomic situation on the other.

Most of the countries in the Region now have over 200 physicians and 400 nurses and midwives per 100 000 inhabitants. Between 1965 and 1978, there was a high rate of increase in such

health personnel, in some countries over 70%. There was a smaller, though still considerable, increase in the number of dentists. In many Member States, the number of doctors is increasing at such a pace that several countries have already taken measures to reduce future output. In at least eight European countries, physicians are now having difficulties finding employment, and the situation is similar for dentists (owing to the effectiveness of dental caries prevention programmes). The number of health personnel is often determined mainly by the availability of people with the required educational background who wish to undergo a particular form of training.

In general, there is a gross maldistribution of physicians and dentists, who tend to congregate in cities. Even in the cities themselves, distribution is far from equitable, so that it is almost the rule for slum areas to be underserved. Large differences also exist in the ratios to population of pharmacists, nurses and midwives, but comparisons are difficult owing to the incompleteness of the statistics and to differences in the tasks allocated to the different categories.

Suggested solutions

Health manpower planning Clear health manpower development policies should be established in every country — due account being taken of specific characteristics in each of the Member States — in order to ensure the coordinated training of health personnel in the right numbers and with the right qualifications to meet the needs specified in our health for all strategies. When health needs are being assessed, due account should be taken of the findings of epidemiological and health services research. The type of coordination machinery will depend on the national political structure and health manpower system, but it must cover all health training establishments.

Well thought out collaboration and coordination in the development of health services and health manpower among the different responsible bodies would put an end to oversupply, overspecialization and the improper utilization of personnel. All Member States should develop the training programmes required

by their health manpower plans, particularly by making training more relevant to primary health care. The capacity of the educational system to respond to the changing needs for certain types of health personnel should be strengthened. This will help to ensure appropriate staffing of the primary health care services, but will require cooperation at all levels among decision-makers in health and education as well as in other sectors concerned directly or indirectly with health development. In countries with state-run systems, such coordination will be easier than in other types of society, although a proper balance between incentives and regulations will achieve results in any system.

With a view to attaining health for all by the year 2000, the training programmes should be reoriented to satisfy the health needs and demands of individuals and communities and not primarily to conform to professional interests. For that reason, the health sector as well as the educational sector should be responsible for and play an active part in deciding questions of syllabus content. The health system should provide students with the opportunity to be exposed during their formative years to the realities confronting primary health care personnel, so that they acquire skills and technical competence to deal with the most basic and common health problems facing people and communities.

There should accordingly be a systematic review of undergraduate and postgraduate syllabuses for different categories of health personnel in order to discuss any changes that may be needed in curricula, training methods and the ways in which the numbers trained are matched with anticipated needs. The teaching of medical and allied sciences should be community-oriented and should pay close attention to local health-promotive, preventive, curative and rehabilitative activities. Account should also be taken in medical education of the findings from research on the health needs of the community.

Basic education In view of the need to make basic education for the health professions more responsive to primary health care and community needs, teachers should be better trained in ways of bringing students into early contact with primary health care

activities and in designing curricula and syllabuses that make it simpler to educate them for their new tasks.

Support will be given to educational institutions and programmes, especially in the training of front-line workers and their supervisors, and emphasis will be laid on the importance of teacher training in this context.

Continuing education Systems of continuing education should be developed that will allow practising health professionals to bring their work more closely into line with the health needs of the population and to improve their qualifications. Continuing education programmes should take into account the need for existing health workers to adapt themselves to the changing patterns of health care and public health administration and to give better service to the community. Since most of the health professionals who will be working in the year 2000 are studying now or have already completed their studies, continuing education syllabuses will be needed that take into account changing national health needs and policies for health for all and lay emphasis on primary health care. For this purpose, new methods, including self-learning techniques, must be developed, and individual members of health teams must be given an opportunity to learn how to solve problems of common concern to all the team's members so that they become better aware of their role.

Target 37
Education of personnel in other sectors

Before 1990, in all Member States, education should provide personnel in sectors related to health with adequate information on the country's health for all policies and programmes and their practical application to their own sectors.

This could be achieved if public policy stressed that health protection was also a key concern for sectors other than health, and if training programmes for the personnel in such sectors stressed the reasons for actively supporting health for all activities.

Problem statement

The strategies for health for all rely heavily on action in sectors other than health: the provision of adequate and safe water and food, the design of safe homes and population centres, the education of children that enables them to make wise choices regarding lifestyles, the reduction of alcohol consumption and smoking, greater social equity in the distribution of resources, etc. These are all domains in which it is other sectors that will have the major role to play.

The degree to which they respond effectively to this challenge will depend on several factors. Of key importance is a firm statement by a country's highest authorities (see target 33) that health is an important concern for all sectors, as well as the readiness of the health sector to discuss this point with other sectors. It is also important that the public and the media should understand the positive effects on health, in particular at the local level, that intersectoral cooperation can exert.

Suggested solutions

Training programmes should be carefully reviewed in the light of countries' health for all policies and programmes.

Basic and continuing education programmes for personnel outside the health sector should be based on a careful analysis of the ways in which their activities may affect the drive towards health for all. The programmes should not balk at innovation and should inspire trainees to act. This will require much closer cooperation between those in the health sector responsible for policy-making and education and their counterparts in other sectors.

As will be apparent from the previous chapters, particularly those on lifestyles and the environment, policies for health for all present personnel in health and other sectors with many new challenges.

When designing housing or planning population centres, architects should take into account not only their effect on general wellbeing but also the need to improve accident prevention, social contact and health-promoting activities. Teachers should master techniques of helping children develop a capacity for making sound decisions and choosing healthy lifestyles; they should also understand the crucial influence their own behaviour has on the

children they teach, particularly with regard to adopting a lifestyle. Economists should study the cost to society of ill health, disability and premature death and learn the techniques and problems of applying cost–benefit and cost-effectiveness analysis to health matters. Engineers should be alive not only to the safety aspects of consumer goods, road design, etc., but also to such things as methods of assessing the technical devices used in health care and the less obvious effects of technology on lifestyles and health. Journalists should be grounded in the principles of health for all and made aware of the active role that the mass media should play in giving effect to strategies for health for all. In view of their influence on the general public, actors and other public entertainers should be encouraged to set a positive example in their own behaviour in relation to health and by refusing publicity and other assignments that glamorize unhealthy habits, such as smoking or excessive alcohol consumption. Policemen and other law enforcers should be given an understanding of the psychosocial factors underlying drug abuse so that they can cooperate sympathetically with self-help groups, the community and the health and social sectors in such matters.

Health technology assessment

Target 38 ☞
Appropriate health technology

Before 1990, all Member States should have established a formal mechanism for the systematic assessment of the appropriate use of health technologies and of their effectiveness, efficiency, safety and acceptability, as well as reflecting national health policies and economic restraints.

This could be done if governments adopted a clear policy for the systematic and comprehensive assessment of all new technical devices designed for use in the health field, to be carried out in a manner suited to the characteristics of their countries; and if an international system for the exchange of information on this subject were set up.

Problem statement

The increasingly rapid advances being made in science and technology and their practical application have profound health and economic implications. The industrialized countries have a particular responsibility to develope further applications of advanced technology to health in all its aspects, particularly those that can be used to advantage in primary health care and help to solve the problems of the primary health care system. However, all new technical advances require thorough assessment from the point of view of safety, effectiveness, cost-effectiveness and acceptability. This applies not only to products connected with health that are manufactured by industry for general consumption, but also, and more particularly, to techniques, equipment and chemical substances developed specifically for use in the health sector. Any assessment should be based on behavioural, physical, economic and clinical criteria.

Suggested solutions

Governments should adopt national policies for the practical and systematic assessment of all new technical advances that have a possible application in health care, as well as any existing products that have not yet been assessed, with a view to eliminating any device or procedure that is harmful, unnecessary or not cost-effective. Such policies need to take due account of the specific characteristics of each Member State. This would require coordinated action by the government departments concerned, industry, the providers and consumers of health care and research institutions. Governments should also stimulate technical development, with particular emphasis on its practical application and assessment in previously neglected fields, such as primary health care, lay care and aids for the disabled.

Since its scope is already too vast for many countries to deal with on their own, technology assessment provides an opportunity for international technical collaboration, to which WHO could contribute by devising suitable methods and setting up an information network for reporting on the results of assessments already made.

It will be particularly important for professional associations and industry to intensify their existing activities in this field and to

extend their criteria to include such issues as patient acceptability and social cost. This will also include the introduction of special sections on the assessment and use of technical advances in health into the training programmes for health staff and for those categories of personnel in other sectors that will be involved in health technology development.

9

Conclusion

Health for all is a challenging goal for every country of the Region, as well as for Europe as a whole. Through their resolutions in the World Health Assembly and the Regional Committee, all Member States have accepted the duty and responsibility of taking the necessary action, both individually and collectively, to ensure its attainment by the year 2000.

This book provides a framework for initiating such action, stressing as it does the improvements needed in the health of the people if they are to lead socially and economically productive lives. It shows the directions in which action must be taken and the amount of collective effort that will be needed. The regional targets set forth in this book outline a European health policy that should stimulate Member States — their public authorities, professional groups and general public — in the development of health for all policies and programmes, although they will not in any way be legally binding on individual countries. Their achievement depends, above all, on the capacity of the individual Member States and the Region as a whole to mobilize the necessary support and to motivate all the different groups to take their fair share of responsibility in the health for all movement. At least five important groups of active participants can be distinguished, and their respective responsibilities are briefly described below.

The people

The health for all movement is *for the people.* On this basis, the book has stressed the rights and privileges of people: the right to an equal opportunity for health, the right to health care, the right to be informed and the right to be involved.

Health for all is also a movement *with the people.* People are partners in that movement; they share responsibilities. They must therefore be fully conscious of the importance of their own active contribution at individual, family, group and community levels towards achieving health for all. They should play an active role in grasping the available opportunities to develop and maintain health. It is people who ultimately decide on the value of health in their lives, although their real options may be severely restricted by the economic, social, cultural and physical environment. People must develop the ability to define, recognize and express their needs and should be aware of when and how to use health care to satisfy those needs. People have the right to be informed; they should actively use the opportunities that exist to obtain the required information, to analyse it and to draw conclusions.

People have the right to be involved. They need to ensure actively that their right can be given practical expression, that satisfactory prerequisites for health exist for all, that the environment in which they live is healthy and provides conditions in which it is easy to select a healthy lifestyle, and that the health care system is responsive to their needs. It is for this reason that health for all is, above all, a movement *by the people.*

Health authorities

It has been repeatedly emphasized, in the health for all resolution of the World Health Assembly, in the global and regional strategies and in this book, that most of the action needed to reach health for all falls within the responsibility of Member States, individually and collectively.

The first task of governments is to launch the health for all movement within their own boundaries. Ministries of health and health authorities at all levels share a special responsibility in that respect. The task of initiating the necessary action to ensure the full

commitment of governments to this goal will necessarily fall on the shoulders of ministries of health. They should also actively support the principle that health should be an overriding concern of all related public sectors, and should take steps to stimulate a wide debate around the goal of health for all so as to mobilize the support of the public, professionals and community groups.

Health authorities will also have to take responsibility for leading the development of health for all strategies where they have not yet been developed. To do this, countries may have to strengthen their managerial processes for health development. A main priority in this respect may have to be further development or strengthening of their health information systems in order to make it easier to determine countrywide health priorities. Special emphasis should be put on developing appropriate ways and means of obtaining adequate information on environmental and behavioural health risks, as well as on the socioeconomic and geographical groups that are at greatest risk. Another priority is to ensure that legislation and the allocation of resources give full support to the implementation of countries' strategies for health for all. Finally, health authorities also have a special duty to ensure that the public is better informed on health matters related to lifestyles, environment and health care issues, so as to allow individuals, groups and communities to play an active part in health for all development.

The health professionals

Health professionals have a very important role to play in health development in all countries of the Region. Their expert knowledge and the influence they have within the health sector vis-à-vis the politicians and the general public may make them an important force in mobilizing support and initiating change for the health for all movement. To accomplish this, they must assume certain responsibilities.

Collectively, they share the responsibility for broadening the framework traditionally used to define and analyse health problems, by looking more into the psychological, social, economic and

environmental determinants of health, establishing closer working relationships with professionals in the fields concerned, and stressing the importance of acting on those determinants if health is to be improved. Health professionals should also help in making the facts in this regard better known to the public, the politicians and the health authorities. Individually, health personnel should give higher priority to health promotion, disease prevention, care and rehabilitation than is often the case at the moment. They should try to take a more holistic view of health problems by also looking at the family and the community in which people live for potential causes of, and often solutions to, many individual health problems.

The quality of care provided also depends on health professionals as a whole and individually.

Finally, health professionals face a particular challenge in planning the studies and undertaking the research needed to produce a deeper understanding of the many problems involved and to find more effective ways of solving them.

Sectors other than health

The importance of sectors other than health has been stressed throughout this book. The health for all movement gives them new and important responsibilities, i.e. to take fully into account the impact of their activities on health and to try to attain their respective goals in ways that are not detrimental, but beneficial, to health. This gives many categories of professional from sectors other than health important roles to play in health for all development.

Employers and trade unions can do much to improve safety and wellbeing at work. Industries are responsible for ensuring that their products pose no risk to health. It is the duty of the mass media to give health-related matters the space they deserve, to inform the public as objectively as possible, and to dissociate health-damaging behaviour from the concept of a socially exciting and satisfying life. It is the responsibility of universities to review the training of health personnel so as to prepare them better to face the challenges of the health for all movement, as well as the training

of people working outside the health sector to make them more concerned with the health implications of their future work. Universities and research institutions should give priority to obtaining the knowledge needed to implement countries' strategies for health for all.

International organizations

Many of the major health problems facing Member States today have their roots and their solutions outside national boundaries, and for that reason international cooperation is needed. United Nations agencies and other intergovernmental organizations have an important role to play in ensuring cooperation among countries on various matters related to health, but it is WHO that bears special responsibility in that respect.

It is the collective responsibility of Member States to ensure that the WHO Regional Committee for Europe can play its key role in stimulating individual countries to take up the challenge of health for all, and it is the responsibility of the Regional Committee to develop the regional policy of health for all, to monitor its implementation regularly, and to evaluate its effectiveness in achieving the regional targets. It is also the duty of the Regional Committee to ensure that the work done by the WHO Regional Office for Europe and the resources allocated to it are used to give full support to the development and implementation of health for all strategies, both in the countries and in the Region.

The European Region has the people, the knowledge and the resources necessary to attain health for all. The greatest need is the will to bring those forces more effectively to bear on the prevailing problems. Each step made together will bring us closer to reaching the regional targets for health for all however remote some of them may seem at the moment. By jointly making a commitment to a regional policy of health for all and by setting clear targets with a view to their ultimate attainment, the Member States of the Region can create a broad movement that will foster better understanding among nations and leave a legacy of value beyond our time.

Annex 1

Resolution EUR/RC34/R5 adopted by the thirty-fourth session of the Regional Committee for Europe, Copenhagen, 24–29 September 1984

The Regional Committee,

Bearing in mind resolution WHA30.43 which calls upon all countries to collaborate in the achievement of the goal of health for all by the year 2000 (HFA2000) through the development of corresponding health policies and programmes at the national, regional and international levels;

Recalling resolution EUR/RC30/R8 which endorses the regional strategy for attaining HFA2000 and acknowledges that it should foster the development and implementation of national health policies, strategies and plans of action;

Further recalling resolution EUR/RC33/R4 which requests the Regional Director to submit a final version of the regional target document to the thirty-fourth session of the Regional Committee, together with a plan of action and a list of indicators for monitoring progress towards achieving the targets in the Region;

Having considered:

(*a*) the proposed regional targets in support of the regional strategy for health for all (EUR/RC34/7);

(*b*) the list of proposed indicators for monitoring progress towards health for all in the European Region (EUR/RC34/13);

(*c*) the proposed plan of action for implementation of the regional strategy for attaining HFA2000 (EUR/RC34/14);

(*d*) the reports of the Consultative Group on Programme Development (EUR/RC34/8 and EUR/RC34/8 Add.1), the Regional Health Development Advisory Council (EUR/RC34/5), and the European Advisory Committee for Medical Research (EUR/RC34/6);

1. THANKS the Regional Director, the advisory groups and the other experts involved in the preparation of these documents for their valuable contributions;

2. ENDORSES, for application as appropriate, having regard to the particular circumstances of individual Member States:

(*a*) the regional targets in support of the regional strategy for health for all (EUR/RC34/7);

(*b*) the list of indicators for monitoring progress towards health for all in the European Region (EUR/RC34/13) as being preliminary only, to be used for the first time in the 1985 evaluation — the results of which will be discussed at the next session of the Regional Committee — and thereafter adjusted as necessary;

(*c*) similarly, as being preliminary only, the plan of action for implementation of the regional strategy for HFA2000 (EUR/RC34/14);

3. URGES Member States:

(*a*) to step up their efforts to establish national policies and programmes that are in line with the regional strategy for health for

all, and to set national targets in such a way that they also contribute to attainment of the regional targets;

(*b*) to give special emphasis, when so doing, to the managerial processes and structures required to support national developments towards health for all, and to information systems in order to ensure coverage of the lists of global and essential regional indicators as far as possible;

(*c*) when reporting to the Regional Director, as far as possible to provide all the necessary information on progress and effectiveness in implementing their strategies for health for all, and in particular data related to the global and essential regional indicators, as reflected in the plan of action and by resolution WHA35.23;

(*d*) to seek cooperation as and when required for these purposes;

4. REQUESTS the Regional Director:

(*a*) to transmit these documents, amended where necessary to take account of constitutional matters in particular Member States, together with the minutes of the Regional Committee, to the Director-General as a European regional contribution to attainment of the global target of health for all;

(*b*) to give priority, in the programme of work and budget allocations of the WHO Regional Office for Europe, to activities designed to provide Member States with adequate support in working out national strategies for health for all, as well as to those developments in the Region as a whole which may facilitate attainment of the regional targets;

(*c*) to report to the Regional Committee in accordance with the plan of action.

Annex 2

List of proposed indicators for monitoring progress towards health for all in the European Region

Introduction

The regional strategy for health for all by the year 2000 (HFA2000), adopted by the Regional Committee in 1981, has now been further developed and specific targets have been formulated. Indicators are needed to assess progress towards these targets.

When the regional targets were being drawn up, the tentative list of indicators annexed to the first version of the strategy was reviewed and refined in consultation with national experts. That list was then submitted to the Regional Health Development Advisory Council (RHDAC) and the Consultative Group on Programme Development (CGPD) in April 1984. A consultation of experts amended it in May 1984, taking into account the comments of those advisory groups. A subcommittee of the CGPD met in June 1984 to review the outcome of that consultation.

The list of indicators relates directly to the revised target document (EUR/RC34/7), and will be used to monitor progress and evaluate implementation of the strategy for health for all. To those ends, the list will be included in the common framework and

format (CFF) proposed for evaluation of the strategy at global level. In the list, global indicators and items of the CFF are referred to by number, in order to avoid repetition of information already provided elsewhere.

Types of indicator

Global indicators

All countries of the world are expected to report at least on the 12 global indicators agreed upon by the World Health Assembly, and these indicators have been included in the regional list. Most of the countries in the European Region have already reached the values proposed for these indicators. They should concentrate on the "equity" aspect of health for all, and analyse differences between geographical areas and socioeconomic groups as well as the trends in such differences.

Regional indicators

The proposed list is the result of a choice among hundreds of possible indicators to measure progress towards attainment of the regional targets. Owing to the nature of the targets, the list includes different types of measurement related to health status, behaviour, individual awareness, social and environmental factors, policy decisions, health services coverage and utilization, existence of regulatory mechanisms, etc.

In many cases, the information to be collected provides the elements for construction of indicators rather than constituting indicators as such. The Regional Office will have the task of analysing and aggregating the information received, in order to produce regional indicators. In most cases, these will be expressed as "regional values" or as the number of countries having reached a given level.

The indicators in the list do not all have the same importance or periodicity for reporting. Those considered very important at regional level, and on which all countries should report, are listed in the column marked "Essential regional indicators". Other suggested indicators, on which reporting would be welcome, are listed under the heading "Optional regional indicators".

Although each Member State is of course responsible for deciding how often it collects information, a periodicity for reporting to WHO is suggested for each indicator. Those considered necessary for monitoring should be updated at least every two years and those considered useful mostly for evaluation should be updated at least every six years, while for some only ad hoc reporting is required.

A large number of the indicators can be derived from existing routine reporting systems but some will require special analysis, while for others ad hoc surveys will have to be made.

For each indicator, a possible source of information is given by a letter in brackets. The code used is as follows;

(a) indicators for which information is currently available in routine reporting systems in most countries;

(b) indicators directly related to global indicators and/or questions in the CFF;

(c) other indicators based on statements by countries concerning existing processes and mechanisms;

(d) indicators for which information is currently available in certain countries, but which in others would require special surveys (e.g. sample surveys, censuses, national health surveys).

Countries are invited to concentrate first on the essential regional indicators. Sixty-five indicators or groups of indicators are proposed in this part of the list. Fifty-five of them belong to categories (a), (b) and (c) above, and will therefore not require additional information collection in most countries. For those indicators in categories (a) and (b) for which information is available in the Regional Office, a data sheet will be issued for correction and updating by the countries concerned.

Ten of the essential indicators belong to category (d) and hence a special effort will have to be made by those countries where they are not currently being collected. They relate to measurement of disability (indicators 4.1, 4.2 and 4.4), health promotion (indicators 16.1, 16.2, 16.3, 17.1, 17.2, 17.3) and use of contraceptive

methods (indicator 28.2). These indicators should be considered for progressive inclusion in population-based surveys.

Optional indicators are also proposed, mostly as examples of the type of additional information that would be useful for further evaluation. Member States should be encouraged to develop, with WHO support, their capacity to collect and analyse information in these fields.

Wherever relevant, Member States are asked to break down the information supplied. For population-based indicators, values should be disaggregated at least by age, sex, geographic location and socioeconomic status. Other criteria may be used according to the nature of the indicators.

National indicators

The Regional Office would appreciate receiving any information on additional indicators found useful in relation to national health policies and strategies. This would help in evaluating the progress made at country level, and also when reviewing the list of regional indicators in the future.

Future developments

The final version of the list of regional indicators will be included in the common framework and format for evaluation of the strategy which will be used by Member States as a guide for reporting to WHO in March 1985. The analysis of this first evaluation exercise will serve as a basis for further adaptation of the list.

In a number of areas, especially those related to disability, health promotion and environmental health, further studies should be made with the aim of steadily refining the list of indicators. The Regional Office intends to promote and support research in this field, in order to develop and standardize measurement instruments.

Regional indicators for HFA2000 in relation to regional targets

Target		Essential regional indicators			
No.	Description	No.	Description	Reporting	Comment
1	*Reducing health inequalities*	Assessment of health inequalities will be based on observed range for indicators listed below in items 4–12, using relevant disaggregation by age, sex, geographical location, and socioeconomic categories			
2	*Promoting health capabilities*	2.1	Existence of policies and programmes for the promotion of health capabilities of all people, and especially the elderly and handicapped	6 y (c)	Description of policy, laws, regulation and programmes for increasing the opportunities for self-reliance and independence and developing and using the individual's health potential *See also* indicators for target 3
3	*Increased opportunities for disabled persons*	3.1	Existence of laws and regulations or other arrangements for improving the social and economic life of disabled persons	6 y (c)	Major points to be considered should include measures for facilitating physical and economical accessibility of services

Optional regional indicators				Target	
No.	Description	Reporting	Comment	No.	Description
				1	*Reducing health inequalities*
2.2	Measurement of self-perception of health status	6 y (d)	The refinement of this type of indicator needs more research on the relationship between individual perception of health, expectations, and "objective" measurement of health status	2	*Promoting health capabilities*
2.3	Measurement of independence in activities of daily living	ad hoc (d)	For indicators 2.2 and 2.3, WHO should contribute to the development and use of common methods; countries are invited to report on their experience of function-based disability indicators		
3.2	Percentage of disabled persons aged 15–64 engaged in regular occupational activities	6 y (d)	To be collected by survey	3	*Increased opportunities for disabled persons*

Target		Essential regional indicators			
No.	Description	No.	Description	Reporting	Comment
4	*Reducing disease and disablement*	4.1	Number of disability days per person and per year, by level of restriction	6 y (d)	From OECD list of social indicators *(1)*; comparisons will be made on trends; data could be obtained from random sample interview surveys
		4.2	Percentage of the population experiencing different levels of long-term disability, by age and sex	6 y (d)	From OECD list of social indicators *(1)*; comments as for 4.1
		4.3	Incidence of:	2 y (a)	Figures in brackets refer to rubrics of ICD 9; information from national notification systems; incidence of other communicable diseases will be used whenever useful; registration systems should be improved
			● tuberculosis (010–018)	2 y	
			● intestinal infectious diseases (001–009)	2 y	
			● viral hepatitis (070)	2 y	
			● venereal diseases (091–099)	2 y	
			● influenza (487)	2 y	
		4.4	Absenteeism at work due to disease or injury	2 y (d)	Countries should use their own definitions; research needed for common definitions; comparisons will be made only on trends; data from social security systems

Optional regional indicators				Target	
No.	Description	Reporting	Comment	No.	Description
4.5	Expectation of life free of disability	6 y (d)	Indicators proposed by Sullivan *(2)*; obtained by deducting from a mortality table all years spent in a given state of disability; definitions of disability need to be adapted to national context; more research needed for comparative use of this type of indicator	4	*Reducing disease and disablement*
4.6	Incidence and/or prevalence of selected major chronic conditions; (the most important conditions should include mental disorders, malignant neoplasms, diseases of the circulatory system, diseases of the musculoskeletal system, chronic diseases of the respiratory system)	6 y (d)	Member States should select the most important conditions leading to disability; data to be obtained from hospital records, disease registers, health surveys; WHO should advise on common methods; comparisons will be made only on trends		
4.7	Average number of decayed, missing or filled teeth in 12-year-old children	6 y (d)	From school health reports and/or surveys		
4.8	Incidence of selected hereditary diseases and other genetic disorders	6 y (d)	The list should include at least thalassaemia, haemolytic disease, Down's syndrome, Duchenne type muscular dystrophy, phenylketonuria		

Target		Essential regional indicators			
No.	Description	No.	Description	Reporting	Comment
5	*Elimination of specific diseases*	5.1	Incidence of:		Information from existing notification systems
			● measles (055)	2 y (a)	
			● poliomyelitis (045)	2 y	
			● tetanus (037)	2 y	
			● neonatal tetanus (771.3)	2 y	
			● congenital rubella (771.0)	2 y	
			● diphtheria (32)	2 y	
			● congenital syphilis (090)	2 y	
			● indigenous malaria (84)	2 y	
6	*Life expectancy*	6.1	Life expectancy at birth, by sex	2 y (a)	Global indicator No. 10
		6.2	Life expectancy at ages 1, 15, 35 and 65, by sex	2 y (a)	Will be based on routine reports on age- and sex-specific mortality rates *(3)*
7	*Infant mortality*	7.1	Infant mortality rate	2 y (a)	Global indicator No. 9; disaggregation by geographical area and socioeconomic group; disaggregation according to birth weight recommended
8	*Maternal mortality*	8.1	Maternal mortality rate *(4)*	2 y (a)	Disaggregation by age, cause and socioeconomic group

Optional regional indicators				Target	
No.	Description	Reporting	Comment	No.	Description
				5	*Elimination of specific diseases*
6.3	Number of years of life lost due to deaths occurring before age 65	6 y (a)	Same comments as for 6.1 and 6.2	6	*Life expectancy*
7.2	Neonatal mortality rate (first 4 weeks of life)	ad hoc (d)	Disaggregation for indicators 7.2, 7.3 and 7.4 as for infant mortality	7	*Infant mortality*
7.3	Post-neonatal mortality rate (second to eleventh months of life)	ad hoc (d)			
7.4	Perinatal mortality rate (definition as per ICD 9, p. 765)	ad hoc (d)			
				8	*Maternal mortality*

Target		Essential regional indicators			
No.	Description	No.	Description	Reporting	Comment
		Targets 9–12. Indicators will be calculated on large age groups using standardization by age and sex. Data will be required using 5-year groups, as already done in routine reporting to WHO. The proposed indicators have been limited to conditions specifically referred to in the corresponding targets, but it will be possible, using routine reporting, to make more detailed analyses. For example, breast cancer and cancer of the digestive organs should be analysed. Whenever possible, further disaggregation, including occupation, for example, is recommended.			
9	*Cardiovascular diseases*		Mortality rates, by sex and age, from:		Figures in brackets refer to rubrics of ICD 9
		9.1	diseases of the circulatory system (390–459)	2 y (a)	
		9.2	ischaemic heart diseases (410–414)	2 y (a)	
		9.3	cerebrovascular diseases (430–438)	2 y (a)	
10	*Cancer*		Mortality rates, by sex and age, from:		
		10.1	malignant neoplasms (140–234) (more detailed information by site recommended)	2 y (a)	
		10.2	trachea, bronchus and lung cancer (162)	2 y (a)	
		10.3	cancer of cervix uteri (180)	2 y (a)	
11	*Accidents*		Mortality rates, by sex and age, from:		
		11.1	external causes of injury and poisoning (E800–E999)	2 y (a)	
		11.2	motor vehicle traffic accidents (E810–E819)	2 y (a)	

Optional regional indicators				Target	
No.	Description	Reporting	Comment	No.	Description
9.4	Incidence of ischaemic heart diseases	6 y (d)	Countries should be encouraged to develop schemes for the monitoring of trends in cardiovascular diseases	9	*Cardiovascular diseases*
9.5	Incidence of cerebrovascular diseases	6 y (d)			
10.4	Incidence of cancer of cervix uteri	6 y (d)	Recording of the incidence of cancer by site and type should be facilitated by the development of cancer registries	10	*Cancer*
11.3	Occurrence of motor vehicle traffic accidents	6 y (d)	Information from police reports	11	*Accidents*
11.4	Accidents and poisoning occurring in the home	6 y (d)	Information from routine reporting, where available, or from surveys		
11.5	Accidents related to work	6 y (d)			

Target		Essential regional indicators			
No.	Description	No.	Description	Reporting	Comment
12	*Suicide*	12.1	Mortality rates, by sex and age, from suicide (E950–E959)	2 y (a)	
13	*Healthy public policy*	13.1	Existence of laws, regulations and programmes aiming at the protection of the public against the distribution and use of potentially harmful goods	6 y (c)	Reference to, and brief summary of, the most important developments concerning the safety of goods, their labelling, the adjustments of tax and subsidy policies and advertising practices to the requirements of health promotion
		13.2	Existence of laws, regulations and practices integrating representative public participation in bodies responsible for health promotion at all levels	6 y (b)	Part of the information will come from answers to item 7 in the CFF
14	*Social support and social network*	14.1	Existence of health and welfare programmes directly aimed at strengthening the learning support and caring function of the family and other social groups	ad hoc (c)	Description of the roles and functions of family and social groups; description of programmes implemented

Optional regional indicators				Target	
No.	Description	Reporting	Comment	No.	Description
12.2	Incidence of attempted suicide		From police and hospital records	12	*Suicide*
				13	*Healthy public policy*
14.2	Existence, purpose and membership of recognized mutual aid groups	ad hoc (d)	Where they exist, give information on the place and role of groups of persons with common problems	14	*Social support and social network*
14.3	Proportion of the population without social contact	ad hoc (d)	Or any other type of information on "loneliness" in ad hoc surveys; more research on type of indicator will have to be promoted by WHO		

Target		Essential regional indicators			
No.	Description	No.	Description	Reporting	Comment
15	*Education for health*	15.1	Existence of national information and education campaigns aimed at promoting healthy behaviour	2 y (c)	Description of current campaigns on alcohol, smoking, physical exercise, balanced diet, etc.
		15.2	Adult literacy rate, by sex	6 y (b)	Global indicator No. 11
16	*Promoting healthy behaviours*	16.1	Tobacco consumption per capita	2 y (d)	From sales and tax reports
		16.2	Proportion of nonsmokers and heavy cigarette smokers (20 cigarettes and more per day), by sex and age group	2 y (d)	To be collected through current health surveys
		16.3	Average daily intake of calories, proteins, lipids and carbohydrates, by age, sex and level of activity	6 y (d)	To be collected in nutrition surveys
		16.4	Percentage of newborns having a birth weight of at least 2500 g *(6)*	2 y (b)	Global indicator No. 8; collection through birth registration, maternity records or surveys
		16.5	Percentage of children having a weight for age corresponding to reference values *(7)*	2 y (b)	Global indicator No. 8; collection through surveys; reference values may be nationally accepted values or those developed by the US National Center for Health Statistics
17	*Decreasing health-damaging behaviour*	17.1	Alcohol consumption per capita in people aged 15 and above	2 y (d)	In litres of pure alcohol per year (from sales and tax reports)

Optional regional indicators				Target	
No.	Description	Reporting	Comment	No.	Description
15.3	Time devoted to health education in primary and secondary school programmes	6 y (c)	In addition countries should be invited to provide information on any evaluation of the results of specific health education programmes	15	*Education for health*
15.4	Time devoted to health information and education in television programmes	6 y (c)			
16.6	Percentage of children breastfed at five months of age	2 y (d)	To be collected through interview surveys and MCH records	16	*Promoting healthy behaviours*
16.7	Per capita amount of time spent daily on selected free-time physical activities	6 y (d)	OECD indicator *(5)*; to be collected in interview surveys		
17.5	Incidence of selected alcohol-related diseases	ad hoc (d)	For 17.5 and 17.6, countries should select their indicators according to their own priorities	17	*Decreasing health-damaging behaviour*

Target		Essential regional indicators			
No.	Description	No.	Description	Reporting	Comment
17	*Decreasing health-damaging behaviour* (contd)	17.2	Distribution of alcohol consumption, by quantity consumed, age and sex	6 y (d)	To be collected by surveys
		17.3	Consumption of the principal narcotic drugs falling under the convention per million inhabitants	2 y (d)	Data from UN International Narcotics Control Board *(9)*
		17.4	Occurrence of homicide and injuries purposely inflicted by other persons (E960–E969)	2 y (a)	Disaggregation by type of injury recommended (including rape — E960.1, and child battering — E967)
18	*Policies for environmental health*	18.1	Existence of an established system for public information on environmental health hazards	6 y (c)	Description of the system required; Member States are encouraged to develop indicators of results, for example, in terms of public awareness
		18.2	Existence of laws, regulations, bilateral and multilateral agreements for the control of transfrontier pollution and the international movement of hazardous substances	6 y (c)	Reference and short summary of existing texts required
19	*Assessment, monitoring and control of environmental risks*	19.1	Existence of national systems for monitoring and control of environmental health hazards involving all interested sectors	6 y (c)	Description of the national system required

Optional regional indicators				Target	
No.	Description	Reporting	Comment	No.	Description
17.6	Consumption of psychotropic substances	ad hoc (d)	List of substances to be selected by Member States; see the list used by the UN International Narcotics Control Board *(8)*	17	*Decreasing health-damaging behaviour* (contd)
17.7	Number of violations of traffic regulations involving speed limits, alcohol, safety belts	6 y (d)	From police reports		
				18	*Policies for environmental health*
19.2	Existence of programmes for the screening of toxic agents	2 y (c)	Agents may be lead in blood, cadmium, mercury, organochlorides and salmonella in food, micropollutants in drinking-water, sulfo-oxides in air, etc.	19	*Assessment, monitoring and control of environmental risks*

Target		Essential regional indicators			
No.	Description	No.	Description	Reporting	Comment
19	*Assessment, monitoring and control of environmental risks* (contd)				
20	*Water pollution*	20.1	Proportion of the population served by safe water in the home or within 15 minutes' walking distance and adequate sanitary facilities in the home or immediate vicinity	2 y (a)	Part of global indicator No. 7; disaggregation recommended by type of water supply
21	*Air pollution*	21.1	Existence of laws, regulations, guidelines and programmes for monitoring and control of air quality	ad hoc (c)	Description of the existing system required
22	*Food safety*	22.1	Existence of national systems for evaluation and surveillance of food safety	6 y (c)	Description of the systems required, including specific measures concerning biological and chemical pollutants and food additives
23	*Hazardous waste*	23.1	Existence of a national system for monitoring the generation, transportation and disposal of hazardous wastes	6 y (c)	Description of the system required

Optional regional indicators				Target	
No.	Description	Reporting	Comment	No.	Description
19.3	Existence of programmes for the determination of human exposure to ionizing radiations	ad hoc (c)	Description of programmes dealing with national exposure, exposure at work and in the home, medical application, proximity of nuclear plants, etc.	19	*Assessment, monitoring and control of environmental risks* (contd)
20.2	Proportion of the population using water complying with WHO guidelines for water quality	2 y (d)	Information from water quality control services and from the global water quality monitoring project (GEMS/WATER)	20	*Water pollution*
			Member States are encouraged to report on exposure to selected types of air pollution when such information is available; WHO will make use of the information from the global environmental monitoring system (GEMS/AIR)	21	*Air pollution*
22.2	Outbreaks of food poisoning	2 y (d)	*See also* indicator of intestinal infectious diseases (4.3)	22	*Food safety*
23.2	Major chemical accidents reported	ad hoc (c)		23	*Hazardous waste*

Target		Essential regional indicators			
No.	Description	No.	Description	Reporting	Comment
24	*Human settlement and housing*	24.1	Existence of policies and programmes for housing and human settlements	6 y (c)	National guidelines and standards in terms of indoor living space, occupancy, basic amenities, etc. should be indicated
25	*Working environment*	25.1	Existence of laws, regulations and programmes for assessment and monitoring of risks related to work	6 y (c)	Description required; as far as possible, place of work should be mentioned, including the home
		25.2	Incidence of certified occupational diseases	2 y (a)	Due to national differences in recording, international comparisons will be based on trends only; national definition of occupational diseases required; *see also* accidents related to work (11.5)
26	*Health system based on primary health care (PHC)*	26.1	Proportion of the population for whom PHC is available	6 y (b)	Global indicator No. 7; information from CFF item 5
		26.2	Existence of laws, regulations and established practices for the orientation of the health system following the PHC approach and principles	6 y (b)	Information from CFF item 5, where points to be considered are listed

Optional regional indicators				Target	
No.	Description	Reporting	Comment	No.	Description
			Member States are invited to report on national indicators for monitoring their housing and human settlement policies, including elements such as accessibility for disabled persons, indoor climate, etc.	24	*Human settlement and housing*
				25	*Working environment*
				26	*Health system based on primary health care (PHC)*

Target		Essential regional indicators			
No.	Description	No.	Description	Reporting	Comment
26	*Health system based on primary health care (PHC)* (contd)	26.3	Existence of a mechanism for involving people in the implementation of national health strategies	6 y (b)	Global indicator No. 2; information from CFF item 7
27	*Distribution of resources*	27.1	Percentage of national health expenditure devoted to local health care (first-level contact)	2 y (b)	Global indicator No. 4; description in CFF item 9
		27.2	Distribution of resources: ratio between population and health facilities and personnel (primary care units, hospital beds, physicians, qualified nurses, auxiliary nursing personnel, midwives, dentists, pharmacists)	2 y (a)	Global indicator No. 5; this series of indicators may be disaggregated by geographical area (urban, rural) and by type of service provided (primary care, preventive/curative, etc.)
28	*Content of primary health care*	28.1	Proportion of children under 5 fully immunized	2 y (a)	Disaggregation by age, according to national regulations; global indicator No. 7 includes immunization against diphtheria, tetanus, whooping cough, measles, poliomyelitis and tuberculosis
		28.2	Proportion of the population using contraceptive methods, by age, sex and type of method		Information to be collected in interview surveys and from family planning services; WHO should advise on proper methodology and survey instruments, and disseminate examples

Optional regional indicators				Target	
No.	Description	Reporting	Comment	No.	Description
				26	*Health system based on primary health care (PHC)* (contd)
27.3	Proportion of doctors and nurses working in primary health care	2 y (d)	Disaggregation by type of service and geographical area	27	*Distribution of resources*
27.4	Percentage of the population covered by public or insurance funds	6 y (d)	Information from national health services, public insurance funds, private insurance funds		
28.3	Proportion of children under 5 having permanent services for child care available in the community	ad hoc (b)	Extension of global indicator No. 7; information from CFF item 5	28	*Content of primary health care*
28.4	Proportion of pregnant women receiving antenatal care according to nationally recommended schedule	ad hoc (b)	Information for indicators 28.3 to 28.6 from routine reporting systems, MCH reports and/or analysis of samples of hospital and maternity records		
28.5	Induced abortion per 1000 live births, by age	2 y (d)			
28.6	Deliveries before age 15 per 1000 girls aged 10–14	6 y (d)			

Target		Essential regional indicators			
No.	Description	No.	Description	Reporting	Comment
29	*Providers of primary health care*	29.1	Existence of mechanisms for ensuring full utilization of human resources in the implementation of primary health care	ad hoc (b)	Description of measures taken for reorienting the work of health manpower, facilitating teamwork, public involvement, family care, mutual aid groups, etc.; more research needed for further development of indicators; information from CFF items 7 and 8
30	*Coordination of community resources*	30.1	Existence of mechanisms at community level for the coordination of services provided by different sectors	6 y (b)	Health councils; *see also* CFF items 7 and 13, and global indicator No. 2
31	*Quality of services*	31.1	Existence of mechanisms for the assessment of quality of care	6 y (b)	Infant mortality, maternal mortality and perinatal mortality will also be used as indicators of quality of care; information from CFF items 17 and 18

Optional regional indicators				Target	
No.	Description	Reporting	Comment	No.	Description
				29	*Providers of primary health care*
				30	*Coordination of community resources*
31.2	Incidence of accidental poisoning by pharmaceuticals and biologicals	2 y (a)	Information for indicators 31.2 to 31.4 from routine reporting, hospital reports and/or sample survey of hospital records; Member States are invited to report on the indicators they use for assessing quality of services; further research is needed on other indicators to measure the "commitment to quality", such as frequency of post-mortem examinations, utilization of supporting services (X-ray, laboratory, etc.)	31	*Quality of services*
31.3	Mortality due to: ● appendicitis (540–543) ● inguinal hernia (550)	2 y (a)			
31.4	Incidence of nosocomial infections	6 y (d)			

Target		Essential regional indicators			
No.	Description	No.	Description	Reporting	Comment
32	*Research support to strategies for HFA*	32.1	Existence of a research plan based on the national strategy for HFA	2 y (b)	Information from CFF item 19
		32.2	Existence of a national mechanism for the coordination of health research	2 y (b)	Information from CFF item 19
		32.2	Proportion of public health expenditure spent on research	6 y (c)	
33	*Health policies formulation*	33.1	Endorsement of HFA policies at the highest official level	ad hoc (b)	Global indicator No. 1; CFF item 2
		33.2	Existence of a national strategy for HFA	ad hoc (b)	Information from CFF item 3
34	*Planning and resource allocation*	34.1	Percentage of GNP spent on health	2 y (b)	Global indicator No. 3; in addition, Member States should report on measures taken for the reorientation of the health management process; information from CFF item 6
35	*Health information system*	35.1	Existence of a national information system covering the information needs of the national strategy	6 y (c)	Description of the system should include information for health management, reporting on strategies, health documentation and information of the public
		35.2	Number of regional and global indicators for which information is available	2 y (c)	

Optional regional indicators				Target	
No.	Description	Reporting	Comment	No.	Description
			Member States are invited to report on national indicators used to assess the support given to research projects directly oriented towards the national strategy for HFA (in terms of financial resources, number and type of institutions involved, etc.)	32	*Research support to strategies for HFA*
				33	*Health policies formulation*
				34	*Planning and resource allocation*
				35	*Health information system*

Target		Essential regional indicators			
No.	Description	No.	Description	Reporting	Comment
36	*Health personnel*	36.1	Existence of national plans for the training, continuing education and utilization of health personnel, in relation to the strategy for HFA	6 y (b)	Information from CFF item 8
37	*Education in other sectors*	37.1	Existence of training programmes on HFA principles and implications for professionals in other sectors	6 y (c)	*See also* CFF item 13
38	*Technology assessment*	38.1	Existence of a mechanism for systematic evaluation of health technology	2 y (c)	Description of the system and its outcome, and the type of evaluation performed (safety, effectiveness, efficiency, cost, etc.)

Notes

(1) **McWhinnie, J.R.** *Measuring disability.* Paris, OECD, 1982 (OECD Social Indicator Development Programme, Special Study No. 5). (Definitions of disability day, level of restriction, long-term disability and level of disability are given, with model of questionnaire for data collection.)

(2) **Sullivan, D.F.** A single index of mortality and morbidity. *HSMHA health reports,* **84**: 347–354 (1971).

(3) WHO Health for All Series, No. 4, p. 70.

(4) WHO Health for All Series, No. 4, p. 74.

(5) **As, D.** *Measuring the use of time.* Paris, OECD, 1982 (OECD Social Indicator Development Programme, Special Study No. 7).

(6) WHO Health for All Series, No. 4, p. 63.

Optional regional indicators				Target	
No.	Description	Reporting	Comment	No.	Description
36.2	Yearly number of students starting education in each category of health personnel per 1000 population	2 y (d)	Reports should give at least information for doctors, nurses, midwives, dentists, pharmacists and selected specialists considered important at national level	36	*Health personnel*
36.3	Yearly production in each category of health personnel per 1000 population	2 y (d)			
				37	*Education in other sectors*
				38	*Technology assessment*

Notes (contd)

(7) WHO Health for All Series, No. 4, p. 64.

(8) **UN International Narcotics Control Board.** *Statistics on psychotropic substances.* 1982 (DOC. E/INCB/1983.4).

(9) **UN International Narcotics Control Board.** *Statistics on narcotic drugs.* 1982 (DOC. E/INCB/1983.3).

Annex 3

Proposed plan of action for the implementation of the regional strategy for attaining health for all by the year 2000

Introduction

This plan of action is an operational continuation of the regional strategy and regional target documents in the sense that it shows who should exercise the main responsibility for taking each type of action and by what date. Its aim is threefold:

- first, to provide guidelines for countries to formulate their own plans of action for the development and implementation of their national HFA strategies;

- second, together with the list of indicators, to constitute a tool for the Regional Committee to monitor the implementation of the regional strategy and to evaluate the attainment of the regional targets;

- third, to link, even more closely, the programme of work and the allocation of resources of the Regional Office to the support needed by Member States and the Regional Committee in carrying out their share of the plan.

Actors

The plan addresses itself to the three actors who, within the context of this Organization, share the main responsibility for initiating activities for implementing the regional strategy and attaining the regional targets: (*a*) Member States, both individually and collectively through intercountry cooperation; (*b*) the Regional Committee and, through it, the consultative bodies for the European Region; and (*c*) the Regional Director and, through him, the entire secretariat of the Regional Office.

Member States

It is strongly emphasized, in both the regional strategy and the regional target documents, that most of the action needed to achieve HFA in Europe falls, individually or collectively, within the responsibility of Member States.

The plan stresses three types of action that may be undertaken by Member States, namely action:

1. to determine, through the formulation of their own national HFA priorities, strategies and targets, the extent of their contribution to the attainment of the regional strategy in general and the regional targets in particular;

2. to review their national machinery for intervention in HFA priority areas and to revise it as necessary, so as to bring it more into line with, and make it more supportive of, their own national strategy;

3. to report at intervals to the Regional Committee on the progress made in implementing their own national strategy and reaching their own national targets.

Ten major areas are identified in the plan. Their listing below reflects only the time sequence of their realization and not their relative importance in the target document:

- managerial process and health information;
- primary health care development;

- quality of care assurance and health technology assessment;
- health personnel;
- health research;
- policies affecting lifestyles;
- policies and mechanisms related to environmental health;
- health education;
- policies ensuring the prerequisites for health;
- support for social groups whose activities influence health.

In May 1982, the Thirty-fifth World Health Assembly approved a global plan of action for implementing the global strategy for health for all (resolution WHA35.23). It was thereby envisaged that the regional committees would monitor the implementation of the regional strategy every two years from 1983, and evaluate the effectiveness of the strategy in reaching the targets every six years from 1985.

Regional Committee

The main responsibilities of the Regional Committee are:

- first, based on the reports by Member States, to monitor the implementation of the regional strategy every two years and to evaluate its effectiveness in reaching the regional targets every six years;
- second, on this basis, to update as necessary the regional plan of action, strategy and targets, and list of indicators;
- third, to submit proposals on the European regional contribution to the General Programme of Work every six years and on the biennial programme budget every two years, which fully support the implementation of the strategies and the attainment of the targets at both national and regional levels.

Regional Office

The main responsibility of the Regional Office is to give full support to Member States and the Regional Committee in carrying out

their respective shares of the plan. In so doing, the four main roles given to WHO in the European Region for the Seventh General Programme of Work should be kept in mind:

1. to help make existing knowledge better known by identifying innovative and improved health care approaches in Member States;

2. to promote priority health research;

3. to act as a catalyst in promoting national health policy development towards HFA principles;

4. to improve cooperation and coordination between international organizations active in the health field.

This support is outlined in general terms in the European regional contribution to the General Programme of Work and, in more detail, in the biennial programme budget. The plan of action sets out only the major action to be taken by WHO to support Member States and the Regional Committee in their efforts to reach the regional HFA targets.

Future amendments to the plan of action

The plan will have to be amended in the light of the progress that Member States make in their HFA development, which can be influenced by many factors. It would therefore seem logical to update the plan in accordance with the monitoring of the implementation of the regional strategy every two years and with the evaluation of the effectiveness of the strategy every six years.

Plan of action

Date	Member States		Regional Committee	Regional Office
	Action for national health development	Reporting to Regional Committee		
1984				
September			Thirty-fourth session to review and endorse: ● regional target document ● list of indicators ● plan of action ● 1986/87 programme budget	
by October				Has distributed the agreed list of regional indicators and the common framework and format for evaluating HFA strategies
1985				
by March		Have submitted information on global and essential regional indicators as a base for evaluating the implementation of the global, regional and national HFA strategies		Has launched a publicity campaign to make both the regional strategy and the target documents fully known to health authorities at all levels, health professionals and the general public

Date	Member States		Regional Committee	Regional Office
	Action for national health development	Reporting to Regional Committee		
1985 (contd)				
by June				Has developed and disseminated modules for forecasting health situations, as a tool for priority-setting
				Has set up regional information bases to be used by Member States for international comparisons
				Has developed and published guidelines enabling decision-makers to identify needs for information to support their managerial process relative to the regional HFA strategy and targets
September			Thirty-fifth session to: ● evaluate the progress made since the adoption of the regional strategy in 1980 ● update the plan of action, as necessary	Regional Director to submit a report on the result of the evaluation of the regional HFA situation and trends since the adoption of the regional strategy in 1980

Date	Member States		Regional Committee	Regional Office
	Action for national health development	Reporting to Regional Committee		
1985 (contd)				
by December	Have reviewed the health information systems and adapted them, as necessary, so that they are fully supportive of the managerial process and cover at least the list of indicators agreed upon (36)[a] Have analysed the national health situation in the light of the HFA strategies and have identified major national health development priorities (35)			The EACMR to submit an HFA regional research plan based on priorities related to the regional targets Has developed and issued guidelines for formulating the national HFA strategy with regard to certain critical European health policy issues Has developed and disseminated scenario methodology for formulating the HFA2000 strategies
1986				
September			Thirty-sixth session to: ● review and endorse the 1988/89 programme budget ● review and endorse the HFA regional research plan ● set policy for increased extraordinary support to regional HFA development	Regional Director to submit a proposal for the regional HFA research plan, for the 1988/89 programme budget and for increased extrabudgetary financial support to regional HFA development

[a] Numbers in parentheses refer to the target number to be reached by the proposed action.

Date	Member States		Regional Committee	Regional Office
	Action for national health development	Reporting to Regional Committee		
1986 (contd)				
by December	Have analysed the national HFA policy and strategy and revised them, as necessary, to ensure that they are in line with the regional HFA principles and contain clear national targets, supportive of the overall regional HFA targets (34) Have reviewed and revised, as necessary, the managerial process for HFA development, implementation, monitoring and evaluation, while ensuring full community and multisectoral involvement (35)			Has developed and publicized the guidelines on functional criteria for selected PHC issues specific to the European context Has diffused information on effective organizational patterns of health service delivery existing throughout the Region and identified certain pitfalls to be avoided Has collected and disseminated particularly interesting national experiences of policies, mechanisms, methodologies and achievements with regard to quality of care and technology assessment
1987				
March		Have submitted a monitoring report on the formulation and implementation of the national HFA strategy		

Date	Member States		Regional Committee	Regional Office
	Action for national health development	Reporting to Regional Committee		
1987 (contd)				
by June				Has diffused the regional HFA research plan and contacted national health research councils or equivalent authorities to convince them of the research needs for HFA development
September			Thirty-seventh session to: ● review a report on monitoring of the implementation of the regional strategy ● revise the regional plan of action, as necessary	Regional Director to submit a report on monitoring of the implementation of the regional strategy
by December	Have analysed the overall organizational pattern of health service delivery and prepared a comprehensive national plan, as necessary, for improvement of PHC (26–30) Have assessed and reviewed, as necessary, the policy on quality of care and health technology assessment (31,39)			Has developed and diffused case studies and guidelines on coordinated health manpower planning and on health manpower scenarios Has promoted the development of model projects on environmental health improvements for industrialized areas

Date	Member States		Regional Committee	Regional Office
	Action for national health development	Reporting to Regional Committee		
1987 (contd)				
by December (contd)				Has provided guidelines and given assistance for the development of policies for health promotion, especially in relation to schools, workplaces, the family and the community
1988				
September			Thirty-eighth session to: ● endorse the regional contribution to the Eighth General Programme of Work ● endorse the 1990/91 programme budget	Submit proposals for the 1990/91 programme budget and the regional component of the Eighth General Programme of Work
by December	Have analysed health manpower development experience and adopted comprehensive plans for such development in line with the national HFA strategy (37,38)			Has disseminated basic principles and guidelines on public information through collaborating centres Has developed guidelines regarding critical HFA issues relative to sectors other than health

Date	Member States		Regional Committee	Regional Office
	Action for national health development	Reporting to Regional Committee		
1988 (contd)				
by December (contd)	Have developed a national HFA2000 research plan that gives priority to major areas where knowledge is lacking, in order to reach the national HFA targets (32,33)			
	Have reviewed public policies that affect lifestyle and revised them, as necessary, to make a healthy lifestyle the easier one to choose (13)			
	Have reviewed environmental health policy as well as mechanisms for monitoring, assessing and controlling environmental hazards, and revised them, as necessary, so as to be fully supportive of the national strategy (18,19,24)			
1989				
by March		Have submitted a monitoring report on implementation of the national strategy		

Date	Member States		Regional Committee	Regional Office
	Action for national health development	Reporting to Regional Committee		
1989 (contd)				
September			Thirty-ninth session to: ● review the report on monitoring of the implementation of the regional strategy ● revise the plan of action, as necessary	Regional Director to report on the monitoring of the regional strategy
by December	Have analysed and revised, as necessary, public policies related to income security, employment, housing, food and education, so as to eliminate pockets of poverty and areas of deprivation and give preferential treatment and special support to the most needy and thereby provide equal opportunities for all to develop, maintain and make full use of their health potential (Chapter 2)			Has developed model projects in consumer-oriented health care and health policy Has provided guidelines for the special reporting on national progress with regard to: ● the Expanded Programme on Immunization (EPI) ● the International Drinking Water Supply and Sanitation Decade (IDWSSD) which is required in the light of the global target dates set for 1990

Date	Member States		Regional Committee	Regional Office
	Action for national health development	Reporting to Regional Committee		
1989 (contd)				
by December (contd)	Have reviewed health education programmes and revised them, as necessary, so as to reinforce basic aspects of the national strategy			
1990				
by March		Have reported on the national progress in implementing programmes which have 1990 as their target date: ● the EPI ● the IDWSSD		
September			Fortieth session to: ● review the reports on: ○ the EPI ○ the IDWSSD ● approve the 1992/93 programme budget	Regional Director to submit a report on regional progress in reaching the global targets related to: ● the EPI ● the IDWSSD

Date	Member States		Regional Committee	Regional Office
	Action for national health development	Reporting to Regional Committee		
1990 (contd)				
by December	Have reviewed activities and practices with regard to social groups involved in lifestyle, environment and self-help issues and adopted policies and programmes, as necessary, to strengthen their impact in priority areas of the national strategy (14)			
1991				
by March		Have submitted an evaluation report on the effectiveness of the national strategy and the degree of attainment of the national targets		
September			Forty-first session to: ● review the evaluation report on the effectiveness of the regional strategy and the degree of attainment of the regional targets	Regional Director to submit an evaluation report on the effectiveness of the regional strategy and the degree of attainment of the regional targets

FURTHER READING

You can learn in more detail about what you can do to help achieve health for all in other WHO publications, many of which contain recommendations for practical action in specific target areas.

Recent publications from the WHO Regional Office for Europe have dealt with AIDS, Alcohol policies, Catering hygiene, Childbirth, Children in hospital, Demographic trends, Drugs for the elderly, Heart disease, Infectious diseases, Occupational health, Planning, Primary health care, Sex and family planning, and Unemployment (see list of titles on the next page).

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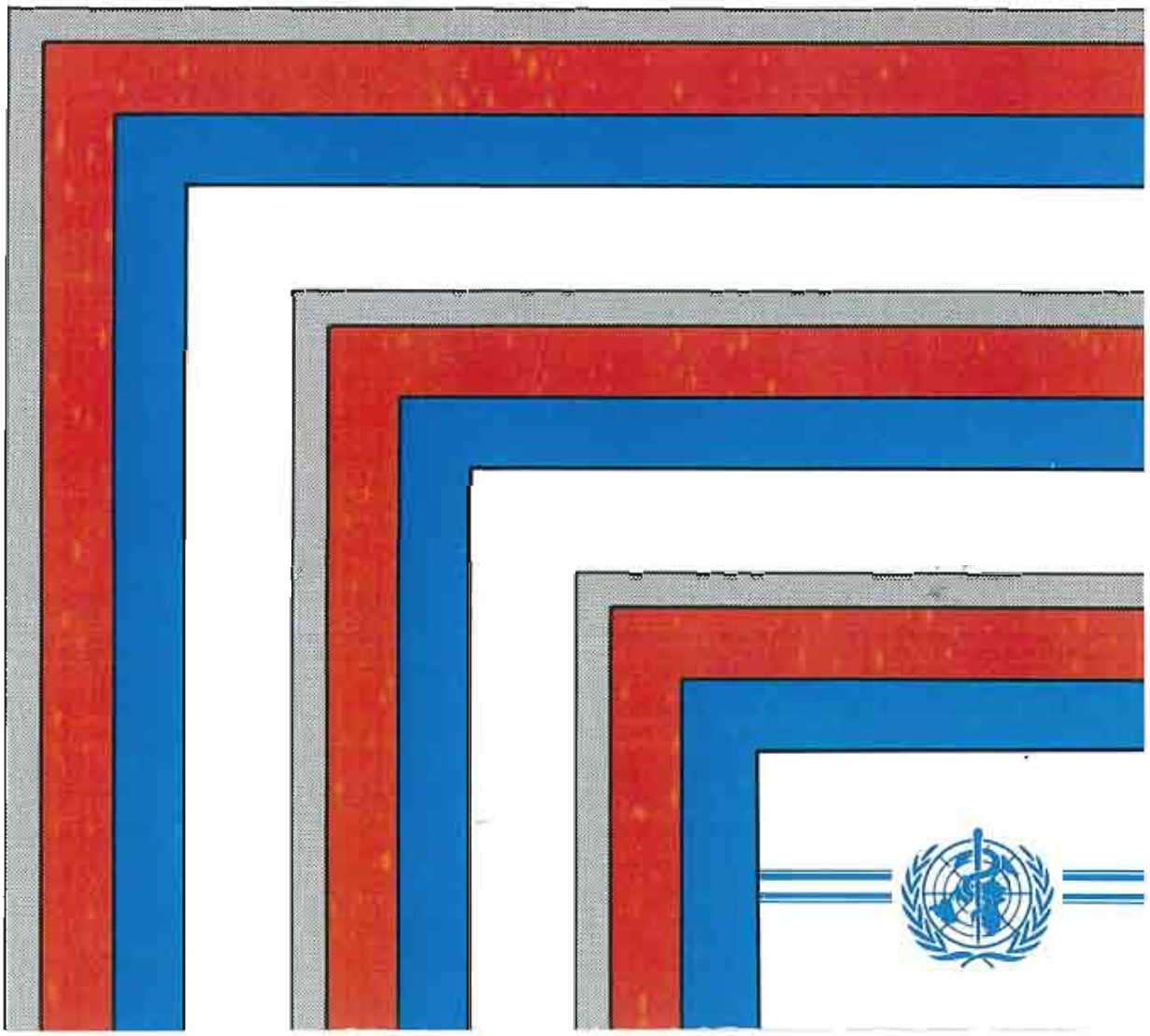
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