



02

What we are
aiming for:
European targets
for health and
well-being

Through an intense process of consultation, the work of several expert groups and endorsement by the sixty-second session of the WHO Regional Committee for Europe, Health 2020 arrived at six goals (overarching targets), which it aims to achieve by 2020. These include a reduction in premature mortality, increases in life expectancy, a reduction in inequalities, and the enhancement of well-being, universal coverage and demonstrated target-setting efforts at the country level. The WHO Regional Director for Europe will report progress towards achieving the targets as regional averages, but monitoring of indicators at the country level is necessary to inform such regional targets. For this purpose, health information that is routinely collected by countries should be used to the greatest possible extent and the collection of new data should be avoided where possible. Every effort will be made to ensure that the targets and indicators used will be fully aligned with global target-setting work.

In the context of Health 2020 a target is defined as “a desired goal”. The desired outcome is health improvement, and targets are drafted in terms of, for example, reductions in mortality or morbidity. In addition, where improvements in health outcomes can be linked to processes or outputs with adequate scientific evidence, targets can also be legitimately drafted in terms of a process or an output, such as increases in public health expenditure or the introduction and enforcement of legislation fostering public health objectives.

One of the difficulties is to find the appropriate mix of indicators to reflect progress towards strategic goals and targets in a valid and reliable way. In monitoring health policy, the time lags between interventions and their impact on health status, as well as the difficulties of attributing an outcome to specific interventions, have usually encouraged the use of process or output indicators in addition to outcome indicators. The coherence of process, output and outcome indicators lies at the centre of measuring progress towards agreed goals and their associated targets. All need to be measured as long as the causal link cannot be ascertained. All need to evolve dynamically as the link is being tested in a wide range of contexts. For example, when process indicators improve, is there a measurable improvement in outcome indicators?

Thinking about the role of targets in Health 2020 needs to consider the principles of performance measurement and accountability. In the case of Health 2020, accountability can only be exercised collectively by and between Member States. If people in each country are the ultimate principals in a complex accountability chain, we as a Region should ask

how well policy and systems serve the population. This chapter sets out the process that led to agreement on the goals – the overarching targets aligned to the Health 2020 policy – and proposes more specific target areas and indicators to assess progress at the European level (Box 9).

A baseline is provided for several indicators, reflecting the most recent data reported to the WHO Regional Office for Europe from across the Region's 53 Member States. The chapter concludes with a framework for the monitoring of targets and indicators for Health 2020 that will be refined in consultation with Member States.

Previous target-setting and monitoring experiences

The use of targets

Historically targets were first suggested in the European Region as part of the first common health policy: the European strategy for attaining health for all. The policy called for the formulation of specific regional targets to support the implementation of the strategy. Aptly described as a “wonderful blend of today’s realities and tomorrow’s dreams” (47), the 1984 WHO Regional Committee for Europe, meeting in Copenhagen, Denmark, adopted 38 specific regional targets and 65 indicators to monitor and assess progress at the regional level. The European Health for All policy and targets were updated in 1991 and the Regional Committee adopted a renewed policy, “HEALTH21 – Health for All in the 21st century”, in 1998.

Health for All

In 1981 WHO published its global strategy for Health for All by the year 2000 (48); the WHO Director-General at the time, Dr Halfdan Mahler, stated that this was “not a separate ‘WHO strategy’, but rather an expression of individual and collective national responsibility, fully supported by WHO”. Soon afterwards, WHO regional offices started developing regional health targets. The WHO Regional Office for Europe led the way by producing the most comprehensive list in 1984.

The then 32 Member States in the WHO European Region debated the new European health policy, Health for All by the year 2000, and

Box 9. Terminology for target setting

A **policy** is an agreement on goals and objectives, the priorities between those objectives and the main directions for achieving them.

A **goal** refers to the long-range aims of society and is usually expressed in rather general terms.

A **strategy** refers to the broad lines of action for achieving the goals and objectives.

A **target** is an intermediate result towards the achievement of goals and objectives; it is more specific, has a time horizon and is frequently, though not always, quantified.

An indicator is a measurement that helps us to understand where we are, where we are going and how far we are from the target. Targets and indicators are sometimes confused. Targets should be set before indicators are selected to monitor progress towards a target.

regional targets were aligned to the new policy. The formulation of European targets was a major undertaking, with the staff of the Regional Office working with more than 250 experts from across Europe, going through more than 20 drafts and a complex consultative process with Member States, over about three years (49). The result was 82 targets presented for consideration to the Regional Committee for Europe, which unanimously adopted a reduced set of 38 in 1984. Then the new European health policy was published (50).

The policy and accompanying targets stimulated European Member States to reassess their health strategies and, in many cases, to set their own targets for health improvement. The original 38 targets addressed health goals (targets 1–12), strategies to reach them (targets 13–21) and sustained political, managerial, financial support and mobilization (targets 22–38) to inspire and guide (50). This was the first time the European Region had had a distinct health policy with goals, strategies and targets outlined (see Box 9).

In 1991 the 38 targets were revised to reflect the changes in the Region since the mid-1980s. The intention was to provide a contemporary understanding of the problems involved in target setting and in approaches to achieving them. The six major themes of the first target set were retained (promoting equity in health, community participation, health promotion and disease prevention, reorientation of the health system towards primary health care and collaboration for health across sectors), and an explicit concern with ethics and inequalities across different population groups was added. The Regional Office supported the implementation of the targets by aligning its budgets and programmatic activities with it and responding to Member States' requests.

HEALTH21 – a more focused strategy

The major political, economic and social changes in the Region during the 1990s transformed the European landscape. One result was a dramatic increase in the number of European Member States to more than 50 by the end of the decade. Unsurprisingly, the WHO Regional Office for Europe revisited its European health policy and regional targets. In 1999, it published the HEALTH21 policy document with a new set of “21 targets for the 21st century”, identifying two main aims, three basic values, and four main strategies (4). The new policy made a first step towards approaches to monitor compliance, as it noted how each target could be achieved and suggested areas for formulating indicators. In addition, HEALTH21 was aligned with Agenda 21 on

sustainable development. In practice, the focus remained on the construction of targets at the country and local level, with no regional reporting.

In 2005, the Regional Office published an update of the European health policy that reviewed and affirmed HEALTH21: “incorporat[ing] the knowledge and experiences that have accumulated since” 1998 (3). The publication (3) noted that the HEALTH21 targets continue to provide a regional framework – “the essence of the regional policy” – yet emphasized that the 21 targets provided an inspiration “for the construction of targets at the country and local levels”.

Some lessons learned about target setting

The WHO European Region has about 30 years of experience in setting targets as part of regional health policies and strategies, albeit in the context of a Europe that has changed dramatically. Dr Jo E. Asvall, WHO Regional Director for Europe between 1985 and 2000(51), summarized targets’ functions:

These targets and indicators made the European Health for All policy sharper and provided a model for the Region as a whole, which countries could adapt to their own contexts. They also provided public health advocates, professionals, academics and government decision-makers at grassroots with a lever to push for Health for All within countries.

Several lessons have been learned over the decades.

- A broad consensus needs to be developed among stakeholders. The development of a health policy at the political level requires both recognition of the need for action and political will to implement it.
- Targets need to be limited to a manageable number. WHO’s original 38 were widely agreed to be too many, but so perhaps were the subsequent 21. Most national and regional programmes have focused on 5–10.
- Any plan should be based on evidence of effectiveness. Although health promotion is supported by more evidence of effectiveness than is often thought, much remains poorly evaluated and is often dependent heavily on context.
- To be achieved, targets need to be linked to resources.
- Once a target-based strategy is agreed, technical challenges remain. Target setting requires an understanding of the current pattern

of health in a population, including determinants, and projections based on the best available models (52).

While the Health for All targets (50) were not generally quantified and were meant to be achieved at the country level, not the regional, those of HEALTH21 (4) tended to be too specific and – with hindsight – to a large extent unachievable.

Health for All database

The Health for All database (6) is the basis for monitoring and reporting on the European targets and indicators. It has evolved to cover 53 countries and is widely used across the Region. The database includes several hundred indicators, and health statistics covering basic demographics, health status, health determinants and risk factors, and health care resources, utilization and expenditure. These data are compiled from various sources, inform the interactive atlases of health in the European Region (20), and are updated twice a year.

In 2012, the WHO Regional Office for Europe launched a new annual publication reporting on core indicators from the Health for All database. It will launch a new web portal in 2013, which permits users to access and analyse all databases simultaneously from one location. Additional added value to users will include new data visualization tools, including dashboards and the interactive atlases (Box 10).

Box 10.
**Interactive atlases –
visualization of EUROSTAT databases**

Publicly available socioeconomic and health-related indicators from across European databases – particularly those of EUROSTAT (the statistical office of the EU) – were used to produce interactive atlases. The NUTS 2 regions (the second level of regions in the Nomenclature of Units for Territorial Statistics used in the EU) are the main geographical units of analysis. Variables displayed in maps, graphs and tables represent more than 600 individual indicators. To analyse and display data, the WHO Regional Office for Europe developed the following interactive atlases: a correlation map atlas, atlases of social inequalities and a regional comparison atlas (20).

The atlases aim not only to provide more visibility to the subnational patterns of health and their determinants but also to analyse how such an integrated information system and its underlying data can inform policy across European countries. For example, the atlases of social inequalities allow visualization of the difference between a target value and the value in a region or group of regions. The target value is the population-weighted average of the most advantaged quintile of the population with available data, and is considered an achievable goal. Differences between the target and the individual region are visualized as absolute differences (area target differences) and as relative differences (area target ratios). The amenable mortality atlases show an example of the socioeconomic variable of disposable income, the net purchasing power standard based on final consumption per inhabitant.

Health 2020 targets – building on and updating Health for All and HEALTH21 in a contemporary context

Consultation on and endorsement of the Health 2020 targets

At its sixty-first session in September 2011 in Baku, Azerbaijan, the WHO Regional Committee for Europe endorsed proposals that Health 2020 would:

- set out an action framework to accelerate attainment of better health and well-being for all;

- be adaptable to the different realities that make up the Region; and
- have regional targets for achievement by 2020.

The process of target setting was informed by previous efforts, detailed participatory discussion and written consultation, and the results were approved by WHO governing bodies at each stage. At its sixty-second session in September 2012 in Malta, the Regional Committee endorsed the Health 2020 policy, its overarching targets and the need for specific targets and indicators to monitor implementation by 2020 (53) (Box 11).

At its sixty-second session, the Regional Committee discussed in great depth the principles and criteria for selecting targets as part of the formulation and implementation of Health 2020, along with sample indicators to monitor progress and the elements of a monitoring framework (53). The targets would clearly help to define the Health 2020 policy's direction and goals. Much work went into setting the targets for Health 2020. The Regional Committee's key message on monitoring and reporting was that existing, available health information should be used as much as possible, and that the targets would be regional, not national, with progress reported at the

| Box 11. Key consultation milestones 2011–2012 | |
|--|--|
| Date | Action |
| May 2011 | The Standing Committee of the Regional Committee (SCRC) endorses the development of targets and forms an SCRC working group on targets and indicators to lead the process. |
| November 2011 | The technical divisions of the WHO Regional Office for Europe propose a long list of 51 high-level targets and monitoring indicators for each major area of Health 2020. |
| January 2012 | Using agreed criteria, the SCRC working group reduces the number of target proposals to a shortlist of 21. |
| February 2012 | The Regional Office conducts extensive written and face-to-face consultations with Member States on the targets, resulting in an initial framework of 16 potential targets and associated indicators, largely drawn from existing data reporting by countries. |
| April 2012 | Based on the consultation results, the third meeting of the European Health Policy Forum of High-level Government Officials proposes six overarching regional or headline targets. |
| May 2012 | The SCRC fully supports the target work, further endorses the six overarching targets, agrees that they will feature in all Health 2020 documents and confirms that indicators will monitor progress and achievement by 2020. |
| September 2012 | The Regional Committee endorses the six overarching regional targets, recognizing the need for quantification and for detailed indicators to be developed as part of the resolution endorsing Health 2020 (53). |

European level. Representatives of Member State delegations and nongovernmental organizations alike congratulated the WHO Regional Office for Europe on its efforts, and underlined the need to ensure that targets and indicators were specific, measurable, achievable, relevant and timely (SMART).

The Regional Office will reconvene the expert group that had guided the process and, after further broad consultation, submit the final list of indicators to the SCRC and then the Regional Committee for adoption in 2013. The key debates and decisions within these processes are described further in this chapter.

Formulating targets – general principles and specific criteria

Targets have often been associated with reductionist views of system behaviour and performance, as well as mechanisms of hierarchical thinking and control. Yet the present literature on health systems increasingly considers these to be systems characterized by complexity and uncertainty; thus, targets may help to clarify expectations, motivate performance and improve accountability in this context. Moreover, the concept of “collective benchmarking” (54) provides a participatory process for the setting of goals and targets, in which the parties are accountable to one another, to facilitate overall improvement. Box 12 summarizes both the strengths of targets and limitations on their usefulness.

Targets should be adaptable and dynamically assessed. In the context of policy implementation, targets are a heuristic that gives a concrete direction useful in assessing and adjusting activities along the way. A crucial consideration is the availability of data. Monitoring progress towards health targets depends on the availability of comparable data of reasonable quality and reliability. In practice this is often a key constraint. Data availability is one criterion for either regional or country indicators to monitor Health 2020 targets. Even so, experience in the European Region has shown that setting targets and selecting indicators can be a huge motivating and innovating factor for countries to strengthen and/or expand data collection and incorporate reporting within national routine information systems. This includes stimulating the use of new and existing data to inform public health policy, including wider government policies promoting health. For some countries, this has catalysed the inclusion, analysis and use of data that had not previously existed at the national level.

These issues were considered by the internal and external steering groups for Health 2020, and in the Regional Office's wider consultations with Member States and experts. Clear guiding principles and criteria were set for the use of targets within Health 2020. From the start, Member States agreed that targets would be set at European rather than country level, leading to reporting of regional averages. Hence targets should be both relevant for the whole Region and important for every Member State. A European-level target is meant to inspire and to promote learning, solidarity and engagement – particularly, yet not only, on cross-border issues. At the same time, Member States are encouraged to develop their own national targets and strategies for action; the specific context should be the development of national policies for health.

Moreover, a good balance had to be struck between different types of targets, given the themes of Health 2020: a mixture of outcomes, determinants, risk factors and processes; input targets on, for example, investment, capacity and resources; and some targets looking at distribution within a country or across countries to address health inequalities – gradients and gaps, relative and absolute – and promoting “levelling up” rather than being satisfied with regression to the mean.

Box 12.
Strengths and limitations of targets

| Strengths | Limitations |
|--|---|
| Targets are a concrete way to express policy and focus direction, including raising awareness and facilitating political and organizational support (for example, the MDGs). | Targets are difficult to align with strategy. |
| They reflect a scientific view on the future, in terms of achievable improvements in population health. | There is a risk that priority will be given to targets that can be measured easily (“what can be measured gets done”). |
| They provide a learning experience for stakeholders. | They may be liable to bureaucratic capture – elements of the organizational bureaucracy justify their existence in terms of a target. |
| They are seen as a tool for strengthening accountability and communication. | They are subject to the law of diminishing returns – achieving the last few percentage points of a target may be very resource-demanding. |
| They provide a map for partners. | They may be associated with “gaming” – managing the target rather than the task. |
| They serve as reference points for day-to-day action. | If too numerous or complex, they may be seen as burdensome and demotivating. |
| They provide motivation for action, creating a virtuous cycle. | They are often expressed in terms of averages (as with the MDGs), thus hiding distributive or equity issues that will be fundamental for Health 2020. |

Another important consideration was to be realistic and parsimonious, yet not simplistic: for example, by creating a set of 5–10 understandable and measurable targets, possibly with quantitative and qualitative measures. Consultation with Member States and governing bodies confirmed the need for mechanisms for accountability.

Further, the targets had to refer explicitly to existing global frameworks, conventions, targets and strategies to which all countries had agreed, or signed, in the case of conventions and treaties. In the contemporary context, it was important to be in line with not only the MDGs but also new global targets on NCDs, among other global and regional issues.

SMART targets are more likely to be accomplished than general goals. Targets must be clearly expressed and unambiguous. To arrive at measurable targets, concrete criteria for measuring progress must be established. For targets to be achievable, they must be realistic and set against a defined time scale: a time frame, preferably with deadlines, maintains momentum and increases targets' use to catalyse collective action. Targets are considered relevant when they represent objectives to which a policy can contribute. Again, although a heuristic, every target should represent real progress with qualitative or quantitative measures. In fact, the SMART criteria should apply to both qualitative and quantitative targets.

Formulation of specific targets for Health 2020

Process

The process of target and indicator setting is complex and previous experience with the Health for All approach in the 1980s and 1990s – and more recently with setting goals for the MDGs – showed that a well-organized mechanism was needed to achieve SMART outcomes. It needed to include a monitoring framework and structured reporting, as well as elements of interpretation of the indicators and what achievement of SMART targets would mean for the European Region. The process had to be participatory, but not too complex and cumbersome. The SCRC proposed forming a small working group on targets and indicators, composed of the following members:

- experts from Member States (represented in the SCRC and the Forum of High-level Government Officials) with expertise in the subject areas and health information;

Box 13.
The SCRC working group on targets and indicators

The SCRC working group on targets and indicators agreed on its terms of reference during its first teleconference:

- to finalize the modus operandi of the working group, including a roadmap;
- to summarize the results of the discussions within the SCRC and WHO Regional Office for Europe in relation to Health 2020 targets and to examine previous target-setting exercises;
- to agree on the technical methodologies used for setting targets and indicators, placing particular emphasis on recommending a process and methodology for the development of qualitative targets;
- to identify salient issues for presentation to the Regional Committee;
- to establish two high-level targets for each major area, and to discuss and propose up to two subtargets for each high-level target;
- to research and propose the indicator(s) for each target that follow the principles agreed on and for which information is available;
- to accompany the consultation with Member States, to be coordinated by the Regional Office;
- to propose and finalize the targets to be presented to the sixty-second session of the Regional Committee in connection with the finalized Health 2020 policy.

The group co-opted other experts as required, and maintained close links with the groups conducting studies to support the development of Health 2020, particularly the task group on measurements and targets involved in the review of social determinants of health and the health divide in Europe. At each meeting, the working group made clear recommendations to narrow the list of potential targets and indicators in line with the three broad areas initially identified as part of Health 2020:

- the burden of disease and risk factors;
- healthy people, well-being and determinants;
- processes including governance and health systems (47).

The Regional Office Secretariat collated inputs and recommendations on the process, as well as potential targets for inclusion, for the various consultations with Member States.

- senior staff of the WHO Regional Office for Europe; and
- Regional Office staff with experience and expertise in target setting and health information.

Member States contributed to the technical deliberations, working closely with the WHO Secretariat, as proposed by the SCRC in May 2011. Representatives of the following Member States were nominated for this working group: Andorra (previous SCRC chair), Poland, Sweden (subsequent SCRC chair), the former Yugoslav Republic of Macedonia (former SCRC chair), Turkey, Ukraine and the United Kingdom. A representative of a Member State (Sweden) with extensive experience in this area and the WHO Regional Director for Europe co-chaired the group. The group held meetings via video or teleconferencing every 1–2 months and face to face in connection with SCRC and Regional Committee meetings, with terms of reference spelled out in Box 13.

Health 2020 targets

As mentioned, the Regional Committee adopted the text with the six overarching targets and agreed on the development of indicators to assess the success of the implementation of Health 2020 across Europe. The targets have the advantage of being inextricably linked to the strategic objectives and policy priorities of Health 2020. The rationale for choosing them was that they either are in line with contemporary global target-setting efforts, for example, in the area of NCDs, or extend and update previous European target-setting strategies and approaches acknowledged or agreed by European Member States.

Here are the overarching targets.

1. Reduce premature mortality in Europe by 2020.
2. Increase life expectancy in Europe.
3. Reduce inequities in health in Europe.
4. Enhance the well-being of the European population.
5. Provide universal coverage in Europe.
6. Establish national targets set by Member States.

Table 2 shows the correlations between the areas addressed by the Health 2020 targets and the Health for All and HEALTH21 targets.

Although progress on the overarching targets will be reported at the European Region level, most actions will occur at the country level. The sixth overarching target makes this explicit, and reflects many

European countries' inclusion of target setting in their national health policies (Box 14).

Identifying ways to set target levels and indicators

Once target areas are agreed, the next step is to identify target levels and indicators to monitor progress towards the target. Moreover, since the WHO Regional Director for Europe is to report progress towards achieving the targets as European averages, the regional targets need to be informed by monitoring of indicators at the country level.

The Regional Office held a special meeting of an expert group to identify indicators in June 2012 (56). The group agreed on the principle criteria for selecting indicators for five of the six areas (excluding well-being). Indicators should:

Table 2.
The areas addressed by the overarching targets of Health 2020 and previous European targets

| Health 2020 target area | Health 2020 overarching target | Equivalent targets | |
|---|--|--|---|
| | | Health for All (50) | HEALTH21 (4) |
| Burden of disease and risk factors | 1. Reduce premature mortality in Europe by 2020 | No direct equivalent but indirect ones through targets on reduction of infant, child and maternal mortality and healthy ageing | Premature mortality targets under various headings, including young people, road safety, communicable diseases and NCDs |
| Healthy people, well-being and determinants | 2. Increase life expectancy in Europe | "By the year 2000 life expectancy at birth in the Region should be at least 75 years and there should be a sustained and continuing improvement in the health of all people aged 65 years and over" | "By the year 2020 ... the gap in life expectancy between the third of European countries with the highest and the third of countries with the lowest life expectancy levels should be reduced by at least 30%" |
| | 3. Reduce inequities in health in Europe (social determinants target) | "By the year 2000 the actual differences in health status between countries and between groups within countries should be reduced by at least 25%; people with disabilities should be able to lead socially, economically and mentally fulfilling lives" | "By the year 2020 ... the gap in life expectancy between socioeconomic groups should be reduced by at least 25%; the values for major indicators of morbidity, disability and mortality in groups across the socioeconomic gradient should be more equitably distributed" |
| | 4. Enhance the well-being of the European population (to be further elaborated during 2012/2013) | "By the year 2000, all people should have the opportunity to develop and use their own health potential in order to lead socially, economically and mentally fulfilling lives" | "By the year 2020, people's psychosocial well-being should be improved" |
| Processes, governance and health systems | 5. Provide universal coverage in Europe | Formulated as access to care, particularly primary health care, without financial burden to households | "By the year 2010 funding systems for health care [should] guarantee universal coverage, solidarity and sustainability" |
| | 6. Establish national targets set by Member States | Support provided to target setting and health information in countries, including indicators and adequate information systems at the country level | A high proportion of targets also formulated for national achievement |

Box 14.
Case study:
targets in action in Austria (55)

Through an extensive and broad process of consultation during 2011 and 2012 the Austrian Federal Ministry of Health arrived at 10 national framework health targets. A committee was set up to develop the targets, comprising representatives of almost 40 public authorities at the federal, regional and local levels (covering different political sectors), social insurance and social partners; experts on the health care system and health care professionals; and representatives of institutions of the health and social care system, and of patients, children and adolescents, elderly people and socioeconomically disadvantaged people.

Interested citizens were able to participate in the process by using an internet platform that allowed them to provide input at the start and feedback on the draft targets at the end of the process. Two large conferences – to start the process in May 2011 and to present the draft health targets in May 2012 – were organized to involve a wider group of health experts and members of the public.

The targets cover a wide span: from a healthy environment and equity to health literacy, from social cohesion and healthy lifestyles to health care, and from healthy childhood and nutrition to promotion of psychosocial health. The overall target is to increase healthy life expectancy by 2 years within the next 20 years. Following approval by the Federal Health Commission and a resolution by the Council of Ministers in July 2012, Austria is now identifying suitable indicators for each of the 10 targets and setting up a binding plan for implementation and health reporting. For implementation and evaluation, the same cross-sectoral group of political and societal institutions and stakeholders will be nominated as a target monitoring board.

- be routinely collected, simple and inexpensive to administer for Member States where possible (most often already being processed for international databases);
- have a high level of robustness and validity, to measure target achievement;
- inform policy options, to support decisions on priorities;
- offer disaggregation at the lowest regional or subnational level possible to facilitate monitoring of regional differences within and across Member States;
- be able to be stratified by age and sex, and where possible by ethnicity, socioeconomic characteristics and vulnerable groups; and
- be available in the majority of Member States.

For these purposes, health information routinely collected by countries should be used as much as possible, and new data collection should be avoided where possible.

Methods for setting target levels

The technical methods used for setting a target level and selecting existing or developing new indicators vary according to the objectives to be attained. Several approaches exist that vary in relation to the data and evidence required and the complexity of calculation methods (see Box 15 on setting target levels and identifying indicators for NCDs). The following sections outline alternative methods for the first target area: the burden of disease and risk factors.

Counterfactual method

This method is based on comparing a biologically achievable or theoretical minimum with the existing reality according to available information. Murray and Lopez (57) described it in 1999 as a taxonomy of counterfactual exposure distributions that assist with mapping options for policy implementation. These include distributions that correspond to a theoretical minimum, a plausible minimum, a feasible minimum and a cost-effective minimum of any risk factor or target described. For this target area the method takes account of the fact that a certain burden of disease will be unavoidable, no matter how favourable the environment.

Trend analysis

This method is often used, and involves observing and documenting trends by geographical areas, either within or across countries or groupings of countries, or by social, economic or demographic

population characteristics, such as sex, educational level or occupational group. It provides a basis for considering the evolution of broader determinants of health, risk factors, and health outcomes or consequences, between different groups. A target could therefore be set to reduce differences in rates between groups of countries.

Other methods

Many other methods exist, including approaches to further refining target setting. One is the pooling of intervention studies: studies examining and quantifying the effect of interventions (including

Box 15.
Illustrating approaches to setting target levels and identifying indicators for NCDs

The counterfactual method

An indicator of premature mortality from diseases of the circulatory system, a target area for NCDs, could be used. (Premature mortality is used purely for illustrative purposes and may not be appropriate, since it excludes the elderly as an important vulnerable group.) The target content can be formulated in different ways, including:

- a reduction of mortality from diseases of the circulatory system in the European Region of at least 1.5% annually by 2020, with the most significant reductions achieved in countries with the highest current rates; or

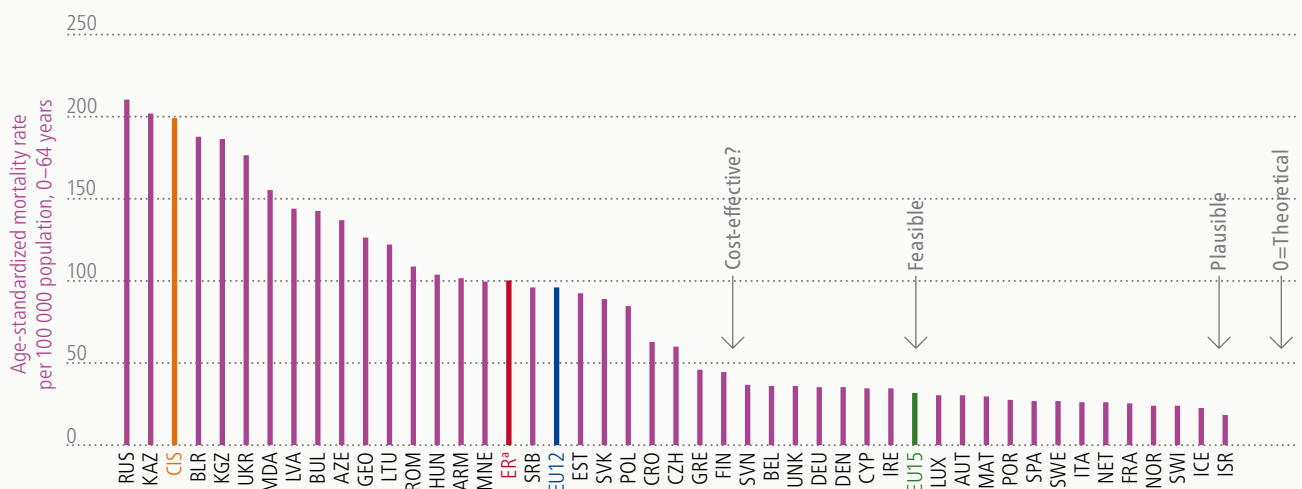
- a reduction of mortality from diseases of the circulatory system in the Region to the lowest current subregional average. This would immediately become a quantified target, as it would set the European Region average to decline from 100 per 100 000 in 2010 to a currently observed rate within the Region by 2020.

The indicator for this target could be “age-standardized mortality rate for diseases of the circulatory system per 100 000 population, 0–64 years”. The figure below shows this rate for all countries in the European Region, as well as the average rates for the previously used subgroups of countries within the European Region:

- the 15 countries belonging to the EU before 1 May 2004 (EU15);
- the 12 countries joining the EU since May 2004 (EU12); and
- the Commonwealth of Independent States (CIS) until 2006 (see Annex 1 for details).

To achieve an age-standardized mortality rate of zero would be a theoretical but not physiologically plausible minimum rate. One could argue, however, that, given the right environment and conditions, all countries in Europe should be able to attain the lowest rate (in this example, that of Israel) as it is already a biological reality, and hence plausible; or, as noted above, to reach the lowest current subregional average (in this

Premature mortality from diseases of the circulatory system
in countries and subregions in the European Region, last reported data 2006–2010



cost-effectiveness) from various countries in Europe can be pooled and the percentage reduction of the outcome of the intervention can be used as a quantifier for the target. These are important as they link directly with policy options.

Comparative risk assessments offer another approach: these studies examine and quantify the effect of risk factors on disease, and predict the development of the disease burden based on predictions with changes in the determinants over time. There is plenty of literature on this subject, especially from Europe.

example, that of the EU15) as this is also already observed, and hence feasible.

Alternatively, one could argue that countries with the highest rates should be able to attain the average rate for the whole Region. Further information from intervention studies would be required to debate a cost-effective minimum. The choice of the standard (often called the counterfactual) against which progress would be compared and the target set would either be through expert opinion, consensus or other methods (described further below).

The highest country rate in this figure is more than 10 times the lowest, and more than 2 times the average for the European Region. Depending on which rate is used as the counterfactual or target rate, the percentage reduction of the target would vary. Alternatively, a positive expression could be used, focusing on life expectancy rather than mortality; the highest life expectancy in the Region could then be identified as counterfactual for regional comparisons.

To quantify this sensibly, further steps would be required. Moreover, many factors determine the differences in rates, but overall mortality is an important one, where low rates of cause-specific mortality may only reflect high rates of competing mortality from other avoidable causes.

Trend analyses

Another illustration of mortality from diseases of the circulatory system demonstrates how trends in rates can be used to arrive at a target, this time in the area of inequalities. The figure right shows how premature mortality from diseases

of the circulatory system has changed in Europe. It demonstrates that the differences in rates between countries in the Region have increased, particularly in the past 20 years. This may lead to the formulation of a target such as "a reduction in the inequalities in mortality from diseases of the circulatory system within the European Region by x%". The indicator would be the "proportional difference in mortality from diseases of the circulatory system between the highest and the lowest countries". Alternatively, the target could be to "reduce the differential of mortality from diseases of the circulatory system between certain subgroups of countries (that would need to be identified) by x%"; many different options are available. In both cases, the percentage of reduction needs to be set with the agreement of Member States.

Further analysis is required to assess whether a quantified target is realistic. This would include the examination of correlations using predictor variables, particularly those that are prone to respond to interventions, or the analysis of quintiles where the countries within the best quintile are examined for commonalities. This requires more detailed knowledge of the effectiveness of interventions to reduce either disease or risk factors/determinants. This analysis would examine the commonalities of countries, subgroups or regions with the highest and the lowest rates.

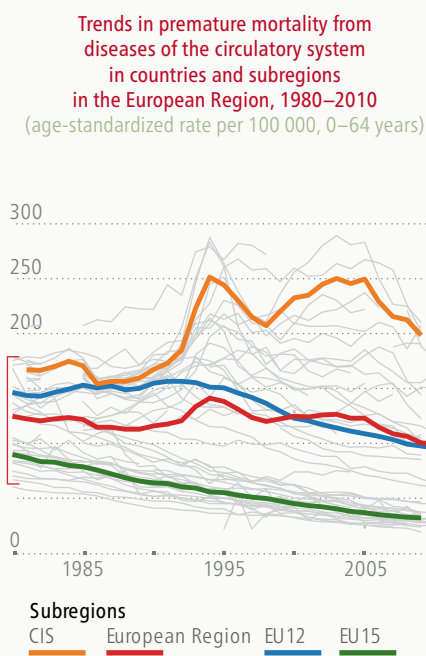
Pooling of intervention studies

As a hypothetical example, if the aggressive use of statins and certain health system improvements have reduced mortality from diseases of the circulatory system by 5% in some countries, then a potential

target could be set at a 5% reduction in premature mortality rates for diseases of the circulatory system.

Comparative risk assessments

Here is another hypothetical example. If declines in tobacco consumption have been followed by a reduction in mortality from diseases of the circulatory system by 10% in some countries, then a potential target could be set at a 10% reduction in premature mortality rates for diseases of the circulatory system.



Setting target levels and selecting indicators to monitor progress towards 2020

The expert group meeting in June 2012 proposed a preliminary set of potential indicators for monitoring the six overarching targets (56). The main points of agreement from this meeting should be noted in the light of the indicators currently available in the Health for All database and a few other sources.

- There should be a set of core indicators for which data should be available across the European Region, with the opportunity for countries to expand this list and make use of additional indicators available to them.
- Member States should report on core indicators and refer to the expanded list if resources are available.
- A dimension of accountability is needed: the list of core indicators could provide it.

As Member States agreed that the baseline for monitoring of Health 2020 targets should be set at 2010, this provides a ten-year window for monitoring and reporting progress.

Based on criteria proposed to monitor progress, the expert group proposed a target level for each of the overarching target areas, and drafted two sets of indicators for further discussion (see Table 3): core indicators that clearly meet all or almost all criteria and a menu of additional indicators from which Member States may select the most relevant or to which they may wish to make additions where appropriate.

The indicators proposed by the expert group are placeholders. Following the 2012 session of the Regional Committee, the WHO Regional Office for Europe started extensive consultation with Member States to finalize the indicators for the agreed targets for submission to the Regional Committee in 2013. This includes discussions at all governing body meetings and a written, web-based consultation.

To stimulate the debate on relevant indicators for the endorsed overarching targets for Health 2020, some of the indicators proposed by the expert group are used here to illustrate a baseline, including trends for four of the overarching targets. In addition, a framework for monitoring is illustrated for one indicator.

Table 3.
Monitoring progress towards Health 2020

| Health 2020 overarching target | Key target areas | Proposed core indicators | Additional potential indicators |
|---|--|--|--|
| 1. Reduce premature mortality in Europe by 2020 | <p>1.1. 1.5% relative annual reduction in overall mortality from diseases of the circulatory system, neoplasms, diabetes, and chronic respiratory disease by 2020</p> <p>1.2. Achieve and sustain elimination of selected vaccine-preventable diseases (poliomyelitis, measles, rubella, prevention of congenital rubella syndrome)</p> <p>1.3. 30% reduction in road traffic injuries by 2020</p> | <p>1.1a. Age-standardized all-cause mortality rate per 100 000 population, disaggregated by sex and broad cause of death</p> <p>1.1b. Prevalence of major risk factors, including those formulated in the global NCD monitoring framework</p> <p>1.1c. Infant mortality per 1 000 live births</p> <p>1.2a. % of children vaccinated against measles, poliomyelitis and rubella</p> <p>1.3a. Age-standardized mortality rates per 100 000 population from all external causes</p> | <p>a. Overall and premature mortality for four major NCDs by sex (diseases of the circulatory system, neoplasms, diabetes, and chronic respiratory disease)</p> <p>b. Daily tobacco smoking in population aged 15 years and over by 2020</p> <p>c. Alcohol consumption</p> <p>d. Overweight/obesity</p> <p>e. Transport accidents</p> <p>f. Accidental poisonings</p> <p>g. Alcohol poisoning</p> <p>h. Suicides</p> <p>i. Accidental falls</p> <p>j. Homicides and assaults</p> |
| 2. Increase life expectancy in Europe | 2.1. Continued increase in life expectancy at current rate coupled with either 50% or 25–30% reduction in the difference in life expectancy between European populations by 2020 | 2.1a. Life expectancy at birth | <p>a. Life expectancy at birth and at ages 1, 15, 45 and 65</p> <p>b. Healthy life expectancy at birth and 65</p> |
| 3. Reduce inequities in health in Europe (social determinants target) | 3.1. Reduce the gap in health status between population groups experiencing social exclusion and poverty and the rest of the population | <p>3.1a. % of early school leavers</p> <p>3.1b. Poverty, including in special groups (children, the elderly)</p> <p>3.1c. Infant mortality per 1 000 live births</p> <p>3.1d. Qualitative indicator documenting establishment of national policy addressing health inequities</p> <p>3.1e. Life expectancy</p> <p>3.1f. GINI coefficient</p> <p>3.1g. Human Development Index</p> <p>3.1h. Suicide/homicide rates</p> <p>3.1i. Teenage pregnancy rates</p> | <p>a. % of primary school enrolment</p> <p>b. % of children at risk of poverty</p> <p>c. Life expectancy by sex and rural/urban split</p> <p>d. Human Development Index – adjusted for inequities</p> |
| 4. Enhance the well-being of the European population | To be developed during 2012/2013 | <p>4.1a. Prevalence of childhood obesity</p> <p>4.1b. To be developed (including mental health, ill health, mortality, including suicide rates; objective and subjective measures)</p> | a. Participation rates of people with mental disorders in employment |
| 5. Provide universal coverage and the “right to health” in Europe | 5.1. Funding systems for health care to guarantee universal coverage, solidarity and sustainability by 2020 | <p>5.1a. Private households’ OOP expenditure as a proportion of total health expenditure</p> <p>5.1b. % of children vaccinated against measles, poliomyelitis and rubella</p> <p>5.1c. % of low-birth-weight babies (<2.5 kg)</p> <p>5.1d. Per capita expenditure on health (as % of GDP)</p> | a. More detail on OOP expenditure indicator |
| 6. Establish national targets set by Member States | 6.1 National target-setting processes established and targets formulated | <p>6.1a. Qualitative indicator documenting both process and formulation</p> <p>6.1b. Qualitative indicator documenting use of health-in-all-policies approach</p> <p>6.1c. Qualitative indicator documenting: (i) establishment of national Health 2020 policy; (ii) implementation plan; (iii) accountability mechanism</p> | |

Target 1. Reduce premature mortality in Europe by 2020

The key target areas involve the relative reduction in overall mortality from diseases of the circulatory system, neoplasms, diabetes and chronic respiratory disease; the elimination of selected vaccine-preventable diseases; and the reduction of road traffic accidents.

Indicator: age-standardized all-cause mortality rate per 100 000 population, disaggregated by sex and broad cause of death

As noted in Chapter 1, although the overall average has decreased in recent years, all-cause mortality rates show large discrepancies across the European Region (see Fig. 10, p. 10).

Premature mortality (deaths occurring before the age of 65 years), disaggregated by broad groups of causes of death and sex, has been suggested as a potential additional indicator for this target (Fig. 63). Trends for the European Region show large differences of magnitude between males and females, twofold or higher for all groups of causes, but particularly marked for diseases of the circulatory system, neoplasms and external causes. Disease incidence patterns also diverge: females are now similarly affected by both diseases of the circulatory system and neoplasms and affected to a lesser extent by external causes. Males are significantly more affected by diseases of the circulatory system than any other cause group, followed by external causes and neoplasms. Mortality trends for most groups of causes are decreasing, although at different paces, except for diseases of the digestive system (most related to chronic liver disease and cirrhosis).

Indicator: prevalence of major risk factors

Another proposed core indicator is the prevalence of major risk factors for NCDs, including tobacco smoking and alcohol consumption. The prevalence of regular smoking has decreased towards 25% in Europe. Nevertheless, smoking prevalence rates are not recorded in all countries, which poses some challenges to monitoring.

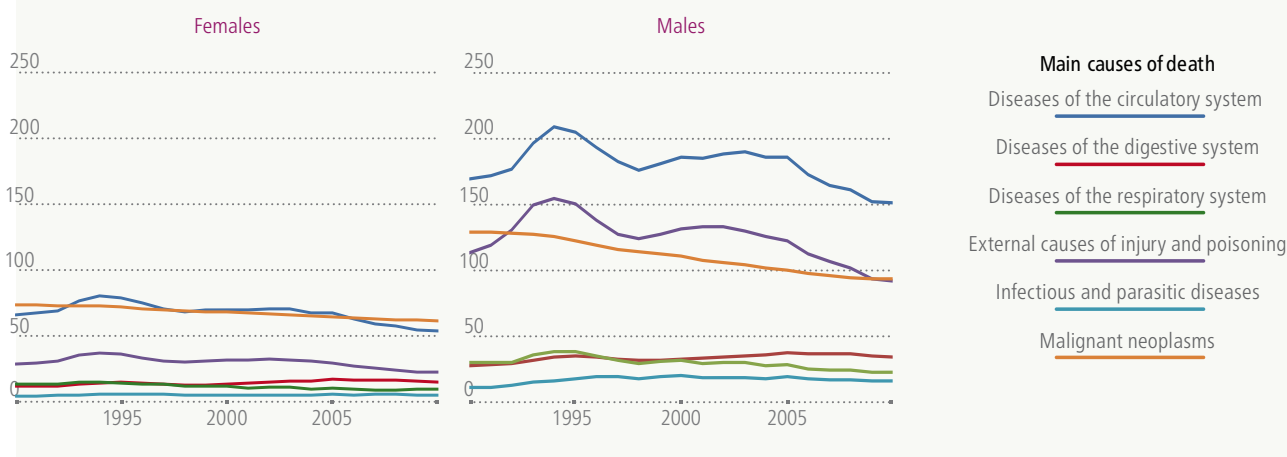
In contrast, alcohol consumption rates in some parts of the Region have risen strikingly fast, masked by the overall European Region average (Fig. 64). This is accompanied by similar patterns of mortality from alcohol-related causes.

Indicator: percentage of children vaccinated against measles, poliomyelitis and rubella

A crucial target area for reducing premature mortality is achieving and sustaining the elimination of selected vaccine-preventable

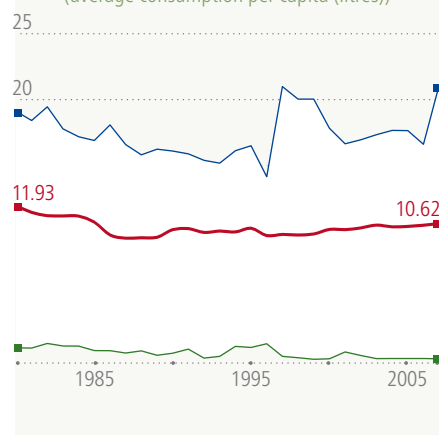
diseases. Potential indicators for monitoring are those relating to efforts of the health system, particularly immunization. Over the past decade, the proportion of children protected against measles and poliomyelitis has reached levels above 90% in the European Region (Fig. 65). The levels have been slightly higher in countries in eastern Europe and central Asia. In some countries, recent declines in immunization rates have created the conditions for outbreaks. Increased efforts will be required to achieve effective protection of the population in such scenarios.

Fig. 63.
Trends in premature mortality by sex and main broad group of causes of death in the European Region, 1990–2010
(age-standardized rate per 100 000, 0–64 years)



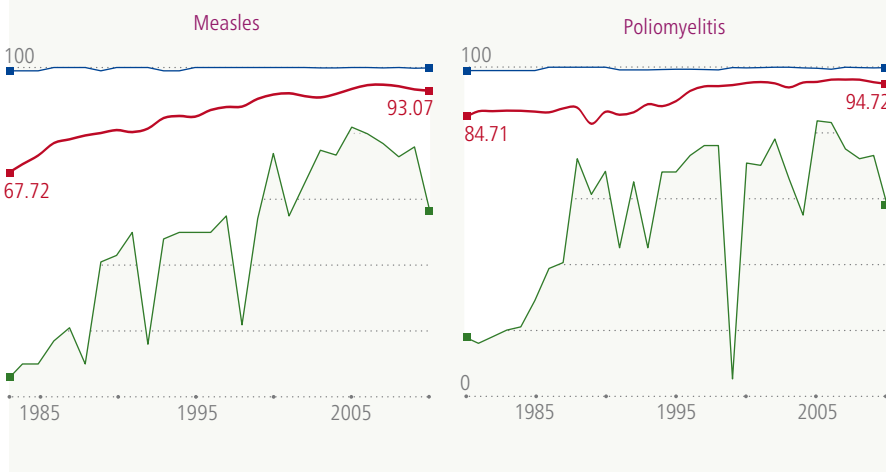
Source: European Health for All database (6).

Fig. 64.
Average alcohol consumption per capita among the population aged 15 years and over in the European Region, last reported data, 1980–2007
(average consumption per capita (litres))



Source: European Health for All database (6).

Fig. 65.
Immunization against measles and poliomyelitis in the European Region, 1980–2010
(infants immunized (%))



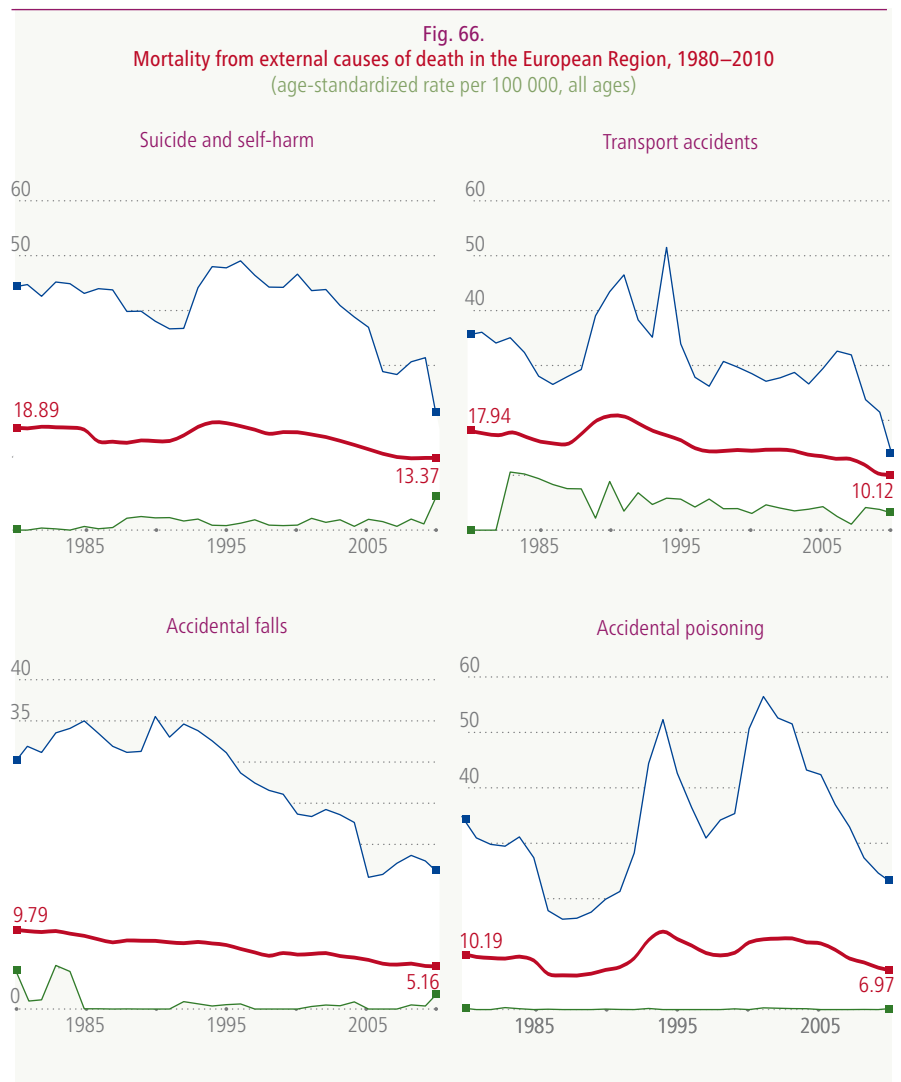
Source: European Health for All database (6).

Indicator: age-standardized mortality rates per 100 000 population from all external causes

Given their importance for mortality, road traffic accidents (and other external causes of death) are considered another relevant target area. In 2010, mortality rates from external causes varied from 25 to 103 per 100 000 in the Region, a nearly fourfold difference (see Fig. 35, p. 29). Rates from specific external causes also vary considerably between countries (Fig. 66), as discussed in Chapter 1.

Target 2. Increase life expectancy in Europe

The key target area is the continued increase in life expectancy at the current rate, combined with a reduction in gaps between populations.



Source: European Health for All and mortality databases (6,11).

Indicator: life expectancy at birth

Over the past three decades, life expectancy has increased in Europe at an average annual pace of 0.17 years (see Fig. 4, p. 5). Projections suggest that it will nearly reach 81 years by 2050, at a pace similar to that in 1980–2010 (7). Nevertheless, there are important gaps between groups of countries. For example, in 2010 life expectancy in some western European countries had already reached the level expected for the whole Region in 2050, and will reach 85 years in 2050. In contrast, others are expected to reach only 75 years of life expectancy by 2050 – the level observed in the European Region as a whole in 2010 – or that already achieved by some countries in 1985.

Target 3. Reduce inequities in health in Europe (social determinants target)

The target area will address reductions in health gradients and gaps between population subgroups in countries. The focus is likely to be on those experiencing social exclusion and poverty, in comparison to the rest of the population. This will include differences in life expectancy between European populations by 2020.

Target 4. Enhance the well-being of the European population

This target area requires considerable new work. The WHO Regional Office for Europe has launched an initiative on measuring and setting targets for well-being, led by international experts. This group's proposals for indicators will be intensively discussed with Member States, as discussed in Chapter 3. The group has suggested that the prevalence of childhood obesity may be one of several indicators in this area.

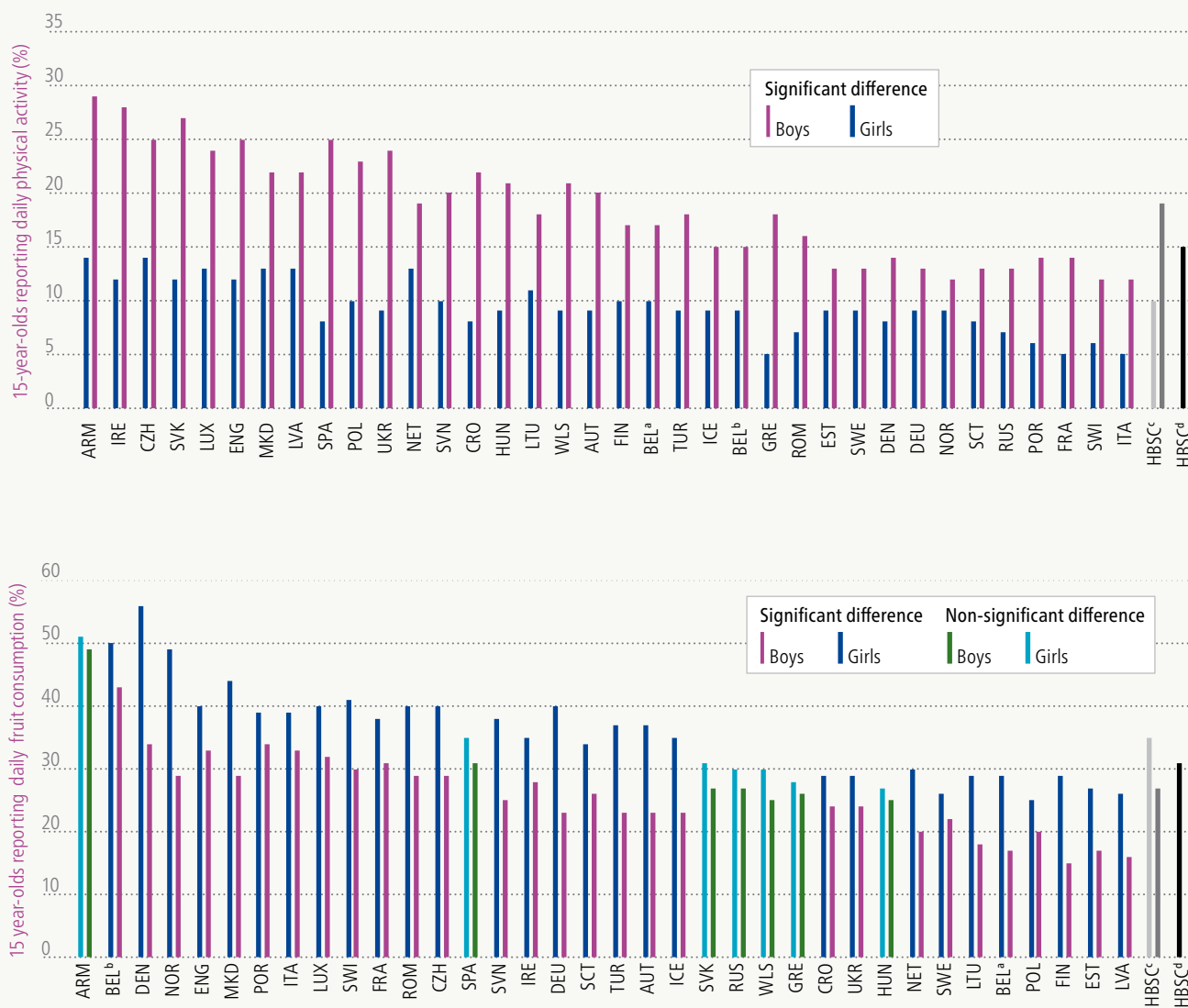
Indicator: prevalence of childhood obesity

New data on the prevalence of obesity are only slowly becoming available for European countries, and some proxy measures linked to health behaviours may be used as alternatives. The latest survey of schoolchildren for the HBSC study provides information on their health behaviours, including physical activity and nutritional habits (40). While 15% of 15-year-olds reported moderate-to-vigorous physical activity in their daily routine (Fig. 67), boys were twice as likely to do so as girls (19% versus 10%). The highest reported rate for both boys and girls was nearly three times the lowest. In relation to healthy eating behaviours, 31% of adolescents overall reported eating fruit daily, although the rates were higher for girls than boys (35% and 27%, respectively). Variation between countries was considerable, with up to twofold differences between boys and girls.

Target 5. Provide universal coverage and the “right to health” in Europe

The key target areas involve the funding of health systems to guarantee universal coverage, which requires solidarity and sustainability in order to be achieved by 2020.

Fig. 67. Prevalence of moderate-to-vigorous physical activity and fruit consumption among 15-year-olds in countries in the European Region, by sex, 2009/2010



Source: Currie et al. (40). Notes: ^a Belgium (Flemish) ^b Belgium (French) ^c HBSC average (gender) ^d HBSC average (total)

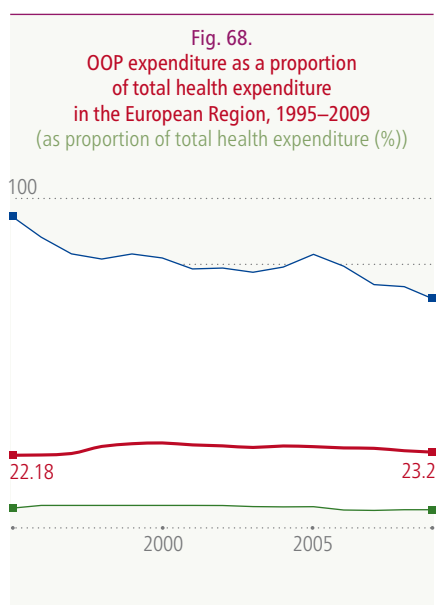
Indicator: private households' OOP expenditure as a proportion of total health expenditure

This indicator provides information on health expenditures made by households that are not covered by a pooled fund (whether from general taxes or insurance schemes), and is a core indicator for universal coverage (representing one of its three dimensions). The average share of OOP expenditure in total health expenditure in the European Region was 23% in 2009 (Fig. 68), but ranged from a low of 5.7% to a high of 79.5% (a fourteenfold gap between countries), as discussed in Chapter 1.

Target 6. Establish national targets set by Member States

This target area will reflect the processes put in place or strengthened by Member States across the European Region (see the example in Box 14), further described below. The focus is likely to be on updating existing efforts, and on adding new areas relevant to the Health 2020 policy and to countries that strengthen the monitoring and reporting of targets and indicators at the country level. In addition, the WHO Regional Office for Europe will support an exchange of best practices across the Region.

Monitoring of targets and indicators for Health 2020



Source: European Health for All database (6).

The Regional Office is finalizing a framework for the monitoring of targets and indicators for Health 2020, in consultation with Member States. Feedback from the 2012 session of the Regional Committee indicated that the following mechanisms would be appreciated.

Reporting mechanisms for Member States

Existing reporting mechanisms should be used to the greatest possible extent. This includes annual or biannual reporting to the Health for All or other databases hosted by the WHO Regional Office for Europe, including joint data collection with EUROSTAT and OECD. The Regional Office will be required to monitor and harvest the information from the databases and ensure its appropriate synthesis, analysis and presentation to Member States.

Platform(s) for reporting from Member States

Member States should not have to provide additional information except where non-routine data are required (potentially for targets 4 and 6). Where indicators are not routinely collected (through either the national reporting system or regular surveys) and already reported to WHO, estimates from WHO headquarters or joint United Nations efforts that are accepted by Member States could be used. The WHO Regional Office for Europe will hold discussions with Member States to determine what options may be pursued to achieve this, and continually consult the SCRC.

Existing platforms, particularly the annual data collection for the Health for All database (6), should be used until the Division of Information, Evidence, Research and Innovation has established a single platform merging all the Regional Office's databases. This is envisaged for 2013. Joint data collection with EUROSTAT and OECD feeds into these mechanisms, so additional reporting will not be required.

Over the coming years, however, this platform is to be replaced by the integrated European health information system that the Regional Office is establishing in collaboration with the European Commission and OECD. The Regional Office's vision is to launch this system with the core indicators required for Health 2020 monitoring and reporting, as all Member States would accept this. The Regional Office will discuss this important issue further with the European Commission and OECD, to agree on a common way forward. In due course, the scope of the system may be expanded, reflecting opportunities, options and eventual agreements. For instance, the Regional Office is analysing how existing platforms can be transferred to an electronic infrastructure for a new system and will report on this regularly to Member States.

For indicators on which information is not routinely collected at present (such as national target-setting efforts and those addressing well-being), existing mechanisms can support any new effort. The Regional Office therefore proposes the following.

- The Regional Office's technical programmes may collect information on the qualitative indicators from Member States through minimal questionnaires, largely requiring a yes/no response; a narrative can be provided, if desired. Regional Office staff should canvass their technical counterparts in countries on this.

- The well-being indicators being developed in 2013 will include a mix of routinely reported data and self-reported information, and will require additional reporting. The Regional Office will regularly consult WHO Member States and governing bodies on the approach to data collection in this area. Existing mechanisms (for example, surveys by Gallup International or other groups conducting annual surveys in all European countries) should be explored for this purpose. The Regional Office is investigating these options (which should not pose any additional burden, including a financial one, on countries) with such providers and will ensure consultation, for example, through the existing annual efforts related to the Health for All database.

Synthesis of reporting through European health statistics and the Regional Director's report

The WHO Regional Office for Europe proposes to provide a synthesis of all data received through existing mechanisms every two years through a special section in a new publication, provisionally called “European health statistics”. Prior to publication, the Regional Office will conduct extensive written consultation with Member States. Reporting may take the form of detailed analyses of the data and their presentation in tables and graphs as regional averages, potentially new subregional averages, ranges giving maximum and minimum values, or detailed interpretative text and executive summaries.

To complement this biennial reporting, the WHO Regional Director for Europe will include an abridged report on the Health 2020 indicators in her annual report to the Regional Committee. This will provide a further platform for direct consultation and feedback. Analysis as outlined above is proposed. In addition, every 2–3 years the Regional Director will give an update on progress towards the quantified targets for the European Region. The SCRC meeting held in May of each year could function as a further platform for consultation on the results, in preparation for the Regional Director's report to the Regional Committee.

Major milestone reporting on the Health 2020 targets and indicators is envisaged to be included in the European health report, which the Regional Office publishes every three years. This will also permit more detailed analysis and discussion. The first milestone report would thus be in 2015, followed by 2018 and a final report in 2020. Moreover, the

Box 16.**Case study: benchmarking health in the Netherlands with the European Community Health Indicators**

Reflecting a 2006 ambition to move the Netherlands back into the top five healthiest European countries, the country adopted a new health policy approach to prevention. To provide evidence, the Ministry of Health, Welfare and Sport commissioned the National Institute for Public Health and the Environment (RIVM) to update the picture of public health and benchmark the Netherlands in the light of other EU Member States. In 2008 RIVM published the report, entitled *Dare to compare* (58), which responded to the following questions.

- How does Dutch public health compare with public health in other European countries in general, and with a focus on young people and the elderly? Where possible, issues of socioeconomic inequalities will be addressed.
- To what extent are Dutch data available and suitable to meet the specifications of the European Community Health Indicators shortlist, and what are the main gaps and bottlenecks when making international comparisons based on the shortlist?

A close examination of the shortlist of European Community Health Indicators covering public health showed that the Netherlands ranges among the top five healthiest European countries for some issues, but among the bottom countries for others. This diversity underlined the need for further investigation of causal pathways and patterns. The director of RIVM raised essential questions, such as why the country was doing so well on some issues and what could be learned for policy action on the ones that lag behind.

Importantly, the report is primarily aimed at policy-makers and public health professionals in the Netherlands, and provides a direct comparison between the Netherlands and other EU Member States on many current issues. Topics include health status, the determinants of health, prevention and care, and the demographic and socioeconomic situation. The report also gives special attention to health at different stages of life, covering children, young people and elderly people.

Regional Office is revitalizing its Highlights on Health series of country profiles; this medium can make progress immediately visible. The Regional Office is also bringing back a brief annual publication on core indicators for all European countries, with varying themes every year. It will publish the information in all these reports using media including the Regional Office web site.

Accountability

The Regional Office Secretariat is working out a process to outline the actions to be taken when:

- Member States do not regularly report on all indicators; or
- the targets as proposed do not appear to be on track for achievement.

In addition, it will need to share and highlight how countries across the Region use information at the national level – perhaps in comparison to the regional level and other countries in the Region – to inform health policies and programmes, and to provide insight into effective approaches in different contexts. Clearly, the wide range of activities underway can illustrate concretely that every country gains further insights through better national and regional health information: for example, through national and international comparative benchmarking studies that are linked to support national health policy, as is the case in the Netherlands (Box 16).

The monitoring framework

The WHO Regional Office for Europe will populate a detailed framework with all indicators, as outlined in Table 4, and present it to Member States for discussion and decisions. This framework outlines the data collection mechanisms, consultation events, reporting formats and timelines for all targets and indicators.

Chapter 2 has documented the process of establishing the overarching targets of the Health 2020 policy – what we are aiming for as a Region – and proposes an approach to setting achievable targets and indicators to monitor progress at the regional level. A key area for further development is measuring progress on health in the context of well-being, or what we value: this is the subject of Chapter 3.

Table 4.
Excerpt from an eventual detailed framework for all indicators

| Overarching target | Key target areas | Potential quantification | Additional potential indicators | Number of countries reporting | Data collection mechanism | Consultation with Member States | Reporting | |
|---|--|---|--|-------------------------------|--|--|--|----------|
| | | | | | | | Format | Timeline |
| 1. Reduce premature mortality in Europe by 2020 | 1.1. 1.5% relative annual reduction in overall mortality from diseases of the circulatory system, neoplasms, diabetes, and chronic respiratory disease by 2020 (To be aligned with global NCD target-setting efforts) | 1.1a. Age-standardized all-cause mortality per 100 000 population (as first indicator), disaggregated by sex and broad cause of death | a. Overall and premature mortality for four major NCDs by sex (diseases of the circulatory system, neoplasms, diabetes, and chronic respiratory disease) | 43 | Health for All database through existing annual mechanism (WHO prompt) | In Health for All context | Direct to countries (existing) | 2013 |
| | | | | | | May SCRC | Regional Director's report to the Regional Committee | 2014 |
| | | | | | | Additional written consultation | European health statistics | 2015 |
| | | | | | | Information document at Regional Committee | European health report | |