

10

HEALTH QUESTIONS ABOUT THE



Cyprus



Czech
Republic



Estonia



Hungary



Latvia



Lithuania



Malta



Poland



Slovakia



Slovenia



EUROPE



10

health questions
about the

10

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health questions
about the
10

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CONTENTS

	Page
Foreword	vii
Technical notes	viii
List of acronyms	1
Cyprus	2
Czech Republic	18
Estonia	34
Hungary	52
Latvia	68
Lithuania	86
Malta	104
Poland	120
Slovakia	138
Slovenia	154
Annex: Environmental health risks	170
References	172
Glossary	176



FOREWORD

This book provides an informative look at 10 countries in the spotlight today: the new members of the European Union (EU). For the World Health Organization (WHO), they are just 10 of the 52 Member States in the European Region. WHO has been working with each of these countries on a regular basis for years. Through these years of collaboration, we have learned much from each other, and I trust our cooperative efforts have enhanced the health of the populations served.

EU accession is a process that the WHO Regional Office for Europe has been following with great interest – and often, active assistance. For not only is it our mission to support health developments in the Member States of our region, but the European Commission is also a principal partner with whom we share a common vision, values and concerns. Very often we act together.

That is why we have prepared this book: to facilitate an exchange of knowledge about these 10 countries. Each chapter is a series of snapshots of one country's health situation, with key population statistics and summaries of current developments in health system policy. Obviously, the material reflects the situation only till spring 2004. The Regional Office will, of course, continue to follow attentively any future developments in the health of these countries' populations and in the progress of their health reforms. We shall continue to work with each of the 10, providing the support they need and have come to expect from us.

Our partnership with the European Commission should assist these efforts greatly.

Highlighting 10 of our Member States does not mean that the Regional Office is neglecting the other 42. We are focusing equal attention on the countries that have become the EU's new neighbours in the eastern part of the Region. They too are reforming their health systems and policies, and the Regional Office will continue to work with them closely. This book will be followed by updates on not only the 10 new EU members, but also other countries of the Region.

The Europe of today is evolving rapidly, and the health and well-being of its peoples is more important than ever. The Regional Office is proud to be part of this inspiring route of change.



Dr Marc Danzon

Regional Director
WHO Regional Office for Europe

TECHNICAL NOTES

The data in this book have been compiled from a wide range of information sources. Health data can vary from one source to another, and due to different methodological approaches, they are not always fully compatible. Priority has been given to figures that lend themselves to reliable and meaningful comparisons. Therefore, on certain indicators data may not reflect the latest available national statistics because earlier years were chosen in order to allow linking national to international data. Even then, comparisons were not always possible.

The source numbers at the end of each question refer to the numbered list in References.

Most figures have been approximated for the sake of the easiness of reading. A list of acronyms and a glossary provide further help for the reader.

The abbreviation EU-15 is used throughout the book to refer to the European Union when it had 15 members, before its enlargement on 1 May 2004. Likewise, EU-25 refers to the enlarged European Union of 25 members.

LIST OF ACRONYMS

AIDS	Acquired immunodeficiency syndrome
CE	Council of Europe
EU	European Union
EU-15	European Union consisting of 15 member states <i>(before 1 May 2004)</i>
EU-25	European Union consisting of 25 member states <i>(beginning 1 May 2004)</i>
GDP	Gross domestic product
GP	General practitioner
HIV	Human immunodeficiency virus
ILO	International Labour Organization
IMF	International Monetary Fund
NAM	Non-Aligned Movement
NATO	North Atlantic Treaty Organization
OECD	Organisation for Economic Co-operation and Development
OSCE	Organization for Security and Co-operation in Europe
UN	United Nations
VHI	Voluntary health insurance
WB	World Bank
WHO	World Health Organization
WTO	World Trade Organization



Cyprus



Czech
Republic



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Poland



Slovakia



Slovenia

CYPRUS

Cyprus is a divided island. Unless stated otherwise, all data, figures and analyses in this chapter refer to those areas of the Republic of Cyprus in which the Government of the Republic of Cyprus exercises effective control.



ΚΥΠΡΟΣ KIBRIS

AREA

9251 km² (the entire island)
Three times larger than Luxembourg
Third smallest country in the EU-25

POPULATION

715 100
Twice as many people as in Luxembourg
0.17% of the total EU-25 population

THE PEOPLE

Greek Cypriots community 80%, Turkish Cypriots community 11%, foreign residents 9%

LANGUAGES	Greek and Turkish (official); English widely spoken
FORM OF GOVERNMENT	Presidential republic Unicameral parliament – House of Representatives (<i>Vouli ton antiprosopon</i>) Head of state and of government – directly elected president, who appoints the ministers
MAIN RELIGION	Greek Orthodox 80%; Muslim 11%; Maronite, Armenian Apostolic and Roman Catholic 1%; other 8% (for the whole island)
INDEPENDENCE	1960
GDP PER CAPITA	€15 198 = <i>63% of the EU-15 average</i> In purchasing power parity (PPP): €17 400 = <i>67% of the EU-15 average</i>
REGIONAL DIVISIONS	6 provinces
CURRENCY	Cyprus pound (1 pound = €1.70)
HUMAN DEVELOPMENT INDEX	0.89 <i>EU-15 lowest: 0.89, highest: 0.94</i>
UNEMPLOYMENT RATE	3.5% <i>EU-15 average: 9%</i>
MEMBER OF	CE, OSCE, Commonwealth, UN, WTO

Sources: 1, 3, 6, 15, 22, 23, 24, 25.

HEALTH

ΥΓΕΙΑ SAĞLIK



Cyprus



Czech Republic



Estonia



Hungary



Latvia



Lithuania



Malta



Poland



Slovakia



Slovenia

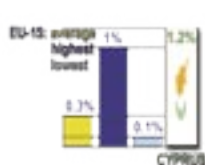
THE TEN HEALTH QUESTIONS

What are the demographic essentials for Cyprus?

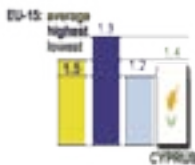
POPULATION PROFILE

Sex ratio	1.04 females/males	<i>EU-15 average: 1.4</i>
Urban concentration	69%	<i>EU-15 average: 80%</i>
Age structure	0–14 years 21%	<i>EU-15 average: 18%</i>
	65+ years 12%	<i>EU-15 average: 17%</i>
Median age	34 years	
Dependency ratio	51%	<i>EU-15 average: 49.5%</i>

POPULATION DYNAMICS



Annual growth rate

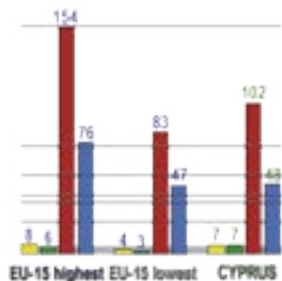


Fertility rate



Birth rates, live births /1000 population

PROBABILITY OF DYING (per 1000 population)



- Before age 5, male*
- Before age 5, female*
- Between age 15 and 60, male*
- Between age 15 and 60, female*

LIFE EXPECTANCY AT BIRTH

Total population	79 years
Male	76 years
Female	81 years

EU-15 average: 79
EU-15 average: 75.5
EU-15 average: 82

HEALTHY LIFE EXPECTANCY

	At birth (in years)			At age 60 (in years)		% of total life expectancy lost	
	Total	Male	Female	Male	Female	Male	Female
Cyprus	68	67	69	14	15	12	13
EU-15 highest	73	72	75	17	20	9	11
EU-15 lowest	69	67	71	15	17	8	9

Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health. The last two columns present this idea in another way, as the percentage of a lifetime that is spent living in less-than-full health.

Points to remember *demographic trends*

The past decade has seen:


- an overall increase in population
- a decline in population growth rate
- a decrease in the proportion of the population younger than 16
- an increase in the proportion of the population older than 65.

Sources: 1, 3, 4, 6, 18, 22.

What do the Cypriots suffer from?

**When analysing the causes of death and disease burden, WHO has divided all countries into different mortality strata according to the level of mortality for children younger than 5 and for males aged 15 to 59. According to this division, the whole of Europe falls in the developed country stratum. However, within this stratum, European countries are divided into three*





*different groups – those with very low child and very low adult mortality, those with low adult and low child mortality, and those with low child and high adult mortality. This division reflects the great variations that exist within Europe and help place figures in a regional context – a European mortality figure that might seem quite low in comparison to figures from Africa or south-east Asia may actually be quite high in comparison to figures from the most-developed European countries. According to this classification, Cyprus is classified in the group of European countries with very low mortality for both adults and children. Every member state of the EU-15 falls in this same group. Throughout this chapter, data marked by * derive from this entire European mortality group, rather than just Cyprus.*

Note: In Cyprus, only 84% of all death registrations clearly list the cause of death. The country data presented in this chapter must be regarded with this statistical limitation in mind.

CARDIOVASCULAR DISEASES

- Circulatory diseases are the leading cause of death, responsible for 63% of all deaths.
- Of the various forms of cardiovascular disease, the major killers for the countries in the Cypriot mortality group are:
 - *ischaemic heart disease*, responsible for 16%* of all deaths and 9%* of the disease burden; and
 - *cerebrovascular diseases*, responsible for 7.4%* of all deaths and 6.7%* of the disease burden.

CANCER (MALIGNANT NEOPLASMS)

- Cancer is the second leading cause of death, responsible for 16% of all deaths.
- Among all deaths from malignant neoplasms, 12% are caused by cancer of the larynx, trachea or lung, 8% breast cancer, 8% prostate cancer and 6% colon cancer.

RESPIRATORY DISEASES

- Respiratory diseases are the third most common cause of death, responsible for 11% of all mortality.

UNINTENTIONAL INJURIES

- Unintentional injuries are the fourth leading cause of death.
- In 2002, there were 3620 cases of death or injury due to road traffic accidents. Two thirds of the victims were men.

INFECTIOUS AND PARASITIC DISEASES

- Infectious and parasitic diseases cause 1.1 % of all deaths.
- In 2003, there were 446 new cases of venereal disease.
- Also in 2003, the tuberculosis rate was 11 per 100 000 population. *EU-15 average: 11/100 000*
- With an HIV/AIDS prevalence of 0.1%, Cyprus is considered a low-prevalence country for the disease.
 - In the vast majority of cases, transmission is via heterosexual intercourse.
 - Needle-sharing transmission and prenatal transmission rates are extremely low.
 - No cases of blood product transmission have been recorded.

NEUROPSYCHIATRIC DISORDERS

- Among Cypriots, 20% suffer from a psychiatric disorder.
- Another 15% suffer from general anxiety, and 7% suffer from depression.

CHILD AND ADOLESCENT HEALTH

- Infant mortality is 4.7 deaths per 1000 live births. *EU-15 average: 5/1000*
- Immunization coverage is more than 98% for diphtheria, tetanus, pertussis and poliomyelitis. For measles it is 86%, and for hepatitis B 94%.



Cyprus



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Points to remember

Always compare!

Causes of death and disease burden

	% of deaths caused*	% of disease burden*
Cardiovascular diseases	41	17
Neuropsychiatric disorders	4.7	27
Cancer/malignant neoplasms	27	17
Unintentional injuries	3.4	5.8
Respiratory diseases	5.6	6.5
Infectious and parasitic diseases	1.2	1.7
Respiratory infections	4.4	1.3
Perinatal conditions	<1	<1
Intentional injuries	1.3	2
Diabetes	2.3	2.1
Sense organ disorders	0	4.7
Total communicable diseases	6	5
Total noncommunicable diseases	89	87
Total injuries	5	8

* *Data refer to the European mortality group that includes Cyprus and all EU-15 countries.*

Points to remember

health status

It is important to consider both mortality and disease burden when looking at how a medical condition affects a population. Each measure reflects a different facet of human suffering.

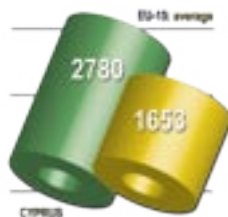
Sources: 1, 6, 8, 22, 27.



Where do the risks lie?

SMOKING

- In 1990, 43% of all men and 7% of all women smoked.
- The intensity of smoking is relatively high; in 1989, 73% of the male and 50% of the female smokers smoked more than 10 cigarettes a day.



Cigarettes consumed by person, 1999

ALCOHOL CONSUMPTION

- Alcohol use disorders are responsible for 1.7%* of the group's disease burden.
- Total alcohol consumption was 8.2 litres per person in 2000.
EU-15 average: 9.2 litres

DRUGS

- In the 1999–2003 period, the reported lifetime prevalence for illegal drug use (the percentage of people who claimed to have ever tried an illegal drug) tripled. The lifetime prevalence for cannabis increased 4 times, for heroin 2.5 times and for ecstasy and cocaine 14 times.
- The number of drug users seeking first-time treatment increased more than fourfold in the period 1995–2002.

OBESITY

- In Cyprus, 44% of men and 30% of women are obese; another 25% of the men and 19% of the women are pre-obese.

Sources: 1, 6, 8, 22, 27.



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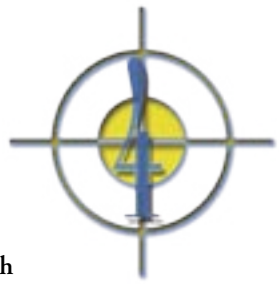


Slovakia



Slovenia

Who's who in the Cypriot public health sector?



PUBLIC ADMINISTRATION Ministry of Health

(responsible for the organization of the health care system and the provision of state-financed health services)

INSTITUTIONS UNDER THE MINISTER OF HEALTH National committees on diabetes, cancer prevention, nutrition, injury prevention among children and violence prevention in families
National Anti-Drugs Council
Agency for the Protection of Mother and Child

Note: There are also a number of entities, such as the National Institute of Neurology, that are private but work closely with the Ministry of Health, which has representatives on their management boards.

PARLIAMENTARY COMMITTEE Parliamentary Health Committee

PROFESSIONAL ASSOCIATION Cyprus Medical Association

ACADEMIC INSTITUTION National School of Nursing

Note: Medicine is not taught at the University of Cyprus.

REGIONAL INSTITUTIONS

Six urban and 23 rural health centres

How are services provided?



PRIMARY HEALTH CARE

Public primary health care is provided at 4 outpatient units of major hospitals and 7 outpatient units of suburban hospitals, as well as in the 6 urban and 23 rural health centres. The health

centres are freely accessible to all Cypriots. The centres are staffed with qualified general practitioners (GPs), nurses and pharmacists; the GPs are responsible for making referrals to specialized units or hospitals. Patients are able to choose their own physicians. Most centres feature regular visits by specialist teams (gynaecologists, paediatricians etc.) who provide free consultations. In areas where people are clustered far away from a rural health centre, health centre teams make regular visits to see patients, most of whom are at risk and elderly. The private sector also offers wide range of possibilities for primary health care, and most families have a private family doctor whom they pay directly. Only in the private sector do patients have an opportunity for choosing a general practitioner.

SECONDARY AND TERTIARY CARE

There are five large public district hospitals (totalling more than 1200 beds) and three small rural hospitals (up to 85 beds each). Also affiliated with some of these hospitals are several large national clinics, specializing in cardiovascular diseases, neurosurgery, neonatology, mental health etc. and accepting patients from the whole country.

In addition, there are approximately 105 private hospitals and clinics that provide secondary health care, either as part of insurance contracts or on a fee-for-service basis. Sometimes the government uses these private facilities to treat patients who are eligible for public funding. Most tertiary health care is provided by the public sector.

THE PUBLIC-PRIVATE MIX

The private sector provides about 65% of outpatient services and the public sector 35%. For inpatient services, the ratio is exactly the opposite, with the private sector providing about 35% and the public 65%.



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Points to remember *service provision*

- The provision of health services is not concentrated or guided by a central authority.
- Health services are provided by various types of funding schemes: public health provision (including a scheme that sponsors patients abroad), private fee-for-service provision, employer and trade union funds, and private health insurance.
- Health care in Cyprus is a balanced mix of public and private systems.
- The public and the private health sectors are seeking to coordinate their services better.

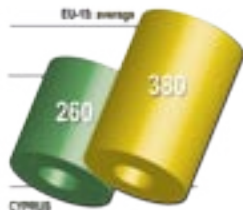
What resources are available?

HUMAN RESOURCES

Of the total Cypriot workforce, 2.7% is employed in the health sector. Physicians are educated primarily abroad, but they can usually serve their internships at public facilities and clinics in Cyprus.

HEALTH PROFESSIONALS (per 100 000 population)

Dentists	90	EU-15 average: 640
Nurses	490	EU-15 average: 670
Pharmacists	104	EU-15 average: 790
Physicians	260	EU-15 average: 380



HOSPITALS

Hospitals (per 100 000) **16.7** EU-15 average: 3.4

Note: This figure includes all public and private clinics providing inpatient services, although some of them hardly can be described as hospitals.

Hospital beds (per 100 000) **435** EU-15 average: 611

Average length of stay **6 days** EU-15 average: 10

PHARMACEUTICALS

A total of 750 pharmacists work in Cyprus, most of them in the private sector. The entire pharmaceutical market is divided between the public and the private sector, and the two operate quite independently from each other at every level. About 40 public pharmacies, located in public hospitals and health centres, dispense medicines to anyone eligible for public coverage. People with chronic diseases and low incomes receive free medicines. Most pharmacies, however, are private – a total of 435. In general, drug prices in the public sector are lower, due to an obligation to put pharmaceutical contracts out to tender.

Points to remember

health resources

- The number of practising physicians has been rising steadily.
- Health care professionals are educated in Greek, British and other foreign universities.
- The Ministry of Health is responsible for public hospital management, decision-making and budgeting.
- Improving and modernizing hospital management culture is near the top of the Ministry agenda, as is giving hospitals more autonomy.
- Public facilities have 43% of all hospital beds in Cyprus.

Sources: 26, 27, 32.

Who pays for what?

GOVERNMENT PROVISION OF HEALTH CARE

is funded directly by the state budget, from general taxes. For approximately 65% of the inhabitants, all state health services are free. Persons eligible include those whose income is lower than a certain level, civil servants (both active and retired), pensioners and persons with chronic diseases and disabilities. Members of the latter group, some of whom receive only partial benefits, include those with cancer, diabetes and multiple sclerosis. For people in the middle-



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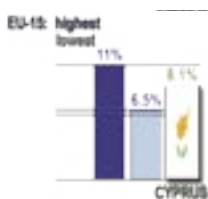
income category, or about 15% to 20% of the population, health care is provided at reduced prices.

The payer for state-subsidized health care is the Ministry of Finance, though it must negotiate the budget with the Ministry of Health. The National Planning Bureau (which is affiliated with the Ministry of Finance but reports to the President) is also involved in negotiations that involve development and capital investments.

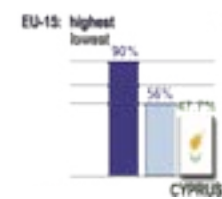
OTHER FORMS OF INSURANCE

There are about 40 private medical insurance funds. Little information is available about these schemes because the law does not require separate reporting. They cover about 5% to 6% of the country's total health needs. For most insurers, health insurance complements other lines of business, and their health packages are simple. Private insurance is collectively organized through contractual arrangements with various employers, organizations and trade unions. The state has no role in regulating these contracts, which are negotiated between the parties involved. When trade unions make collective insurance agreements on their members' behalf, the health care coverage is for outpatient services.

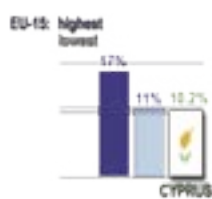
THE ECONOMIC PICTURE



Total expenditure on health, % of GDP



Government expenditure on health, as % of the total expenditures on health



Government expenditure on health, as % of the total government expenditure

Out-of-pocket expenditure on health **5%** of the average private income

Population below national poverty line **16%**



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Slovakia



Slovenia

Points to remember *health care financing*

- There is a rich public–private mix in the Cypriot health sector.
- For health care services provided to permanent residents, 49% of all expenditure is realized in the public sector and 51% in the private sector.
- The percentage of health expenditure that comes from private resources in Cyprus is triple the private share of health expenditure in the EU-15 mortality group as a whole.

Sources: 1, 6, 23, 24, 32, 37.



How have Cypriots been reforming their health care system?

BACKGROUND TO REFORM

The Cypriot health and social protection system is based on the principle of tripartism, which involves the participation of the government, employers and workers.

The public and private sectors provide an equal share of all health care services. Increased coordination is being sought between the two sectors. **The state has had very little role in regulating the private health sector.** At present, Cyprus does not have a primary care gate-keeping system. Patients are free to consult any practising physician, GP or specialist. The state has no role in either inspecting or controlling private sector services.

THE HEALTH REFORMS OF RECENT YEARS:

- prepared a new accreditation law for the private sector that is expected to reinforce and improve the quality of its services;
- carried out decentralization of the system, empowering the provinces;
- separated primary and secondary health care administratively;
- extended the opening hours of the health centres;

- built several large hospitals; and
- began the complete rebuilding of two other hospitals that will open in 2005.

Points to remember *health system reform*

- The Cyprus health care system depends on a very large proportion of private financing.
- The system needs to develop points of contact between the public and private sectors, as well as formal, organized intersectoral competition.
- As a result of planned improvements in primary care, the Ministry of Health is considering ways to rationalize the country's costly secondary care services.
- The country is planning to consider creating a national health benefits package.

What is one of the things Cyprus has learned by doing?

THE NATIONAL HEALTH INSURANCE SCHEME (NHIS)

A law setting up a new general health care scheme was enacted by the House of Representatives in 2001. It envisages the NHIS becoming operational in 2007. According to the new scheme:

- financing of health care services will be largely based on compulsory health insurance contributions;
- comprehensive medical care will be provided to the entire resident population;
- the concept of GP-based primary care will be introduced, and GPs will refer patients to specialist services and treatment;
- every family will be registered with a GP contracted by the Health Insurance Organization;
- primary care professionals will be paid a capitation rate;
- certain areas of competition between the public and private sectors will be introduced;

- a uniform pricing policy for the public and private sectors will be implemented; and
- the products and volume of the private health insurance market will change substantially.

The funding of the NHIS will be tripartite: government 50%, employers 28%, employees 22%. The administration of the NHIS will also be carried out by a public tripartite body – the Health Insurance Organization.



What has WHO been doing in Cyprus?

Cyprus was a member of the Eastern Mediterranean Region of WHO through the end of 2003. It began to work with the WHO Regional Office for Europe after joining the European Region on 1 January 2004.

SOURCES OF INFORMATION ABOUT CYPRUS

Web sites

- Official government website <http://www.cyprus.gov.cy>
 Press and Information Office of the Republic of Cyprus <http://www.moi.gov.cy/pio>
 Office of the Coordinator for Harmonisation <http://www.eu-coordinator.gov.cy>
 European Institute of Cyprus <http://www.eic.ac.cy>
 Cyprus News Agency <http://www.cna.org.cy>
 General information on Cyprus <http://www.kypros.org>

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 Cyprus: on the way to EU membership. 2003, ISBN 9963-38-845-0.
 The Cyprus question. 2003, ISBN 9963-38-860-4.
 Cyprus: no man is an island. 2003, ISBN 9963-38-839-6.



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CZECH REPUBLIC



ČESKÁ REPUBLIKA

AREA	79 000 km ² Approximately equal to Austria <i>2% of the total EU-25 area</i>
POPULATION	10 300 000 2 million more than Austria <i>2.3% of the total EU-25 population</i>

THE PEOPLE	Czechs 94%, Slovaks 3%, Poles, Germans, Roma and Hungarians
LANGUAGES	Czech
FORM OF GOVERNMENT	Parliamentary republic Bicameral parliament (<i>Parlament</i>): Senate and Chamber of Deputies Head of state – directly elected president
MAIN RELIGION	Roman Catholic 40%, Protestant 10%
INDEPENDENCE	1993
GDP PER CAPITA	€ 6 200 = 27% of the EU-15 average In purchasing power parity (PPP): €12 500 = 55% of the EU-15 average
REGIONAL DIVISIONS	13 regions (<i>kraje</i>) and the capital city (<i>hlavní mesto</i>)
CURRENCY	Czech koruna (<i>česká koruna</i>) 1 koruna = €0.03 (€1.00 = 33 koruny)
HUMAN DEVELOPMENT INDEX	0.84 EU-15 lowest: 0.89, highest: 0.94
UNEMPLOYMENT RATE	9% EU-15 average: 9%
MEMBER OF	CE, OSCE, OECD, EBRD, UN, WB

Sources: 1, 3, 4, 5, 6, 7, 15, 16, 17.

HEALTH

ZDRAVÍ



Czech Republic



Estonia



Hungary



Latvia



Lithuania



Malta



Poland



Slovakia



Slovenia

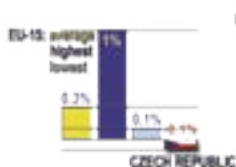
THE TEN HEALTH QUESTIONS

What are the demographic essentials for the Czech Republic?

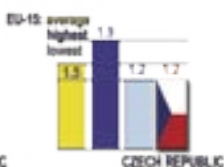
POPULATION PROFILE

Sex ratio	1.05 females/males	<i>EU-15 average: 1.4</i>
Urban concentration	75%	<i>EU-15 average: 80%</i>
Age structure	0–14 years 16%	<i>EU-15 average: 18%</i>
	65+ years 14%	<i>EU-15 average: 17%</i>
Median age	34 years	
Dependency ratio	42%	<i>EU-15 average: 49.5%</i>

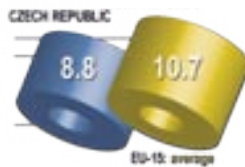
POPULATION DYNAMICS



Annual growth rate

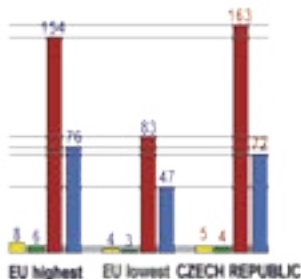


Fertility rate



Birth rates, live births

PROBABILITY OF DYING (per 1000 population) /1000 population



- Before age 5, male
- Before age 5, female
- Between age 15 and 60, male
- Between age 15 and 60, female

LIFE EXPECTANCY AT BIRTH

Total population	76 years
Male	72 years
Female	79 years

EU-15 average: 79
EU-15 average: 75.5
EU-15 average: 82

HEALTHY LIFE EXPECTANCY

	At birth (in years)			At age 60 (in years)		% of total life expectancy lost	
	Total	Male	Female	Male	Female	Male	Female
Czech Republic	68	66	71	13.5	17	9	10
EU-15 lowest	69	67	71	15	17	8	9
EU-15 highest	73	72	75	17	20	9	11

Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health. The last two columns present this idea in another way, as the percentage of a lifetime that is spent living in less-than-full health.

Points to remember *demographic trends*

The past decade has seen:

- increasing life expectancy
- a decreasing birth rate
- ageing of the population
- a substantial decrease in maternal mortality.

Sources: 1, 3, 4, 6, 16, 17, 18, 39.

What do the Czechs suffer from?

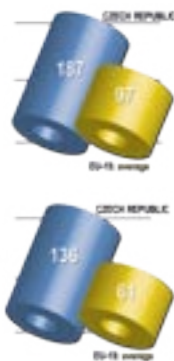
**When analysing the causes of death and disease burden, WHO has divided all countries into different mortality strata according to the level of mortality for children younger than 5 and for males aged 15 to 59. According to this division, the whole of Europe falls in the developed country stratum. However, within this stratum, European countries are divided into three different groups – those with*



very low child and very low adult mortality, those with low adult and low child mortality, and those with low child and high adult mortality. This division reflects the great variations that exist within Europe and help place figures in a regional context – a European mortality figure that might seem quite low in comparison to figures from Africa or south-east Asia may actually be quite high in comparison to figures from the most-developed European countries. According to this classification, the Czech Republic is classified in the group of European countries with very low mortality for both adults and children. Every member state of the EU-15 also falls into the same group. Throughout this chapter, data marked by * derive from this entire European mortality group, rather than just the Czech Republic.

CARDIOVASCULAR DISEASES

- Circulatory diseases are the leading cause of death in the Czech Republic – responsible for 53% of all deaths.
- Of the various diseases in this group, there are two major killers.
 - *Ischaemic heart disease* caused 187 deaths per 100 000 in 2000 (**EU-15 average: 97/100 000**). For the Czech mortality group as a whole, it was responsible for 17%* of the causes of death and 7%* of the disease burden.
 - *Cerebrovascular diseases* led to 136 deaths per 100 000 in 2000 (**EU-15 average: 61/100 000**), or 11% of all deaths. For the Czech mortality group as a whole, these diseases were responsible for 5%* of the disease burden.
- In 2000, 25 people (out of 100 000) died of other circulatory system diseases. **EU-15 average: 14/100 000**



CANCER (MALIGNANT NEOPLASMS)

- Cancer is the second major cause of deaths – responsible for 26% of all deaths.

- In 2000, cancer caused 238 deaths per 100 000.
EU-15 average: 183/100 000
- The standardized death rate from cervical cancer was 6 per 100 000 in 2000 – more than twice the. *EU-15 average 2.6 per 100 000*
- The standardized death rate from cancer of the respiratory system was 49 per 100 000 in 2000.
EU-15 average: 37/100 000
- The most frequent cancer among both men and women is skin cancer.

UNINTENTIONAL INJURIES

- In 2000, external injuries and poisoning were responsible for 6% of all the deaths; they caused 62 deaths per 100 000. *EU-15 average: 39.5/100 000*
- For 2000, the number of road traffic accidents with injury was 254 per 100 000.
EU-15 average: 335/100 000



NEUROPSYCHIATRIC DISORDERS

- Suicide and self-inflicted injuries cause 15 deaths per 100 000.
EU-15 average: 10/100 000

RESPIRATORY DISEASES

- Each year respiratory diseases cause 40 deaths per 100 000.
EU-15 average: 57/100 000

INFECTIOUS AND PARASITIC DISEASES

- In 2000, these diseases caused 2.6 deaths per 100 000.
EU-15 average: 7.3/100 000
- In 2002, the Czech tuberculosis incidence was 11 per 100 000, the same as the EU-15 average. However, the incidence is more than 100 per 100 000 in high-risk groups (asylum seekers, drug addicts and former convicts).
- In 2002, 0.5 new cases of HIV infection were reported per 100 000 (*EU-15 average: 4/100 000*). The incidence of clinically diagnosed AIDS was 0.07 per 100 000.
EU-15 average: 2.4/100 000



Czech Republic



Estonia



Hungary



Latvia



Lithuania



Malta



Poland



Slovakia



Slovenia

CHILD AND ADOLESCENT HEALTH

- Infant mortality is 4.1 deaths per 1000 live births.

EU-15 average: 5/1000

ORAL HEALTH

- Dental caries affects 3% of Czech 5-year-olds, 6% of the 18-year-olds (and 18% of those aged 35–44).

Points to remember *Causes of death and disease burden*
Always compare!

	% of deaths caused*	% of disease burden*
Cardiovascular diseases	41	17
Neuropsychiatric disorders	5	26.5
Cancer/malignant neoplasms	26.5	16.5
Unintentional injuries	3.4	5.8
Respiratory diseases	5.6	6.5
Infectious and parasitic diseases	1.2	1.7
Respiratory infections	4.4	1.3
Perinatal conditions	<1	<1.0
Intentional injuries	1.3	2
Diabetes	2.3	2.1
Sense organ disorders	0	4.7
Total communicable diseases	6	5
Total noncommunicable diseases	89	87
Total injuries	5	8

* *Data refer to the European mortality group that includes the Czech Republic and all EU-15 countries.*

Points to remember *health status*

It is important to consider both mortality and disease burden when looking at how a medical condition affects a population. Each measure reflects a different facet of human suffering.

Sources: 1, 6, 8, 36.

Where do the risks lie?

SMOKING

- Smokers comprise 27% of all men and 13% of all women, for an adult population average of 19.5%. *EU-15 rates are: men 32%, women 23%, together 28%*
- In the period 2001–2002, 11% of 13-year-olds and 30% of 15-year-olds smoked.



ALCOHOL CONSUMPTION

- Alcohol use disorders are responsible for 4.3%* of the disease burden for the Czech mortality group.
- In 2000, there were 86 alcohol-related deaths per 100 000 population. *EU-15 average: 62/100 000*
- In 2001, 13.6 litres of pure alcohol were registered as being consumed by each Estonian adult. *EU-15 average: 9.2 litres*

DRUGS

- The prevalence of illegal drug use among 16-year-olds is less than 1%, which is lower than in the EU-15.
- Cannabis use has been rapidly increasing – in 1994, 23% of 16-year-olds had tried it at least once in their lives, and in 2000, this figure was up to 35%.
- The same period also saw a steady increase in reported use of opiates (from 1% to 4%) and amphetamines (from 3% to 8%) in this age group.

OBESITY

- Among the population older than 15 years of age, 15% of the men and 13% of the women are clinically obese.
- In this same group, 34% of the men and 44% of the women are reported as physically inactive. *Sources: 6, 8, 11, 12, 18, 20, 28.*



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Who's who in the Czech public health sector?

PUBLIC ADMINISTRATION Ministry of Health

INSTITUTIONS UNDER THE MINISTRY OF HEALTH

National Institute of Public Health

National Health Board (intersectoral body chaired by the Minister of Health)

Institute of Health Information and Statistics

National Board on Environment and Health

Drug and Technology Control Institute

Czech Anti-Drug Committee

Committees on AIDS, child abuse, problems of people with disabilities etc.

PARLIAMENTARY COMMITTEE

Chamber of Deputies – Committee for Social Policy and Health Care

Senate – Committee on Health and Social Policy

INSURANCE STRUCTURE

Health Insurance Funds

PROFESSIONAL ASSOCIATIONS

Czech Medical Chamber (Chamber of Physicians)

Czech Medical Association of J.E.Purkyne

Czech Chamber of Pharmacists

Czech Stomatological Chamber

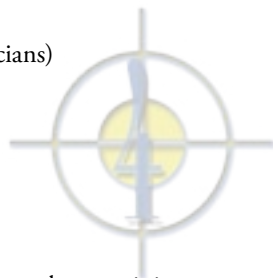
ACADEMIC INSTITUTIONS

Seven university medical faculties

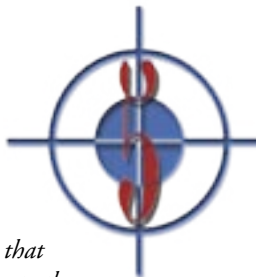
Two university pharmaceutical faculties

Two specialized institutes for professional postgraduate training

REGIONAL INSTITUTIONS One regional hygiene station and one health institute in each of the 13 regions and the capital city, Prague



How are services provided?



As a result of public administration reforms that transferred competencies and executive power to the regions and the districts, the provision and management of health care services is now handled at the regional and district level through the respective health offices.

PRIMARY HEALTH CARE

Primary care is organized at the regional level and delivered in community-owned facilities. Primary care providers are predominantly private (98%). Citizens are free to choose their own primary care physicians. These physicians include general practitioners (GPs) for adults, GPs for children and adolescents, gynaecologists and dentists. The majority of them work in private practices and are paid on a capitation, fee-per-patient basis, but this principle is combined with some fee-for-service payments. Primary care is most often provided in health centres that are owned by the municipalities and rented out by private GPs and outpatient specialists.

SECONDARY AND TERTIARY CARE

Outpatient specialists are predominantly private. Most hospitals are publicly owned by a region, district or municipality. The state also manages the university hospitals and specialized facilities. There are also private inpatient facilities, both profit-making and non-profit-making, though only 9% of Czech hospital beds are in private facilities. The insurance funds reimburse public hospitals, whether university, regional or municipal, only for operating costs. Capital investments are guaranteed by either the state or a regional body. All hospitals, independent of ownership, contract with the health insurance funds. In addition to the country's 216 hospitals, there are also 218 health institutions for patients with special health needs.



Czech Republic



Estonia



Hungary



Latvia



Lithuania



Malta



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Slovakia



Slovenia

Points to remember *service provision*

- There is a wide variety of public and private health services.
- The separation between health and social care is quite clear, though it is still a challenge to coordinate the two.
- Public sector providers are becoming more interested in acquiring more managerial autonomy.

Sources: 2, 8.



What resources are available?

HUMAN RESOURCES

HEALTH PROFESSIONALS

(per 100 000 population)

Dentists	660	EU-15 average: 640
Nurses	970	EU-15 average: 670
Pharmacists	530	EU-15 average: 790
General practitioners	72	EU-15 average: 102



CZECH REPUBLIC
Physicians 350
EU-15 average: 380

HOSPITALS

Hospital beds (per 100 000) 857

EU-15 average: 611

Annual inpatient admissions (per 100) 20

EU-15 average: 18

Average length of stay 11.5 days

EU-15 average: 10



CZECH REPUBLIC
EU-15 average
Hospitals (per 100 000) 3.6
EU-15 average: 3.4

PHARMACEUTICALS

The whole Czech drug regulatory framework has been reviewed. There are three categories of medicines: generic drugs covered by social insurance, non-generic drugs that are reimbursed if medically

indicated, and non-generic drugs paid out of pocket. The vast majority of pharmacies are private. The pharmaceutical industry has also been privatized almost completely. The share of pharmaceutical products that are imported has been increasing rapidly, but domestically produced medicines are still of substantial importance to the health care system.

Points to remember

health resources

- Salaries of public-sector doctors (most of whom work in hospitals) are twice the average national income.
- Efforts continue to ensure an even geographical distribution of health personnel.
- Strategies for cost-containment are being developed in response to the pressure of increasing drug costs.
- There has been much focus on the optimal prescribing and use of medicines.

Sources: 6, 8, 11, 32.

Who pays for what?



The financing of the Czech health system is based on solidarity and equity, and the main sources of financing are public. The primary funding source is compulsory health insurance, which provides about 80% of total health expenditure, while general taxes provide slightly more than 11%. Private voluntary health insurance (VHI) and out-of-pocket payments contribute only 7%. Compulsory health insurance is funded through contributions from employees (4.5%) and employers (9%). The self-employed pay the same total percentage – 13.5% – but only on 35% of their declared profit.

There are nine health insurance funds. They operate in competition with one another, negotiating contracts directly with private



Czech Republic



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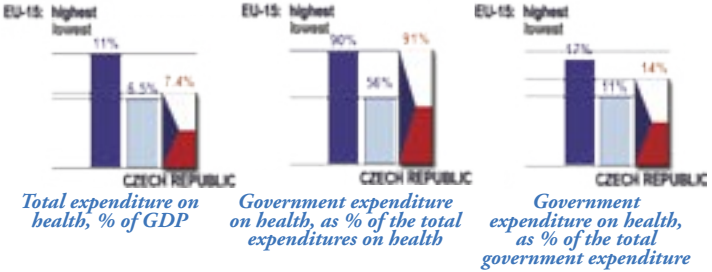
Slovakia



Slovenia

ambulatory providers and hospitals. Reimbursement is mainly on a fee-for-service basis. The General Health Insurance Fund is the biggest among all, covering approximately 75% of the population, and its solvency is guaranteed by the state.

THE ECONOMIC PICTURE



Population below national poverty line **7.6%**

Points to remember *health care financing*

- The key actors in health financing – the insurance funds, the providers and professional associations – participate in joint negotiations on everything concerning coverage and reimbursement
- The government supervises these negotiations and reserves the right to act on its own if the parties fail to agree.
- The insurance funds are the most important actors in health resource allocation, collecting and spending around 90% of the financial resources in the public health sector.
- Since the early 1990s, there has been a rapid increase in health care expenditure.

Sources: 1, 2, 6, 13, 32.



How have the Czechs been reforming their health system?


THE HEALTH REFORMS OF THE LAST DECADE:

- ensured the transition from tax-based financing to health insurance financing;
- brought quality of care to centre stage;
- were based on the principles of de-monopolization, decentralization and liberalization;
- changed the ownership of health care facilities;
- defined a national health care package;
- strengthened regional health policy;
- started defining and distinguishing the responsibilities of different agencies for collecting revenues, pooling funds and purchasing services; and
- preserved the role of the state in guaranteeing health care and the health insurance system.

Points to remember *health system reform*

- National health information systems are under development
- Privatization of smaller hospitals continues. ● The acute and chronic beds balance is being restructured; the number of long-term care facilities increases and home care agencies are being opened.
- Regional public health services fall under double supervision, by both the Ministry of Health and the self-governing regions themselves – a challenge to coordinate well.



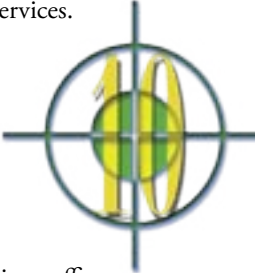


What is one of the things the Czechs have learned by doing?

SYNCHRONIZING SOCIAL SECURITY WITH EU LAW

Two Czech ministries – health and labour – have been working together on two projects aimed at introducing EU standards for social security regulation. The first project was carried out in cooperation with partners from the United Kingdom, and the second one with partners from Finland. By 2002, much had been accomplished on the first project, which strengthened the state's administrative capability to make health care reimbursements in conformity with EU rules. Since late 2002, the second project has been testing the Czech system's ability to implement EU social security regulations. It also addresses cross-border health care payments, mutual recognition of health professionals' licensing, patients' rights and standards for health and social services.

What has the Regional Office been doing in the Czech Republic?



The WHO Regional Office for Europe has had a liaison office in Prague since 1991. The country participates in several WHO networks, including Healthy Cities, Health Promoting Schools, Countrywide Integrated Noncommunicable Diseases Intervention (CINDI), Safe Communities (SAFECOM) et al.

In 2002–2003, the Czech Republic worked with the Regional Office in:

- developing data reporting and health information systems
- developing the national health promotion policy

- improving health financing and quality of health care
- strengthening communicable disease surveillance
- assessing health system performance.

The Regional Office has signed an agreement with the country to provide help during 2004–2005 in the areas of:

- noncommunicable diseases (creating a framework for health promotion and disease prevention);
- alcohol and tobacco (increasing awareness and skills among health professionals, and developing health promotion methodologies and tools for communities);
- strengthened tuberculosis control among risk groups;
- mental health policy;
- health management and human resources; and
- public health threats and emergencies.

SOURCES OF INFORMATION ABOUT THE CZECH REPUBLIC

Web sites

Ministry of Health	http://www.mzcr.cz
Office of the President	http://www.hrad.cz
Parliament of the Czech Republic:	
Committee for Social Policy and Health Care	http://www.psp.cz
Committee on Health and Social Policy	http://www.senat.cz
Government of the Czech Republic	http://www.vlada.cz
Office of the Government of the Czech Republic:	
Council for Health and Environment	http://wtd.vlada.cz/eng
General Health Insurance Office of the Czech Republic	http://www.vzp.cz
Czech Statistical Office	http://www.czso.cz
Institute of Health Information and Statistics of the Czech Republic	http://www.szu.cz
European Commission delegation to Prague	http://www.evropska-unie.cz
Czech Republic Euro Info-Centre Network	http://www.euroinfocentrum.cz
National Information Centre	http://www.nis.cz



ESTONIA



EESTI

AREA

45 227 km²

Approximately equal to Denmark

1.1% of the total EU-25 area

POPULATION

1 400 000

About one fourth the population of Denmark

0.3% of the total EU-25 population

THE PEOPLE	Estonians 68%, Russians 26%, Ukrainians 2.1%, Byelorussians 1%
LANGUAGES	Estonian (official); Russian, and English widely spoken
FORM OF GOVERNMENT	Parliamentary democracy Unicameral parliament (<i>Riigikogu</i>) Head of state – president, elected directly
MAIN RELIGION	Lutheran, Eastern Orthodox
INDEPENDENCE	1991
GDP PER CAPITA	€ 4 500 = <i>19.5% of the EU-15 average</i> In purchasing power standards: € 7 700 = <i>34% of the EU-15 average</i>
REGIONAL DIVISIONS	15 counties
CURRENCY	Estonian kroon (1 kroon = €0.06) 1 € = 15 kroons
HUMAN DEVELOPMENT INDEX	0.81 <i>EU-15 lowest: 0.89, highest: 0.94</i>
UNEMPLOYMENT RATE	6% <i>EU-15 average: 9%</i>
MEMBER OF	CoE, OSCE, UN, NATO

Sources: 1, 3, 4, 6, 15, 16, 18.

HEALTH

TERVIS



Estonia



Hungary



Latvia



Lithuania



Malta



Poland



Slovakia



Slovenia

THE TEN HEALTH QUESTIONS

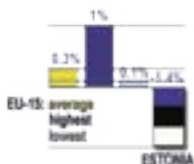


What are the demographic essentials about Estonia?

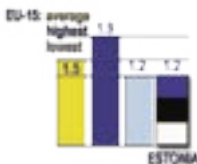
POPULATION PROFILE

Sex ratio	1.16 females/males	<i>EU-15 average: 1.4</i>
Urban concentration	69%	<i>EU-15 average: 80%</i>
Age structure	0–14 years 18%	<i>EU-15 average: 18%</i>
	65+ years 15%	<i>EU-15 average: 17%</i>
Median age	38 years	
Dependency ratio	48%	<i>EU-15 average: 49.5%</i>

POPULATION DYNAMICS



Annual growth rate

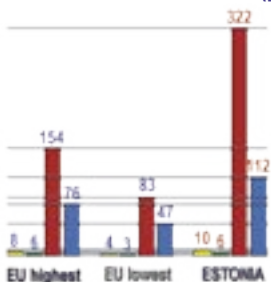


Fertility rate



Birth rates, live births /1000 population

PROBABILITY OF DYING (per 1000 population)



- Before age 5, male
- Before age 5, female
- Between age 15 and 60, male
- Between age 15 and 60, female

LIFE EXPECTANCY AT BIRTH

Total population	71 years
Male	65 years
Female	77 years

EU-15 average: 79
EU-15 average: 75.5
EU-15 average: 82

HEALTHY LIFE EXPECTANCY

	At birth (in years)			At age 60 (in years)		% of total life expectancy lost	
	Total	Male	Female	Male	Female	Male	Female
Estonia	64	59	69	12	16.5	9	10.5
EU-15 highest	73	72	75	17	20	9	11
EU-15 lowest	69	67	71	15	17	8	9

Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health. The last two columns present this idea in yet another way, as the percentage of a lifetime that is spent living in less-than-full health.

Points to remember *demographic trends*

The past decade has seen:

- steadily increasing gender differences in mortality
- a steadily decreasing crude birth rate and negative natural growth
- a fertility rate below replacement level.

Sources: 1, 3, 4, 6, 16, 17, 18.

What do Estonians suffer from?

**When analysing the causes of death and disease burden, WHO has divided all countries into different mortality strata according to the level of mortality for children younger than 5 and for males aged 15 to 59. According to this division, the whole of Europe falls in the developed country stratum. However, within this stratum, European countries are divided into three different groups –*



Hungary



Latvia



Lithuania



Malta



Poland



Slovakia

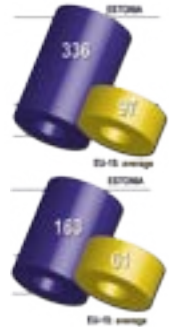


Slovenia

those with very low child and very low adult mortality, those with low adult and low child mortality, and those with low child and high adult mortality. This division reflects the great variations that exist within Europe and help place figures in a regional context – a European mortality figure that might seem quite low in comparison to figures from Africa or south-east Asia may actually be quite high in comparison to figures from the most-developed European countries. According to this classification, Estonia is in the group of European countries with low child and high adult mortality. The member states in the EU-15 are all in another group – that with very low child and very low adult mortality. Throughout this chapter, all data marked by * are not country-specific but refer instead to the European group in which Estonia falls.

CARDIOVASCULAR DISEASES

- Circulatory diseases are the leading cause of death, responsible for 54% of all deaths.
- Of the various forms of cardiovascular disease, the major killers are:
 - *ischaemic heart disease*, responsible for 14%* of the disease burden and 32.5%* of all deaths, or 336 per 100 000 population in 2000 **EU-15 average: 97/100 000**; and
 - *cerebrovascular diseases*, responsible for 9%* of the disease burden and 20%* of all deaths, or 163 deaths per 100 000 in 2000. **EU-15 average: 61/100 000**

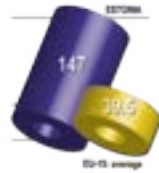


CANCER (MALIGNANT NEOPLASMS)

- Cancer is the second biggest cause of death – 19%.
- In 2000, cancer caused 202 deaths per 100 000. **EU-15 average: 183/100 000**
- The standard death rate from cervical cancer is more than twice the EU-15 average.

UNINTENTIONAL INJURIES

- In 2000, external injuries and poisoning were responsible for 147 deaths per 100 000.
EU-15 average: 39.5/100 000
- External causes are responsible for 11% of all deaths.
- For 2000, the number of road traffic accidents involving injury was almost *one third the EU-15 average*.



NEUROPSYCHIATRIC DISORDERS

- Suicide and self-inflicted injuries cause 26 deaths per 100 000 population each year. *EU-15 average: 10/100 000*
- Mental disorders have risen ten-fold during the last decade.

RESPIRATORY DISEASES

- Each year there are 38 cases per 100 000 – less than the *EU-15 average of 57/100 000*.

INFECTIOUS AND PARASITIC DISEASES

- In 2000, they caused 10.5 deaths per 100 000 population. *EU-15 average: 7.3*
- The tuberculosis incidence of 55 per 100 000 is five times higher than the EU-15 average.
- HIV/AIDS in Estonia is notable for several reasons.
 - Estonia has Europe's most rapid growth in HIV incidence. It has a concentrated epidemic of HIV/AIDS.
 - It also has the highest prevalence rate of the Baltic states – 1%.
 - HIV transmission since 2000 has been rapid, with 90% related to injecting drug use.
 - Among prisoners, 23% were HIV-positive in 2001.
 - *Sixty-six* new cases of HIV infection were reported per 100 000 population in 2002. *EU-15 average: 4/100 000*
 - The incidence of clinically diagnosed AIDS is 0.3 per 100 000. *EU-15 average: 2.4/100 000*



CHILDREN AND ADOLESCENT HEALTH

- Infant mortality is 8 deaths per 1000 live births.
EU-15 average: 5/1000
- Three per cent of the children aged 12 are affected by dental caries.

Points to remember *Causes of death and disease burden*
Always compare!

	% of deaths caused*		% of disease burden*	
	Estonian group	EU-15 group	Estonian group	EU-15 group
Cardiovascular diseases	59	41	28	17
Neuropsychiatric disorders	1	5	14	27
Cancer/malignant neoplasms	13	27	8.5	17
Unintentional injuries	9	3.4	14	5.8
Respiratory diseases	3	5.6	3	6.5
Infectious and parasitic diseases	2.7	1.2	5.2	1.7
Respiratory infections	1	4.4	1	1.3
Perinatal conditions	<1	<1	1	<1
Intentional injuries	4.6	1.3	7.4	2
Diabetes	<1	2.3	<1	2.1
Sense organ disorders	0	0	3.6	4.7
Total communicable diseases	4	6	9	5
Total noncommunicable diseases	82	89	69	87
Total injuries	14	5	22	8

* Data refer to the European mortality groups that include Estonia and the EU-15 countries, respectively.

Points to remember

health status

It is important to consider both mortality and disease burden when looking at how a medical condition affects a population. Each measure reflects a different facet of human suffering.

Sources: 1, 6, 8, 36.

Where do the risks lie?

SMOKING

- Smokers include 45% of all men and 18% of all women, for an adult population average of 29%. *EU-15 rates are men 32%, women 23%, together 28%.*
- In the period 2001–2002, 10% of 13-years-olds and 24% of 15-years-olds smoked.



ALCOHOL CONSUMPTION

- Alcohol use disorders are responsible for 2.8 %* of the disease burden and 0.3% of all deaths – a little more than half the average* for the EU-15 mortality group.
- In Estonia in 2000, there were 172 alcohol-related deaths per 100 000 population – triple the EU-15 average.
- In 2001, 8.2 litres of pure alcohol were registered as being consumed by each Estonian adult – slightly lower than the EU-15 average of 9.2 litres. However, unrecorded consumption was significant, estimated at 6 litres per person.

DRUGS

- Problem drug users make up more than 1% of the population age 15–64. *EU-15 average: 0.5%*
- Cannabis has been used at least once in their life by 13% of all 15- and 16-year-olds and 5% of the total population.
- Among students, there has been a steady increase in the lifetime use of cannabis, ecstasy and amphetamines.
- The most common drug problems among people seeking treatment are with opiates and illegal substances.
- Estonia is the only country among the new EU member states that reports an increase in the problem use of amphetamines.



- Injecting drug users and HIV/AIDS: the incidence of newly diagnosed HIV infections has increased significantly among this group, with a 282% increase in 2001. In Tallinn, the capital, there is a 41% HIV-prevalence among injecting drug users.
- Needle sharing among injecting drug users is also the main risk factor and transmission mode for hepatitis B and C.

OBESITY

- Among the population above 19 years of age, 10% of the men and 6% of the women (nearly 8% overall) are clinically obese, while 32% of the men and 24% of the women (28% overall) are pre-obese. In all, 35% of the adult population is overweight.
- In the group aged 18–64, 29% of the men and 36% of the women are reported to be physically inactive.
- Nutritional deficiencies are responsible for 1.2%* of the disease burden in the Estonian mortality group – more than twice the average* for the EU-15 mortality group.

Sources: 6, 8, 11, 12, 18, 20, 28.



Who's who in the Estonian public health sector?

PUBLIC ADMINISTRATION ● Ministry of Social Affairs, Health Care Division ● State Health Council – advisory body to the government

INSTITUTIONS WITHIN THE HEALTH CARE DIVISION ● Health Protection Inspectorate ● State Agency of Medicines ● Health Care Board ● Centre for Health Education and Promotion

PARLIAMENT ● Social Affairs Committee ● Study Committee for Enhancing the Prevention of HIV/AIDS and Drug Addiction

INSURANCE STRUCTURES Health Insurance Fund,
with four regional branches

PROFESSIONAL ASSOCIATIONS ● Estonian Medical Association
● Estonian Society of Family Doctors ● Estonian Nurses Union
● Estonian Hospitals Association

ACADEMIC INSTITUTIONS ● Medical Faculty, Tartu University
● Three nursing schools

PUBLIC HEALTH INSTITUTIONS ● National Institute for Health
Development ● Health Promotion Union



How are services provided?

PRIMARY HEALTH CARE

General practitioners (GPs) have private contracts for the Health Insurance Fund, either independently or as part of a group. They are paid through a combination of capitation fees (a fixed sum for each person registered with a practice, adjusted to his/her age) and fees-for-service. They provide both general medical care and health promotion/disease prevention services. In most of the country, practically all citizens are self-registered with a general practice, using their right of free choice for this service. In principle, GPs serve a gate-keeping function; however, many people who seek medical help consult a specialist directly. There are eight different categories of specialists whom citizens are free to consult directly, and regulations do permit direct access to these specialists.

SECONDARY AND TERTIARY CARE

The hospital system is geographically decentralized. Hospitals provide both outpatient and inpatient services. There are small (municipal), midsize (county) and national (city) hospitals, as well



as university clinics and specialized hospitals. While all hospitals are quite autonomous in their decision-making, they remain accountable to two parties – to the health insurance fund for health care services, and to the owners (most often municipalities) for financing. Many hospitals have been reorganized as nursing homes, providing long-term care. According to the Hospital Master Plan, there has been extensive merging of hospitals and sharp restructuring: in the beginning of the 1990s, out of 10 000 hospital beds, only 500 were for long-term care, all the others were acute beds, while now the aim is to change this ration to 3500 long-term versus 6500 acute beds.

THE PUBLIC–PRIVATE MIX

Most health care services are provided by the public sector, but private provision has increased in the last few years. Presently, the private sector chief strengths lie in dentistry, gynaecology, urology, ophthalmology and ear, nose and throat care. Private providers have contracts with the sickness funds and must meet the same eligibility criteria as public providers. Patients must pay directly any private charges that exceed the sum covered by public insurance. Among GPs, 92% work in the public sector and 6% in the private sector.



Points to remember *service provision*

- Primary care reform is considered, to a large extent, finished.
- Estonians want to preserve their right to decide in each specific case whether to consult a specialist directly or see their family doctor for a referral.
- The new Health Insurance Act has added quality-of-service requirements to provider contracts (access, waiting times etc.).
- All health care providers in the country are contracted by the Health Insurance Fund.

Sources: 2, 8, 32.





What resources are available?

HUMAN RESOURCES

HEALTH PROFESSIONALS

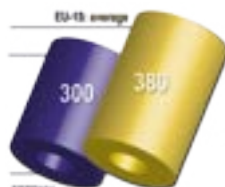
(per 100 000 population)

Dentists 790 *EU-15 average: 640*

Nurses 630 *EU-15 average: 670*

Pharmacists 590 *EU-15 average: 790*

General practitioners 73 *EU-15 average: 102*



Physicians 300
EU-15 average: 380

HOSPITALS

Hospital beds (per 100 000) 671

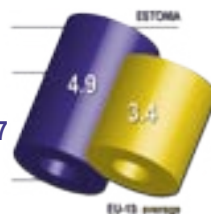
EU-15 average: 611

Annual inpatient admissions (per 100) 19.7

EU-15 average: 18

Average length of stay 8.6 days

EU-15 average: 10



Hospitals
(per 100 000) 4.9
EU-15 average: 3.4

PHARMACEUTICALS

Prescription medicines are available through a well-functioning reimbursement system. There is an obligatory patient co-payment, even for essential-list drugs, and over-the-counter medicines are not reimbursed. The health insurance budget has been strained by rapidly increasing expenditure for pharmaceutical reimbursements. Nationally produced medicines constitute under 10% of the total market. Among pharmacies, 94% are private, and all drug manufacturers and wholesale dealers are private.



Points to remember

health resources

- The number of doctors has been continuously decreasing, however, there is certain shortage of nurses.
- Special attention is paid to the potential benefits of restructuring of the medical specialisation.
- It is one of the system goals to concentrate inpatient care in fewer hospitals with more investment in each.
- During the last decade, the number of hospitals and hospital beds has been reduced sharply, and the average length of hospital stay has halved.
- Though they are publicly owned, a growing number of hospitals operate as private legal entities.
- Only medicines of proven quality and efficacy are included on the essential drug list for reimbursement.

Sources: 6, 8, 11, 32.

Who pays for what?



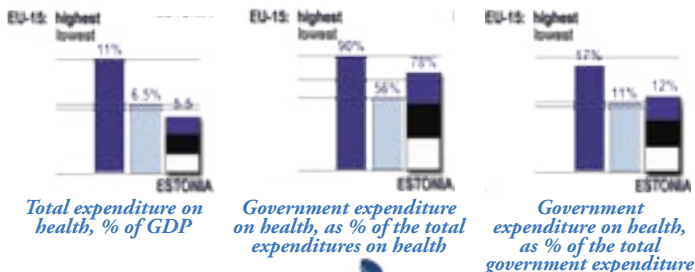
*The health system is financed from both public and private sources. Most of the funding comes from **public** sources – an overall contribution of 80%, from them 12% from general taxation and 68% from health insurance. The Health Insurance Fund with its four regional branches, contracts most providers, and is the main source of financing for the hospitals, also through contracts. The Fund has a 4-members management board and 15-members supervisory board, chaired by the Minister of Social Affairs). The population coverage is quite broad and covers contributors' dependants. The state pays for some special groups, but they account for only 3% of all insured persons.*

Of the total expenditure on health, 74% is for inpatient specialist care, 14% for primary health care and 4% for health promotion and disease prevention. Of the total pharmaceutical expenditure, half is paid through public funds and half directly by patients.

In 1998, private sources accounted for 12% of all health system funding – most of it from out-of-pocket payments, with a very

limited proportion from private health insurance. By 2000, the out-of-pocket share had more than doubled and reached almost 20% of total expenditure on health. Out-of-pocket payments cover mainly pharmaceuticals, dental care and standard visit fees.

THE ECONOMIC PICTURE



Points to remember *health care financing*

- Health insurance funds (national and regional) plan to develop long-term strategies for purchasing services.
- Health insurance often pays for social care when hospital stays are recommended on the basis of social indications rather than medical necessity alone.

Sources: 1, 6, 32.

How have Estonians been reforming their health care system?

THE HEALTH REFORMS OF THE LAST DECADE:

- included the reorganization of primary care, a process that started in 1991 and was considered complete in 2003;
- introduced a national hospital master plan in 2000, which outlined a strategy for specialized care through 2015, envisioning common solutions for social and long-term care;



- decentralized most primary and out-patient health care;
- took a bottom-up approach, in which the county and municipality levels have exercised a significant amount of responsibility and initiative;
- shifted health care financing from a state revenue basis to a social insurance basis; and
- implemented successful pharmaceutical reforms.

Points to remember *health system reform*

- Professional and management culture has come to be seen as vital for the sector.
- Quality of care and quality of management are both high on the agenda.
- Hospitals restructuring, quality performance and accountability are being improved.
- All actors are increasingly attracted by the potential advantages of central leadership and monitoring, and by the benefits of a national vision for health care development.
- A national health strategy is accordingly in preparation.

What is one of the things the Estonians learned by doing?



BOOSTING THE PRESTIGE OF GPs

Before 1998, most Estonian health professionals and members of the general public would have described general practice as low profile and lacking in professional prestige. GPs' self-esteem and status were lower than specialists'. This situation was a poor foundation for primary care reform, since practising and prospective primary care physicians were poorly motivated and the quality of their services questioned. It was also a major reason why patients preferred to consult specialists directly. The challenge

was – and still to a certain extent is – to change this negative attitude and the reasons for it among both patients and health professionals.

The Estonian state has made a remarkably focused effort to do so. It began by creating ample opportunities for GPs to develop their skills. In 1991, a retraining course in family medicine was offered to former district internists and paediatricians, and in 1993, a regular three-year programme in family medicine was initiated for new medical school graduate. Competent specialists were given both professional and financial incentives to retrain in family medicine. The value of GPs was clearly defined by linking their salaries to the amount and quality of the work they performed. Today, about 50% of all GPs are private contractors, which has contributed significantly to their financial stability and professional standing. Finally, public institutions have let the public know explicitly that GPs are now centre stage, and that their work is critical to the success of health reforms.

What has the Regional Office been doing in Estonia?

The WHO Regional Office for Europe has had a Liaison Office in Tallinn since 1994. Estonia now participates in six WHO networks: Healthy Cities, Health Promoting Hospitals, Health Promoting Schools, Countrywide Integrated Noncommunicable Diseases Intervention (CINDI), the European Forum of Medical Associations and the EuroPharm Forum.

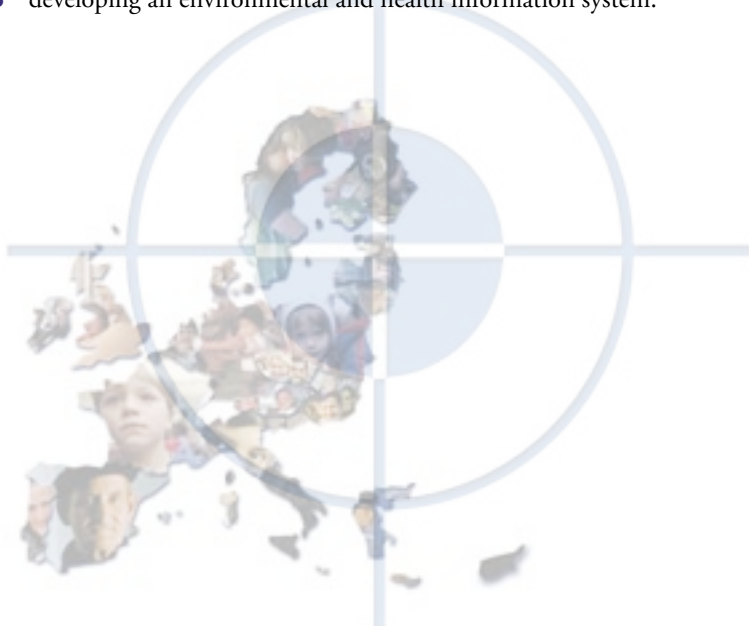


During 2002–2003, the Regional Office worked together with Estonia on:

- developing policy development mechanisms;
- evaluating the national HIV/AIDS programme;
- evaluating primary health care reform; and
- developing guidelines for the economic evaluation of pharmaceuticals (in the Baltic states).

For 2004–2005, the Regional Office has signed an agreement with Estonia to provide it support in:

- building the capacity of the public health system nationally, regionally and locally;
- developing national policies on medicines and cross-sector health actions, as well as a national programme on HIV/AIDS and other sexually transmitted diseases;
- addressing inequalities in health care access and financing;
- assessing the restructuring of the hospital system; and
- developing an environmental and health information system.



SOURCES OF INFORMATION ABOUT ESTONIA

Web sites

Ministry of Social Affairs	http://www.riik.ee/en/valitsus
Estonian Informatics Centre	http://www.ria.ee/atp
Parliament of Estonia	http://www.riigikogu.ee
Health Insurance Fund	http://www.haigekassa.ee
European Commission Delegation to Estonia	http://www.euroopaliit.ee
Estonian EU Information Centre	http://elik.nlib.ee



Estonia



Hungary



Latvia



Lithuania



Malta



Poland



Slovakia



Slovenia

HUNGARY



MAGYARORSZÁG

AREA

93 000 km²

Equal to Portugal

2.4% of the total EU-25 area

POPULATION

10 100 000

Equal to Portugal and to Greece

2.2% of the total EU-25 population

THE PEOPLE	Hungarians 97%
LANGUAGES	Hungarian
FORM OF GOVERNMENT	Parliamentary republic Unicameral parliament (<i>Országgyűlés</i>) Head of state – president, elected by the parliament
MAIN RELIGION	Roman Catholic 58%, Reformed Protestant 18%, Lutheran 4%, Eastern Orthodox 3%
INDEPENDENCE	1920
GDP PER CAPITA	€5700 = <i>24% of the EU-15 average</i> In purchasing power parity (PPP): €10 700 = <i>47.5% of the EU-15 average</i>
REGIONAL DIVISIONS	7 regions (<i>régió</i>), 19 counties (<i>megye</i>)
CURRENCY	Hungarian forint (€1.00 = 250 forints)
HUMAN DEVELOPMENT INDEX	0.89 <i>EU-15 lowest: 0.89, highest: 0.94</i>
UNEMPLOYMENT RATE	6% <i>EU-15 average: 9%</i>
MEMBER OF	CE, NATO, OSCE, UN, WTO

Sources: 1, 4, 5, 6, 7, 15, 16, 17, 18.

HEALTH

EGÉSZSÉG



Hungary



Latvia



Lithuania



Malta



Poland



Slovakia



Slovenia

THE TEN HEALTH QUESTIONS

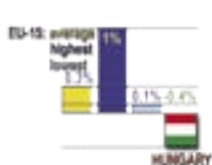


What are the demographic essentials for Hungary?

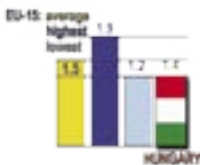
POPULATION PROFILE

Sex ratio	1.1 females/males	<i>EU-15 average: 1.4</i>
Urban concentration	65%	<i>EU-15 average: 80%</i>
Age structure	0–14 years 17%	<i>EU-15 average: 18%</i>
	65+ years 15%	<i>EU-15 average: 17%</i>
Median age	38 years	
Dependency ratio	49%	<i>EU-15 average: 49.5%</i>

POPULATION DYNAMICS



Annual growth rate

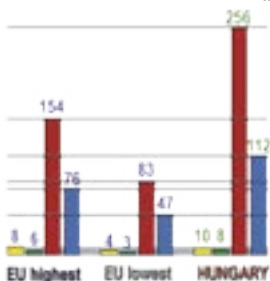


Fertility rate



Birth rates, live births /1000 population

PROBABILITY OF DYING (per 1000 population)



- Before age 5, male
- Before age 5, female
- Between age 15 and 60, male
- Between age 15 and 60, female

LIFE EXPECTANCY AT BIRTH

Total population	73 years
Male	68 years
Female	77 years

EU-15 average: 79
EU-15 average: 75.5
EU-15 average: 82

HEALTHY LIFE EXPECTANCY

	At birth (in years)			At age 60 (in years)		% of total life expectancy lost to poor health	
	Total	Male	Female	Male	Female	Male	Female
Hungary	65	61.5	68	12	16	10	11
EU-15 lowest	69	67	71	15	17	8	9
EU-15 highest	73	72	75	17	20	9	11

Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health. The last two columns present this idea in another way, as the percentage of a lifetime that is spent living in less-than-full health.

Points to remember *demographic trends*

The past decade has seen:

- a very minor increase in the population's life expectancy, which is one of the lowest in Europe; ● ageing of the population; and
- a substantial gender gap in life expectancy and mortality.

Sources: 1, 3, 4, 6, 16, 17, 18.

What do the Hungarians suffer from?

**When analysing the causes of death and disease burden, WHO has divided all countries into different mortality strata according to the levels of mortality for children younger than 5 and males age 15 to 59. According to this division, the whole of Europe falls into the developed country stratum. However, within this stratum, European countries are subdivided into three different groups – those with very low child and very low adult mortality, those*



Hungary



Latvia



Lithuania



Malta




Poland



Slovakia



Slovenia



with low adult and low child mortality, and those with low child and high adult mortality. This subdivision reflects the great variations that exist within Europe and help place figures in a regional context – a European mortality figure that might seem quite low in comparison to figures from Africa or south-east Asia may actually be quite high in comparison to figures from the most-developed European countries. According to this classification, Hungary is in the group of European countries with low child and high adult mortality. (The member states in the EU-15 are all in another group – that with very low child and very low adult mortality.) Throughout this chapter, data marked by * are not country-specific but refer instead to the entire European group into which Hungary falls.

CARDIOVASCULAR DISEASES

- Circulatory diseases are the leading cause of death.
- Of the various forms of these diseases, there are two major killers.
 - *Ischaemic heart disease* caused 227 Hungarian deaths per 100 000 in 2000 (*EU-15 average: 97/100 000*). For the Hungarian mortality group as a whole, it was responsible for 32.5%* of all deaths and 14%* of the disease burden.
 - *Cerebrovascular diseases* led to 142 deaths per 100 000 in 2000 (*EU-15 average: 61/100 000*). For the mortality group as a whole, these diseases were responsible for 19.8%* of all deaths and 9.1%* of the disease burden.
- Thirty-five Hungarians per 100 000 population died of other circulatory system diseases in 2000. *EU-15 average: 14/100 000*



CANCER (MALIGNANT NEOPLASMS)

- Hungarian males have the highest cancer mortality rate in the world.

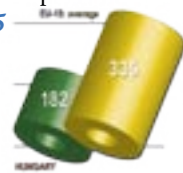
- In 2000, cancer caused 268 deaths per 100 000 population. *EU-15 average: 183/100 000*
- In that same year, the standard death rate from cervical cancer was 7.3 per 100 000, nearly triple the. *EU-15 average: 2.6 per 100 000*
- The standard death rate from cancer of the respiratory system was 65 per 100 000 in 2000. *EU-15 average: 37/100 000*

NEUROPSYCHIATRIC DISORDERS

- Suicide and self-inflicted injury caused 29 deaths per 100 000 annually. *EU-15 average: 10/100 000*
- The Hungarian suicide rate is one of the highest in Europe – 21 per 100 000 population in 1997. It is the most common cause of death for those aged 16 to 24.

INJURIES

- In 2000, external injuries and poisoning were responsible for 82 deaths per 100 000. *EU-15 average: 39.5*
- The number of road traffic accidents involving injury was 182 per 100 000 in 2001 – much lower than the *EU-15 average of 335/100 000*.



RESPIRATORY DISEASES

- There are 40.3 deaths per 100 000 population due to respiratory diseases each year. *EU-15 average: 57/100 000*

INFECTIOUS AND PARASITIC DISEASES

- In 2000, this group of diseases caused 5.2 deaths per 100 000 population. *EU-15 average: 7.3*
- In 2002, the tuberculosis incidence was 27 per 100 000. *EU-15 average: 11/100 000*
- The incidence of HIV/AIDS was 0.3 per 100 000 population in 1999. The incidence of new cases of HIV infection was 0.8 per 100 000. *EU-15 average: 4.3/100 000*

CHILD AND ADOLESCENT HEALTH

- Infant mortality in Hungary is 8.1 deaths per 1000 live births. *EU-15 average: 4.7/1000*



- Compulsory immunization has achieved 99% age-related coverage.

ORAL HEALTH

- Dental caries affects 4.5% of all children age 5 and 6, and 8% of all 18 year-olds. The rate is 15% for adults in the 35–44 age group.

Points to remember
Always compare!

Causes of death and disease burden

	% of deaths caused*		% of disease burden*	
	Hungarian group	EU-15 group	Hungarian group	EU-15
Cardiovascular diseases	59	41	28	17
Neuropsychiatric disorders	1	5	14	26.5
Cancer/malignant neoplasms	13	26.5	8.5	16.5
Unintentional injuries	9	3.4	14	5.8
Respiratory diseases	2.8	5.6	2.8	6.5
Infectious and parasitic diseases	2.7	1.2	5.2	1.7
Respiratory infections	1	4.4	1	1.3
Perinatal conditions	<1.0	<1.0	1	<1.0
Intentional injuries	4.6	1.3	7.4	2
Diabetes	<1	2.3	<1.0	2.1
Sense organ disorders	0	0	3.6	4.7
Total communicable diseases	4.3	6	9	5
Total noncommunicable diseases	82	89	69	87
Total injuries	14	5	22	8

* Data refer to the European mortality groups that include Hungary and the EU-15 countries, respectively.

Points to remember

health status

It is important to consider both mortality and disease burden when looking at how a medical condition affects a population. Each measure reflects a different facet of human suffering.

Sources: 1, 6, 8, 36.

Where do the risks lie?

SMOKING

- Smokers comprise 38% of all men and 23% of all women, for an adult population average of 31%. *EU-15 rates are men 32%, women 23%, together 28%*
- During the period 2001–2002, 8% of 13-year-olds and 27% of 15-year-olds were regular smokers.
- Around 65% of the population is at risk from passive smoking.



Smoking-related deaths per 100 000 population each year

ALCOHOL CONSUMPTION

- Among Hungarians, 30% of the men and 15% of the women drink regularly.
- Alcohol use disorders are responsible for 2.8%* of the disease burden and 0.3%* of all deaths in the Hungarian mortality group – a little more than half the average* for the EU-15 group.
- In Hungary in 2000, there were 160 alcohol-related deaths per 100 000 population – more than double the EU-15 average.
- During 2001, each adult was reported as consuming 10 litres of pure alcohol, a quantity close to the EU-15 average.
- Cirrhosis of the liver is a main cause of mortality among men.



Hungary



Latvia



Lithuania



Malta



Poland



Slovakia



Slovenia

OBESITY

- Among the population older than 18 years of age, 21% of both men and women are clinically obese. Another 42% of the men and 28% of the women (34% combined) qualify as pre-obese. Overall then, 55% of adult Hungarians are overweight.
- In the 18–30 age group, 87% of the men and 95% of the women are reported to be physically inactive.
- Nutritional deficiencies are responsible for 1.2%* of the disease burden in countries of the Hungarian mortality group – more than twice the average* for the EU-15 group countries.

Who's who in the Hungarian public health?



PUBLIC ADMINISTRATION

Ministry of Health, Social and Family Affairs

INSTITUTIONS SUPERVISED BY THE MINISTRY

Hungarian National Emergency and Ambulance Service

National Blood Transfusion Service

National Institute for Health Development

Hungarotransplant Health Care Coordination Public Service Corporation

National institutes of addictology (a medical subspecialty in Hungary), anaesthesiology and intensive care, children's health, dermatology, dietetics, forensic medicine, laboratory medicine, obstetrics and gynaecology, ophthalmology, orthopaedics, otorhinolaryngology, pathology, pharmacy, primary care, stomatology, surgery, urology, vascular surgery etc.

PARLIAMENTARY COMMITTEE

Committee of Health Affairs

Committee of Social and Family Affairs

INSURANCE STRUCTURES National Health Insurance Fund Administration, under the administration of the Ministry

PROFESSIONAL ASSOCIATIONS

Hungarian Medical Chamber
Hungarian Chamber of Doctors
Hungarian Nursing Association
Hungarian Pharmacists' Association
Hungarian Hospital Association
Hungarian Dental Association
Federation of Hungarian Medical Societies

ACADEMIC SETTINGS

Four medical universities: Semmelweis University of Medicine, Budapest, University of Medicine in Debrecen, Szeged and Pécs

PUBLIC HEALTH INSTITUTIONS

National Public Health and Medical Officer Service (provides a full range of public health services. It has three centres, each responsible for one main area of public health: the Johan Béla National Centre for Epidemiology, the Fodor József National Centre for Public Health and the National Institute for Health Development.

REGIONAL INSTITUTIONS

National Public Health and Medical Officer Service – 19 county offices and 1 office in the capital



How are services provided?

PRIMARY HEALTH CARE

Municipalities are responsible for primary health care. General practitioners (GPs) usually work in one of the following two ways. The majority (almost 80%) have private practices and are contracted by their local governments. They receive capitation



Hungary



Latvia



Lithuania



Malta



Poland



Slovakia



Slovenia

fees from the National Health Insurance Fund on the basis of registered patients. Local governments employ another 21% of the GPs on fixed salaries. Three per cent of the GPs choose a third way of working in primary care, in which they run independent practices without municipal contracts. In these cases, they can receive capitation fees from the insurance fund only if they have registered more than 200 patients.

SECONDARY AND TERTIARY CARE

County hospitals provide secondary care to the populations of their respective counties. Municipalities also provide some secondary and specialized care, albeit in polyclinics, dispensaries and small hospitals. Tertiary care is provided in dispensaries and hospices as well as university hospitals. The national government owns hospitals dedicated to both acute and chronic care, as well as to rehabilitation. There are a variety of national clinics and institutes devoted to specific diseases – cancer, alcoholism, mental illness, sexually transmitted diseases etc. The yearly hospitalization rate in Hungary is quite high, 22% (EU-15 average: 15%). Up to 30% of all hospital patients have been referred there on social rather than medical grounds. Of all the hospital beds in Hungary, local governments own 77%, university clinical departments 9.5%, national institutes 7%, various ministries nearly 4% and churches about 2%.



Points to remember *service provision*

- The Hungarian health system is organized on a county basis.
- The uneven geographical distribution of services is a matter of significant concern.
- New legislation is in place to guarantee better quality control and accreditation standards for hospitals.

Sources: 2, 8, 32.





What resources are available?

HUMAN RESOURCES

HEALTH PROFESSIONALS

(per 100 000 population)

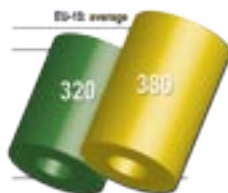
Dentists 470 *EU-15 average: 640*

Nurses 850 *EU-15 average: 670*

Pharmacists 500 *EU-15 average: 790*

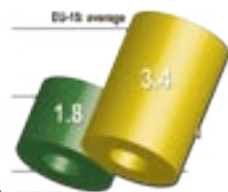
General

practitioners 66 *EU-15 average: 102*



Physicians 320

EU-15 average: 380



Hospitals

(per 100 000) 1.8

EU-15 average: 3.4

HOSPITALS

Hospital beds (per 100 000) 710

EU-15 average: 611

Annual inpatient admissions (per 100) 24

EU-15 average: 18

Average length of stay 8.7 days

EU-15 average: 10

PHARMACEUTICALS

The wholesale pharmaceutical trade is predominantly (90%) private. The retail industry is also privatized. The pharmaceutical market has increased dramatically over the last decade, in terms of not only product range but also expenditure – the average family now spends 10 times as much on medicines as it did in the beginning of the 1990s. The pharmaceutical sector is comprehensively regulated.

Points to remember

health resources

- Except for GPs, most doctors are public employees who receive fixed salaries.
- Nursing lacks prestige, and it offers no solid financial incentives as a career.
- Efforts to reduce the number of hospital beds are often suspected of being linked to personnel reduction.
- The rationalization strategy for hospitals envisages closing facilities at every level, not just in small towns.
- The over-prescription of drugs has become a focus of concern.

Sources: 6, 8, 11.



Hungary



Latvia



Lithuania



Malta



Poland



Slovakia



Slovenia

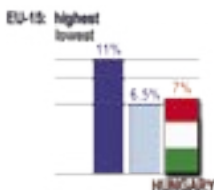
Who pays for what?



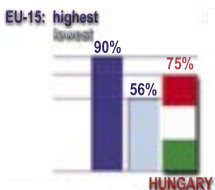
The National Health Insurance Fund is the primary vehicle for covering health care expenditure in Hungary. It receives funding from three main sources: direct contributions from wages (11% from employers and 3% to 4% from employees), general taxation (to cover people who are entitled to coverage but cannot contribute to the Fund), and assets that the central government makes available. Local government budgets also include some health spending.

There are two ways to reimburse health services. GPs receive capitation fees, and outpatient specialists are paid retrospectively according to the medical procedures they perform – according to the scheme of fee-for-service points and disease-related groups for acute care. Cost-containment mechanisms have been put in place.

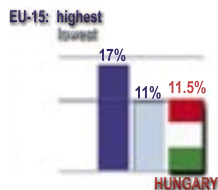
THE ECONOMIC PICTURE



Total expenditure on health, % of GDP



Government expenditure on health, as % of the total expenditures on health



Government expenditure on health, as % of the total government expenditure

Points to remember *health care financing*

- The state has replaced the former tax-based health care system with a contribution-based insurance system.
- Of its overall health budget, the government spends 77% on hospitals, 12% on outpatient care and 11% on primary care.
- The link is identified between quality of care and reimbursement.
- Pharmaceuticals account for 30% of total health expenditure, or twice the average share for EU-15 countries.
- Long-term capital investment in health is being sought.

Sources: 1, 2, 6, 13, 32.



How have the Hungarians been reforming their health system?

THE HEALTH REFORMS OF THE LAST DECADE:

- made a successful transition from an integrated health care system to a contract system in which providers and purchasers are separated;
- transferred ownership of most primary and secondary care facilities from the central government to the local governments;
- strengthened the role of GPs;
- established a statutory health insurance fund, affirmed its new role as purchaser of health care services and set up the administration necessary to manage it;
- introduced quality standards for health services;
- increased the participation of patients and other stakeholders; and
- made the distinction between health care and social care progressively clearer.

Points to remember *health system reform*

- Most dental practices, general practices and pharmacies have been privatized.
- Computerized data collection and quality monitoring information systems have become increasingly important.
- The development of a national human resource strategy is high on the health sector agenda.
- The biggest challenge in the health reform process is, according to Hungarian society, implementing it with due speed.



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What is one of the things Hungary has learned by doing?

NATIONAL STRATEGIC HEALTH DOCUMENTS – FROM GOOD TO BETTER

Hungary has a long unbroken tradition of formulating visions of public health care goals. Beginning in the early 1990s, it developed five successive national health documents. Each referred to strategic issues to be addressed by the entire country, such as health promotion, public health challenges, policy investments, the direction of long-term policy etc. The latest of these strategic documents was developed by the government and approved by the parliament at the end of 2002: the Johan Béla National Programme for the Decade of Health. Its approach is innovative. While previous national health programmes have always been based on a high-risk approach, the Decade of Health programme seeks to alter the entire population's illness–mortality relationship over the long term. One of its goals is to realize a three times increase in life expectancy for both men and women by the end of the decade. Sustainability is being stressed as a key factor in the programme's success, so that the impact of reforms will extend beyond the lifespan of the current administration. The other innovative aspect of the programme is its clarification of the different roles that society and the government play in health choices.

What has the Regional Office been doing in Hungary?

The WHO Regional Office for Europe has had a liaison office in Budapest since 1990. The country participates in a number of WHO programmes and networks, including Healthy Cities, Health Promoting Schools, Healthy Workplaces and



Regions for Health, as well as initiatives in the areas of health-promoting nurseries, environment and health, noncommunicable diseases, health economics etc. There are now seven WHO collaborating centres in Hungary.

In 2002–2003, Hungary worked with the Regional Office in the areas of:

- health promotion
- noncommunicable diseases and mental health
- environment and health.

For 2004–2005, the Regional Office signed an agreement to provide Hungary with assistance in:

- the development of health policies that focus on disadvantaged populations;
- tobacco control (developing a national action plan and relevant legislation);
- management of alcohol and substance abuse;
- implementation of its food and nutrition action plan; and
- environment and health issues.

SOURCES OF INFORMATION ABOUT HUNGARY

Web sites

Ministry of Health, Social and
Family Affairs

Prime Minister's Office

Hungarian Statistical Office

Hungary Euro Info Centre Network

European Commission delegation
to Hungary

European Union Information Centre

<http://www.eszcsm.hu>

<http://www.meh.hu>

<http://www.ksh.hu>

<http://www.euroinfocentre.hu>

<http://www.eudelegation.hu>

<http://www.eu.hu>



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LATVIA



LATVIJA

AREA

64 600 km²

Approximately equal to Ireland

1.6% of the total EU-25 area

POPULATION

2 400 000

Two thirds the population of Ireland

0.5% of the total EU-25 population

THE PEOPLE

Latvians 58%, Russians 29%, Byelorussians, Ukrainians, Poles, Lithuanians

LANGUAGES Latvian (official); Russian and English widely spoken

FORM OF GOVERNMENT
Parliamentary democracy
Unicameral assembly (*Saeima*)
Head of state – president, elected by the *Saeima*

MAIN RELIGION Lutheran, Roman Catholic, Russian Orthodox

INDEPENDENCE 1991

GDP PER CAPITA €3 700 = *15.7% of the EU-15 average*
In purchasing power parity:
€8 500 = *35% of the EU-15 average*

REGIONAL DIVISIONS
26 districts, 7 large cities

CURRENCY Latvian lats (1 lats = €1.50)

HUMAN DEVELOPMENT INDEX
0.79 *EU-15 lowest: 0.89, highest: 0.94*

UNEMPLOYMENT RATE
7% *EU-15 average: 9%*

MEMBER OF CE, OSCE, NATO, UN, WTO

Sources: 1, 3, 4, 5, 6, 7, 8, 15, 16, 18.

HEALTH

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THE TEN HEALTH QUESTIONS

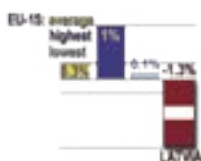


What are the demographic essentials for Latvia?

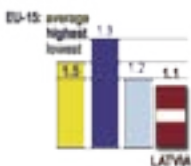
POPULATION PROFILE

Sex ratio	1.17 females/males	<i>EU-15 average: 1.4</i>
Urban concentration	69%	<i>EU-15 average: 80%</i>
Age structure	0–14 years 17%	<i>EU-15 average: 18%</i>
	65+ years 15%	<i>EU-15 average: 17%</i>
Median age	39 years	
Dependency ratio	48%	<i>EU-15 average: 49.5%</i>

POPULATION DYNAMICS



Annual growth rate

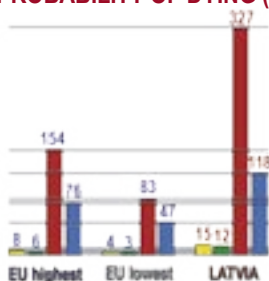


Fertility rate



Birth rates, live births /1000 population

PROBABILITY OF DYING (per 1000 population)



- Before age 5, male
- Before age 5, female
- Between age 15 and 60, male
- Between age 15 and 60, female

LIFE EXPECTANCY AT BIRTH

Total population 70 years
 Male 65 years
 Female 76 years

EU-15 average: 79
EU-15 average: 75.5
EU-15 average: 82

HEALTHY LIFE EXPECTANCY

	At birth (in years)			At age 60 (in years)		% of total life expectancy lost	
	Total	Male	Female	Male	Female	Male	Female
Latvia	63	58	67.5	11	16	10	11
EU-15 highest	73	72	75	17	20	9	11
EU-15 lowest	69	67	71	15	17	8	9

Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health. The last two columns present this idea in yet another way, as the percentage of a lifetime that is spent living in less-than-full health.

Points to remember

The past decade has seen:

demographic trends

- negative national population growth
- low life expectancy
- a decline in the birth rate
- ageing of the population.

Sources: 1, 3, 4, 6, 16, 17, 18.

What do the Latvians suffer from?

**When analysing the causes of death and disease burden, WHO has divided all countries into different mortality strata according to the level of mortality for children younger than 5 and for males aged 15 to 59. According to this division, the whole of Europe falls in the developed country stratum. However, within this stratum, European countries are divided into three different groups – those with very low child and very low adult mortality, those with*



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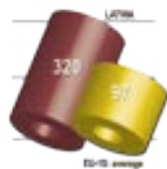
low adult and low child mortality, and those with low child and high adult mortality. This division reflects the great variations that exist within Europe and help place figures in a regional context – a European mortality figure that might seem quite low in comparison to figures from Africa or south-east Asia may actually be quite high in comparison to figures from the most-developed European countries. According to this classification, Latvia is in the group of European countries with low child and high adult mortality. The member states in the EU-15 are all in another group – that with very low child and very low adult mortality. Throughout this chapter, all data marked by * are not country-specific but refer instead to the European group in which Latvia falls.

CARDIOVASCULAR DISEASES

- Cardiovascular diseases are the leading cause of death.
- Of the various forms of cardiovascular disease, there are two major killers.

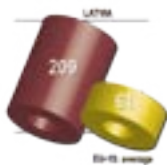
- *Ischaemic heart disease* is responsible for 14%* of the disease burden and 32.5%* of all deaths in the mortality group. In Latvia itself, there were 320 deaths per 100 000 population in 2000.

EU-15 average: 97/100 000



- *Cerebrovascular diseases* is responsible for 9%* of the disease burden and 20%* of all deaths. In Latvia, it led to 209 deaths per 100 000 in 2000.

EU-15 average: 61/100 000

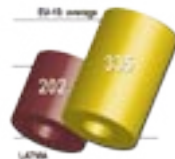


CANCER (MALIGNANT NEOPLASMS)

- In 2000, cancer caused 192 deaths per 100 000.
EU-15 average: 183/100 000
- The standard death rate from cervical cancer is triple the average for the EU-15.

UNINTENTIONAL INJURIES

- In Latvia's mortality group, unintentional injuries are the leading contributor to the disease burden, with 22%*. They're also the third largest cause of mortality, being responsible for 14%* of all deaths.
- In 2000, external injuries and poisoning were responsible for 152 deaths per 100 000.
EU-15 average: 39.5/100 000
- For 2000, the number of road traffic accidents involving injury was 202 per 100 000. *EU-15 average: 335/100 000*



NEUROPSYCHIATRIC DISORDERS

Suicide and self-inflicted injury have caused 31 deaths per 100 000 each year. *EU-15 average: 10/100 000*

RESPIRATORY DISEASES

There are 31 cases per 100 000 annually, which is less than the *EU-15 average of 57/100 000*

INFECTIOUS AND PARASITIC DISEASES

- In 2000, they caused 15.3 deaths per 100 000. *EU-15 average: 7.3/100 000*
- With 83.5 new cases per 100 000 population, Latvians suffer nearly eight times the tuberculosis incidence of the EU-15 average.
- As in the other Baltic states, the HIV/AIDS profile of the country is extremely worrisome.
 - Twenty-three new cases of HIV infection were reported per 100 000 population in 2002. *EU-15 average: 4/100 000*
 - The incidence of clinically diagnosed AIDS is 2.3 per 100 000. *EU-15 average: 2.4/100 000*
 - The reported HIV-prevalence rate in 2001 was 0.4%, with a tendency to decrease in the last two years.



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Slovenia

CHILD AND ADOLESCENT HEALTH

- Infant mortality is 0.3 deaths per 1000 live births.
EU-15 average: 4.7/1000
- There is 94% immunization coverage for most vaccine-preventable diseases. One exception is diphtheria, where coverage is only 76%.

ORAL HEALTH

Dental caries affects 4% of Latvian 4 years-olds and 8% of the 15 years-olds, reaching 18.5% for adults 35–44 years-olds.

	Points to remember Always compare!		<i>Causes of death and disease burden</i>	
	% of deaths caused*		% of disease burden*	
	Latvian group	EU-15 group	Latvian group	EU-15 group
Cardiovascular diseases	59	41	28	17
Neuropsychiatric disorders	1	5	14	27
Cancer/malignant neoplasms	13	27	8.5	17
Unintentional injuries	9	3.4	14	5.8
Respiratory diseases	3	5.6	3	6.5
Infectious and parasitic diseases	2.7	1.2	5.2	1.7
Respiratory infections	1	4.4	1	1.3
Perinatal conditions	<1	<1	1	<1
Intentional injuries	4.6	1.3	7.4	2
Diabetes	<1	2.3	<1	2.1
Sense organ disorders	0	0	3.6	4.7
Total communicable diseases	4	6	9	5
Total noncommunicable diseases	82	89	69	87
Total injuries	14	5	22	8

Points to remember

health status

It is important to consider both mortality and disease burden when looking at how a medical condition affects a population. Each measure reflects a different facet of human suffering.

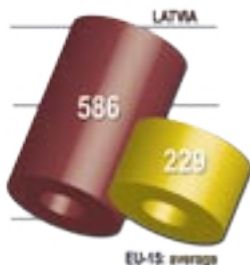
Sources: 1, 5, 8, 36.



Where do the risks lie?

SMOKING

- Smokers comprise 49% of all men and 13% of all women, for an adult population average of 29%.
EU-15 rates are men 32%, women 23%, overall 28%.
- For the period 2001–2002, 11% of 13-year-olds and 24.5% of 15-year-olds smoked.



Smoking-related deaths per 100 000 population each year

ALCOHOL CONSUMPTION

- In Latvia in 2000, there were 180 alcohol-related deaths per 100 000 population – triple the EU-15 average.
- In 2001, 7.7 litres pure alcohol was registered as consumed by each Latvian adult, which is lower than the 9.2 EU-15 average. However, the unrecorded consumption is quite high, estimated at 14.2 litres per person.

DRUGS

- There has been a rapid increase in the use of synthetic drugs, especially amphetamines and other stimulants.
- Six per cent of 16-year-olds reported having tried ecstasy at least once – one of the highest rates in central and eastern Europe.
- In four years, the number of 16-year-olds who have tried marijuana at least once tripled.
- *Injecting drug users and HIV/AIDS* – there has been a dramatic increase in the incidence of newly diagnosed HIV infections among this group, up 67% in 2001. The group's HIV prevalence is 12%.



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OBESITY

- Among the population older than 15 years of age, 9.5% of the men and 17% of the women (almost 14% overall) are clinically obese, while 41% of the men and 33% of the women (37% overall) are pre-obese. In all, 50% of the adult population is overweight.
- In the group aged 18–64, 53% of the men and 51% of the women are reported as physically inactive.
- Nutritional deficiencies are responsible for 1.2%* of the disease burden in the Latvian mortality group – more than twice the average* for the EU-15 mortality group.

Sources: 6, 8, 11, 12, 18, 20, 28.

Who's who in the Latvian public health sector?

PUBLIC ADMINISTRATION

Ministry of Health

INSTITUTIONS UNDER THE MINISTRY OF HEALTH

AIDS Prevention Centre

Centre for Drug Abuse Prevention and Treatment

Health Promotion Centre

Health Statistics and Medical Technology Agency

Latvian Food Centre

Medicines Pricing and Reimbursement Agency

State Agency of Medicines

State Centre for TB and Lung Diseases

State Disaster Medicine Centre

State Pharmaceutical Inspection

State Public Health Agency

State Mental Health Centre

PARLIAMENTARY COMMITTEES

Social and Employment Matters Committee, Health Subcommittee

INSURANCE STRUCTURES

State Compulsory Health Insurance Agency

PROFESSIONAL ASSOCIATIONS

Association of Physicians of Latvia

Association of Nurses of Latvia

Association of Midwives of Latvia

Public Health Association of Latvia

A range of associations of medical-specialists

ACADEMIC INSTITUTIONS

Riga Stradins University, Faculty of Medicine

University of Latvia, Faculty of Medicine

Seven medical schools in nursing and midwifery

School of Public Health

Medical Professional Education Centre

REGIONAL ADMINISTRATION

Social and Health Committees in the Municipalities,

8 Regional Sickness Funds, supervised by the State

Compulsory Health Insurance Agency; 10 Regional Branch

offices of the State Public Health Agency



How are services provided?

PRIMARY HEALTH CARE

Primary care services are provided in a wide variety of institutional settings, some a legacy from the old system and others the result of efforts to restructure primary care. The health centres in the larger cities originated as polyclinics. They are owned by the



Latvia



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Slovenia

municipalities and run by private entities. General practitioners (GPs) rent facilities and work independently. Even though the number of GPs has been constantly increasing since 1999, their number is still not sufficient in some parts of the country. There are also so-called “doctorates” – group or single (usually internist) practices. Providers are self-employed and contracted by the State Compulsory Health Insurance Agency. In 2002, GPs constituted 52% of all primary care physicians; the others are predominantly paediatricians and internists. The GP gate-keeper function was formulated at the end of 1999. Patients are free to choose their primary care physicians, but they need a referral in order to receive specialist or secondary care. Direct access, without a referral from a GP, is granted to gynaecologists, psychiatrists, specialists on sexually transmitted diseases or endocrinologists. A national public support fund supports primary care professionals in retraining and establishing practices; the fund also promotes the new model.

SECONDARY AND TERTIARY CARE

There are two types of public hospitals – state (accountable to the Ministry of Health and municipal (with half of the country’s hospital beds). Specialized hospitals are concentrated only in the capital and in the largest cities. Public hospitals are contracted by the regional branches of the State Compulsory Health Insurance Agency. Most hospitals are non-profit-making entities or joint-stock companies. Secondary and tertiary care in Latvia faces a key problem: hospitals (and even specialized facilities) take care of many patients whose needs are social rather than medical, because social care services are still not fully developed.

THE PUBLIC–PRIVATE MIX

The private sector is rapidly increasing the range and number of services it provides, and in just four years, the number of private doctors has tripled. Only 6% of all the hospitals in Latvia are private. Dentists are self-employed and work on a private basis, however, the State Compulsory Health Insurance Agency contracts them for the provision of dental service for children up to the age of 18. Pharmacies are entirely private.

Points to remember *service provision*

- The primary health care model continues to be implemented.
- There is an ongoing effort to make a clearer separation between primary and secondary care.
- The state encourages primary care practices to register as independent contractors.
- Improving the management capacity and the information systems of health institutions is considered a priority.
- The capitation system for GPs is being improved.
- Outpatient services are increasing.
- Defining a minimal package of health care services to be provided by the state has been a priority for the last few years.

Sources: 2, 8, 32, 40.



What resources are available?

HUMAN RESOURCES

6% cent of the total workforce is employed in the health care and social care sectors.

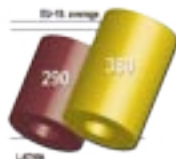
HEALTH PROFESSIONALS

(per 100 000 population)

Dentists **540** *EU-15 average: 640*

Nurses **510** *EU-15 average: 670*

General practitioners **43** *EU-15 average: 102*



Physicians 290
EU-15 average: 380

HOSPITALS

Hospital beds (per 100 000) **820**

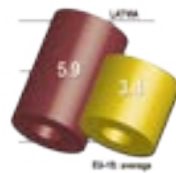
EU-15 average: 611

Annual inpatient admissions (per 100) **20**

EU-15 average: 18

Average length of stay **11.3 days** *Hospitals (per 100 000) 5.9*

EU-15 average: 10



EU-15 average: 3.4



Latvia



Lithuania



Malta



Poland



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Slovenia

PHARMACEUTICALS

There is a positive list of medicines that are either totally reimbursed (according to a register of illnesses and conditions approved by the Cabinet of Ministers) or partially reimbursed (50% to 75%). A product is placed on this list after agreement has been reached between the Medicines Pricing and Reimbursement Agency and the holders of the marketing authorization. Over-the-counter drugs are not reimbursed. Imported drugs account for 85% to 90% of total pharmaceutical consumption. Moreover, the volume of drugs eligible for reimbursement is increasingly putting pressure on the health care budget. The level of funding for ambulatory care medicines that are reimbursed by the state puts additional burden on the hospital sector.

Points to remember

health resources

- Retraining the narrow specialists into GPs is a priority in Latvia.
- It is important to find ways to retain health sector employees, particularly nurses.
- Private competition is especially fierce in the pharmaceutical sector.
- The number of hospitals has been decreasing substantially but is still considered high.
- Hospital reform is continuing.
- Investment opportunities in health care infrastructure and technology are being explored.

Sources: 6,8,11, 32, 41.

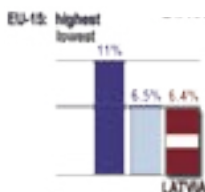
Who pays for what?



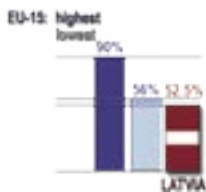
Through its eight regional branches, the State Compulsory Health Insurance Agency administers all state health care funding. The funds consist of three components: general income tax (28.4% of which is earmarked for health care), subsidies from general state revenues and patient contributions. Among the ten new EU member states,

Latvia spends the lowest percentage of its GDP on health care. The Ministry of Health is currently developing two strategic documents, one for compulsory state health insurance and the other for a minimum basket of health care services to be provided by the state. There are two different models of financing primary health care in Latvia – one for the capital Riga and another for rural areas. The main difference lies in the way of controlling the finances. GPs are the main budget holders in rural areas, but in Riga it is the State Compulsory Health Insurance Agency that controls the financing schemes for GPs.

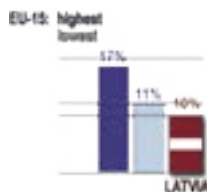
THE ECONOMIC PICTURE



Total expenditure on health, % of GDP



Government expenditure on health, as % of the total expenditures on health



Government expenditure on health, as % of the total government expenditure



Latvia



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Slovenia

Points to remember *health care financing*

- A possible agreement on the state-guaranteed basic health care package has generated much attention.
- The issue of co-payments needs to be addressed.
- Rising pharmaceutical expenditures are being matched to the limited budgets available.
- "Money follows the patient" is a national principle.
- The state's vision is to ensure stable and equitable financing throughout the country and for all citizens.

Sources: 1, 2, 6, 13, 32, 32, 41.



How have the Latvians been reforming their health care system?

THE HEALTH REFORMS OF THE LAST DECADE:

- implemented a series of structural changes in the health care system, which the current government is also in the process of changing;
- officially identified the general-practitioner-based model of health care as a strategic priority in 1996;
- centralized the resources for health system financing;
- made clear the need for national coordination of public health services;
- publicized and recognized the need to constantly improve the quality of the health care system;
- began developing the institutional capacity of the Ministry of Health and the insurance institutions;
- formulated equal access to health care and improved population coverage as key priorities; and
- started identifying health priorities that require state-led procurement (such as HIV/AIDS, substance abuse, mental health, tuberculosis, disaster response and emergency care).



Points to remember *health system reform*

- There is a certain lack of understanding of the distinction between primary and secondary care, therefore a potential to publicize which is provided where.
- General acceptance of the primary care model – by both health professionals and the general public- is not yet visible.
- The needs of young people and how the system might address them have risen high on the Latvian agenda.
- Patients' rights and the credibility of the system are becoming increasingly important.
- The state compulsory health insurance system is being further developed.

What is one of the things the Latvians have learned by doing?



A CROSS-SECTOR APPROACH TO CHILDREN AND YOUTH

A society in transition, Latvia has elected to approach the health, education and well-being of children as a collective challenge. In 2002, a joint initiative was launched to coordinate the activities of all the United Nations agencies that work in the country with children and young people – and thereby synergize their efforts. The core health issue addressed has been AIDS, and an expanded United Nations theme group on HIV/AIDS was created. The group works with the relevant national institutions and other partners to review and reinforce the national strategy on HIV/AIDS prevention. Together, the agencies are working on a common platform for the prevention of AIDS and other sexually transmitted diseases, targeting vulnerable youth in particular. WHO is one of the partners in this initiative, together with the United Nations Development Program (UNDP), the United Nations Office on Drugs and Crime (UNODC), the United Nations Children's Fund (UNICEF) and the World Bank.



Latvia



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What has the Regional Office been doing in Latvia?

The WHO Regional Office for Europe has had a Liaison Office in Riga since 1991. The country participates in the Healthy Cities and Health Promoting Schools networks, as well as a pharmacoconomics programme, polio laboratories and the monitoring of communicable diseases. In Latvia, there is one WHO Documentation Centre and one WHO Collaborating Centre.

During the 1990s, the main areas of joint work between the Latvian government and WHO were in health reform, improving quality of care, and lifestyles and disease prevention. In 2002–2003, Latvia worked with the Regional Office on:

- public health policy, specifically the development of the Public Health Strategy, the Food and Nutrition Action Plan and the Alcohol Action Plan; and
- infrastructure and health system reform.

For 2004–2005, the Regional Office has signed an agreement with the country to provide help in the areas of:

- health policy and systems, with an emphasis on health financing, decentralization, private sector competition, health system monitoring and youth-friendly services;
- mental health;
- tobacco and alcohol; and
- patients' rights.

SOURCES OF INFORMATION ABOUT LATVIA

Web sites

Government of Latvia official website <http://www.mk.gov.lv>

Ministry of Health

<http://www.vm.gov.lv>

Chancery of the President of the Republic of Latvia

<http://www.president.lv>

Saeima (Parliament) of the Republic of Latvia

<http://www.saeima.lv>

European Commission delegation to Latvia

<http://www.eiropainfo.lv>

Latvian European Integration Bureau

<http://www.eib.lv>



Latvia



Lithuania



Malta



Poland



Slovakia



Slovenia

LITHUANIA



LIETUVA

AREA

65 000 km²

Approximately equal to Ireland

1.6% of the total EU-25 area

POPULATION

3 700 000

Equal to Ireland

0.8% of the total EU-25 population

THE PEOPLE

Lithuanians 83%, Russians 6%, Poles 7%,
Byelorussians

LANGUAGES

Lithuanian (official), Russian, Polish,
English – well spoken

FORM OF GOVERNMENT

Parliamentary republic
Unicameral parliament (*Seimas*)
Head of state – president, elected directly

MAIN RELIGION

Roman Catholic 90%, Lutheran, Russian Orthodox, Protestant, Evangelical Christian Baptist, Muslim, Jewish

INDEPENDENCE

1990

GDP PER CAPITA

€3 800 = **16.4% of the EU-15 average**
In purchasing power parity (PPP):
€6 200 = **27% of the EU-15 average**

REGIONAL DIVISIONS

10 counties (*apskritis*)

CURRENCY

Lithuanian litas (1 litas = €0.20)

HUMAN DEVELOPMENT INDEX

0.82 **EU-15 lowest: 0.89, highest: 0.94**

UNEMPLOYMENT RATE

10% **EU-15 average: 9%**

MEMBER OF

CE, OSCE, UN, NATO, Council of the Baltic States

Sources: 1, 4, 6, 7, 15, 16, 17, 18.



Lithuania



Malta



Poland



Slovakia



Slovenia

HEALTH

SVEIKATA

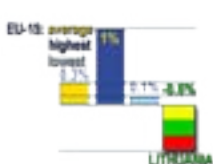
THE TEN HEALTH QUESTIONS

What are the demographic essentials for Lithuania?

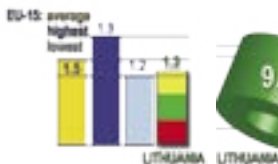
POPULATION PROFILE

Sex ratio	1.06 females/males	<i>EU-15 average: 1.4</i>
Urban concentration	69%	<i>EU-15 average: 80%</i>
Age structure	0–14 years	<i>EU-15 average: 18%</i>
	65+ years	<i>EU-15 average: 17%</i>
Median age	36.6 years	
Dependency ratio	51%	<i>EU-15 average: 49.5%</i>

POPULATION DYNAMICS



Annual growth rate

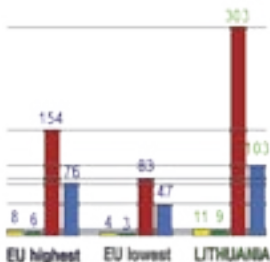


Fertility rate



Birth rates, live births /1000 population

PROBABILITY OF DYING (per 1000 population)



- Before age 5, male
- Before age 5, female
- Between age 15 and 60, male
- Between age 15 and 60, female

LIFE EXPECTANCY AT BIRTH

Total population	72 years
Male	66 years
Female	78 years

EU-15 average: 79
EU-15 average: 75.5
EU-15 average: 82

HEALTHY LIFE EXPECTANCY

	At birth (in years)			At age 60 (in years)		% of total life expectancy lost to poor health	
	Total	Male	Female	Male	Female	Male	Female
Lithuania	63	59	68	12	16	11	13
EU-15 lowest	69	67	71	15	17	8	9
EU-15 highest	73	72	75	17	20	9	11

Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health. The last two columns present this idea in another way, as the percentage of a lifetime that is spent living in less-than-full health.

Points to remember *demographic trends*

The past decade has seen:

- a steady decline in population growth;
- a fertility rate that is 39% below the population replacement rate;
- ageing of the population;
- a large discrepancy between female and male life expectancy, leading to one of the highest female/male ratios in Europe; and
- a decrease in child mortality.

Sources: 1, 3, 4, 6, 9, 13, 16, 17, 18.

What do Lithuanians suffer from?

** When analysing the causes of death and disease burden, WHO has divided all countries into different mortality strata according to the levels of mortality for children younger than 5 and males age 15 to 59. According to this division, the whole of Europe falls into the developed country stratum. However, within this stratum, European countries are subdivided into three different*



Lithuania



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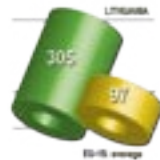


groups – those with very low child and very low adult mortality, those with low adult and low child mortality, and those with low child and high adult mortality. This subdivision reflects the great variations that exist within Europe and help place figures in a regional context – a European mortality figure that might seem quite low in comparison to figures from Africa or south-east Asia may actually be quite high in comparison to figures from the most-developed European countries. According to this classification, Lithuania is in the group of European countries with low child and high adult mortality. (The member states in the EU-15 are all in another group – that with very low child and very low adult mortality.) Throughout this chapter, data marked by * are not country-specific but refer instead to the entire European group into which Lithuania falls.

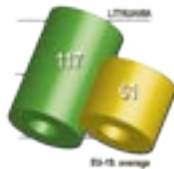
CARDIOVASCULAR DISEASES

- Cardiovascular diseases are the leading cause of mortality in Lithuania, resulting in the deaths of 45% of all males and 65% of all females. They are also responsible 16% of all hospitalizations (*EU-15 average: 13%*).
- Of the various forms of these circulatory diseases, there are two major killers.

- *Ischaemic heart disease* caused 305 Lithuanian deaths per 100 000 in 2000 (*EU-15 average: 97/100 000*). For the Lithuanian mortality group as a whole, it was responsible for 32.5%* of all deaths and 14%* of the disease burden.



- *Cerebrovascular diseases* led to 117 deaths per 100 000 in 2000 (*EU-15 average: 61/100 000*). For the mortality group as a whole, these diseases were responsible for 20%* of all deaths and 9%* of the disease burden.

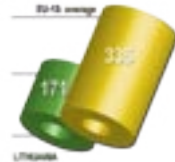


CANCER (MALIGNANT NEOPLASMS)

- Cancer is the second leading cause of death in Lithuania, accounting for 20% of the mortality for men and 18% for women.
- In 2000, it caused 198 deaths per 100 000 population. *EU-15 average: 183/100 000*
- In that same year, the standard death rate from cervical cancer was five times the EU-15 average.

UNINTENTIONAL INJURIES

- In 2000, external injuries and poisoning were responsible for 146 deaths per 100 000 (*EU-15 average: 39.5/100 000*). This made them the third largest cause of mortality in Lithuania, leading to 20% of deaths among women and 6% among men.
- The number of road traffic accidents involving injury was half of the *EU-15 average in 2000*: 171/100 000 vs. 335/100 000. However, the mortality rate for traffic accidents was higher, resulting in 21.5 deaths per 100 000 versus 11 per 100 000 for the EU-15.

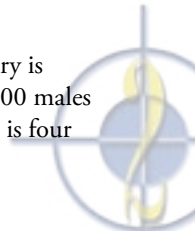


RESPIRATORY DISEASES

- Respiratory diseases lead to 13% of the country's hospitalizations. *EU-15 average: 7%*
- There are 74 cases per 100 000, which is somewhat lower than the average EU-15 rate of 82 per 100 000.

NEUROPSYCHIATRIC DISORDERS

- Mortality from suicide and self-inflicted injury is 42 per 100 000 population – 76.5 per 100 000 males and 13 per 100 000 females. The overall rate is four times the EU-15 average.



Lithuania



Malta



Poland



Slovakia



Slovenia

INFECTIOUS AND PARASITIC DISEASES


- In 2000, this group of diseases caused 14 deaths per 100 000 population (*EU-15 average: 7/100 000*) and 4% of all hospitalizations (*EU-15 average: 2%*).
- The incidence of tuberculosis is 76 per 100 000, seven times the EU-15 average.
- Male mortality from respiratory tuberculosis has increased by 20% in the last 11 years.
- In 2002, the incidence of new HIV infections was 11 per 100 000 population – one of the highest rates among the EU accession countries. *EU-15 average: 4/100 000*
- The prevalence of HIV/AIDS in 2001 was 0.1%, which was lower than in the other two Baltic states.

CHILD AND ADOLESCENT HEALTH

- Infant mortality is 6.7 deaths per 1000 live births. *EU-15 average: 4.7/1000*
- The immunization rates reported are high, ranging from 93% for pertussis to 99% for tuberculosis.

ORAL HEALTH

- Dental caries affects 4.4% of all 6-year-olds and 7% of all 15-year-olds. For adults in the 35–44 age group, the rate is 17%.



Points to remember

health status

It is important to consider both mortality and disease burden when looking at how a medical condition affects a population. The two measures reflect different facets of human suffering.

Points to remember Always compare!

*Causes of death and
disease burden*

	% of deaths caused*		% of disease burden*	
	Lithuanian group	EU-15 group	Lithuanian group	EU-15 group
Cardiovascular diseases	59	41	28	17
Neuropsychiatric disorders	1	5	14	26.5
Cancer/malignant neoplasms	13	26.5	8.5	16.5
Unintentional injuries	9	3.4	14	5.8
Respiratory diseases	2.8	5.6	2.8	6.5
Infectious and parasitic diseases	2.7	1.2	5.2	1.7
Respiratory infections	1	4.4	1	1.3
Perinatal conditions	<1.0	<1.0	1	<1.0
Intentional injuries	4.6	1.3	7.4	2
Diabetes	<1	2.3	<1.0	2.1
Sense organ disorders	0	0	3.6	4.7
Total communicable diseases	4.3	6	9	5
Total noncommunicable diseases	82	89	69	87
Total injuries	14	5	22	8

* Data refer to the European mortality groups that include Lithuania and the EU-15 countries, respectively.

Sources: 1, 2, 6, 8, 22, 36.

Where do the risks lie?

SMOKING

- In 2000, smokers comprised 51.5% of all men and 16% of all women, for an adult population average of 32% (*EU-15 average rates are: men 32%, women 23%, together 28%*).
- Among young people, 9% of 13-year-olds and 27% of 15-year-olds smoke at least once a week.



ALCOHOL CONSUMPTION

- In Lithuania in 2000, there were 170 alcohol-related deaths per 100 000 population – triple the EU-15 average.
- During 2001, the average Lithuanian adult was reported consuming 10 litres of pure alcohol, which was slightly higher than the EU-15 average. However, this is only the officially registered consumption which does not include the consumption of smuggled products, surrogates or home made alcohol.

DRUGS

- Among 15- and 16-year-olds, cannabis is the drug that the largest proportion of them has experimented with – 12% report having used it at least once.
- In the same age group, 4% report having tried ecstasy, and the same percentage have smoked heroin.
- In the general population, 32% have used marijuana at least once.
- Over 90% of all drug addicts live in urban areas.
- In 2001, injecting drug users accounted for 78% of all newly diagnosed HIV cases, a percentage that continues to rise.

OBESITY

- Among Lithuanians age 19 and older, 11% of the men and 18% of the women (15% overall) are clinically obese. Another 41% of the men and 33% of the women (37% overall) qualify as pre-obese. Altogether, 52% of the adult population is overweight.
- In the 19–65 age group, 64% of the men and 57% of the women are reported to be physically inactive.
- Nutritional deficiencies are responsible for 1.2%* of the disease burden in the countries belonging to the Lithuanian mortality group – more than twice the average* for the EU-15 group countries.

Sources: 1, 6, 12, 18, 19, 20, 28.

Who's who in the Lithuanian public health sector?



PUBLIC ADMINISTRATION Ministry of Health

PUBLIC HEALTH INSTITUTIONS UNDER THE MINISTRY

State Public Health Service (responsible for organizing and supervising public health. It coordinates the following specialized centres and institutions:

- Lithuanian AIDS Centre
- State Mental Health Centre
- Lithuanian Health Information Centre (WHO collaborating centre)
- Communicable Diseases Control Centre
- National Nutrition Centre
- National Health Education and Promotion Centre
- State Environmental Health Centre
- National Centre of Radiology
- Institute of Hygiene
- Environmental Medicine Centre
- Occupational Health Centre
- State Pharmaceuticals Control Agency.

PARLIAMENTARY BODIES

- Health Committee
- National Health Board (advisory body to the Parliament)

INSURANCE STRUCTURE

National Health Insurance Company (State Patient Fund), with 5 territorial branches (Territorial Patient Funds)

PROFESSIONAL ASSOCIATIONS

- Lithuanian Physicians Association
- Lithuanian Nurses Association



Lithuania



Malta



Poland



Slovakia



Slovenia

ACADEMIC INSTITUTIONS

Kaunas University of Medicine
Faculty of Medicine, Vilnius University
Six colleges for training nurses and paramedical staff

REGIONAL ADMINISTRATION

State Public Health Service – 21 specialized and country public health centres.



How are services provided?

PRIMARY HEALTH CARE

Primary health care in Lithuania is provided in 452 state and 1284 private institutions. State institutions may be centres, general practitioners' offices, ambulatory clinics and polyclinics – general or specialized. Ambulatory clinics are usually in the smaller towns, while polyclinics are situated in bigger cities, providing more complex services such as outpatient surgery. Paramedical centres (medical posts) and health posts (community nurse) in schools also provide primary care in rural areas. General practitioners (GPs) constitute only a very small part (8%) of the primary care teams, which are dominated by internists (41%) and paediatricians (29%). The gate-keeping role of primary care has expanded dramatically; in 1996, 70% of all specialist consultations were without a GP referral, but just two years later the figure was down to 20%.

SECONDARY AND TERTIARY CARE

Half of the Lithuanian hospitals are general hospitals, and they have 67% of the country's hospital beds. There are also 36 specialized, 3 rehabilitation hospitals and 33 sanatoriums. The Ministry of Health manages 13 of these national health care facilities directly. At the

regional level, the county administrations govern some hospital and specialized care, with Ministry involvement. Municipalities often run small or midsized hospitals.

THE PRIVATE–PUBLIC MIX

The private sector provides chiefly outpatient care, which is purchased out of pocket. Most private services are in dental care, cosmetic surgery, psychotherapy or gynaecology. 41% of all dentists work in a private practice. There are 106 private and 89 state primary health centres. None of the hospitals or polyclinics have been privatized. There is now a plan to partially privatize primary care. It is seen not as an experiment, but rather as part of the government's overall efforts to develop GPs as independent contractors.

Points to remember *service provision*

- Shifting the focus from specialist care to primary care remains a long-term goal.
- In all, 92% of the population has registered with a primary care institution.
- Only 8% of Lithuania's physicians have chosen the specialty of general practice.
- The number of GPs has been increasing.
- The Ministry of Health is focusing on administering secondary and tertiary care.

Sources: 2, 8, 32.



What resources are available?

HUMAN RESOURCES

Six per cent of the Lithuanian workforce is employed in the health sector. The concentration of physicians has remained almost unchanged since 1990 and is now among the highest in Europe. The number of nurses has declined, but the number of graduating physicians is on the rise.



Lithuania



Malta



Poland



Slovakia

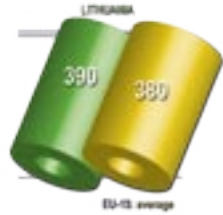


Slovenia

HEALTH PROFESSIONALS

(per 100 000 population)

Dentists	660	EU-15 average: 640
Nurses	770	EU-15 average: 670
Pharmacists	640	EU-15 average: 790
General practitioners	70	EU-15 average: 102



Physicians 390

EU-15 average: 380

HOSPITALS

Hospitals (per 100 000 population)	5.6	EU-15 average: 3.4
Hospital beds (per 100 000)	922	EU-15 average: 611
Annual inpatient admissions (per 100)	24	EU-15 average: 18
Average length of stay	11 days	EU-15 average: 10

During the 1990s, hospitals experienced a steady decline in the length of patient stays but an increase in admissions.

PHARMACEUTICALS

The government only reimburses prescribed drugs. Drugs for inpatient care are free. For primary care and outpatient care, however, reimbursement is complicated by a number of eligibility criteria. As a result, about 60% of the population pays the full cost of medications. Domestic production of medicines has been named as a priority, but domestic pharmaceuticals still account for only 4% of the market. Most of the pharmaceutical trade has been privatized.

Points to remember

health resources

- Efforts are being made to make the specialty of general practice more attractive to physicians.
- The wages of medical personnel still need to be raised to match the average national income.
- Salaries account for about 70% of physician income. Some institutions have introduced fee-for-service elements to their offerings.
- A consistent human resource policy for the health sector might improve the balance between physicians and paramedical personnel.
- Modernization of hospital equipment is high on the health sector agenda.
- Out-of-pocket expenditure on pharmaceuticals has risen more than three-fold since 1995.

Sources: 6, 8, 11, 32.



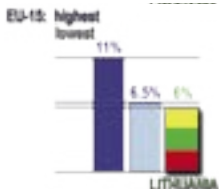
Who pays for what?

FORMS OF INSURANCE

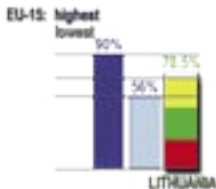
The country has introduced a mixed system of social insurance contributions and taxation. Since 1997, there has been a compulsory health insurance system. The institution responsible for it is the State Sickness Fund, accountable directly to the Minister of Health. It is funded primarily by employer contributions, but 20% of the revenue also comes from payroll taxes and contributions by the self-employed (i.e. self-insured).

Together, statutory insurance and taxes account for 74% of health sector financing, while private insurance accounts for 23%. The Statutory Health Insurance Board was founded as a third-party payer and oversees the democratic functioning of the insurance system, while the Ministry of Health regulates the prices of health care services. The state covers children younger than 18, students and those receiving special benefits, and it contributes to the Fund on their behalf.

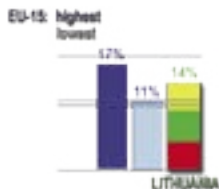
THE ECONOMIC PICTURE



Total expenditure on health, % of GDP



Government expenditure on health, as % of the total expenditures on health



Government expenditure on health, as % of the total government expenditure

Population below national poverty line 16%

Points to remember *health care financing*

- The role of social insurance has increased dramatically. In 1996, statutory insurance accounted for 19% of public health financing, while only three years later it already accounted for 90%.
- The health financing system is a compromise between taxation-based and insurance-based funding. It requires the coordination of the different government bodies.

Sources: 1, 2, 6, 8, 13, 32.



Lithuania



Malta



Poland



Slovakia



Slovenia



How have the Lithuanians been reforming their health system?

The legal framework for Lithuanian health care reform was in place by the mid-1990s, and the relevant legislation was adopted in 1995–1997. Nowadays, the National Health Programme 1997-2010 is under revision.

THE HEALTH REFORMS OF THE LAST DECADE:

- sought to move away from a centralized system that had too many specialized personnel and hospital beds;
- focused on establishing a central role for general practitioners;
- defined general practice and its underlying principles in a Lithuanian context;
- established state accreditation and medical audit agencies to license practitioners and monitor medical malpractice, thus guaranteeing quality of care;
- strove consistently to increase the productivity and efficiency of health service providers;
- introduced a democratic model of decision-making as a central element of the reform process;
- required substantive involvement from a variety of actors (such as the Parliamentary Health Committee and the National Board of Health) in the national decision-making process; and
- won approval in 2002 for a three-year National Health Action Plan and two major laws on public health surveillance and monitoring.





Points to remember *health system reform*

- A 10-year strategy (through 2005) for the development of primary care has gradually raised its profile.
- The overall supervisory role of the Ministry of Health has been preserved.
- The productivity of health providers and their responsiveness to patient needs has become a fundamental performance criterion.
- A large public health network has developed on both the national and the county level.
- A comprehensive long-term national investment plan is now considered essential.
- Health care consumers are increasingly eager to participate in the negotiating and decision-making processes.
- The revision of existing intersectoral policies related to health is now high on the agenda.
- The health care system lacks mechanisms for comprehensive data collection.



What is one of the things Lithuania has learned by doing?

MUNICIPALITIES AT THE CENTRE

Municipalities in Lithuania are assigned a wide range of health care functions and responsibilities. Most notably, they administer the entire network of primary care institutions. In fact, back when the primary care concept was first being launched, it was tested at the local level in four Lithuanian municipalities. Today, mental health centres with psychiatrists and other professionals are being established in each municipality. In some cases, the burden of responsibility has turned out to be too heavy, as when municipalities were told to invest in the reparation and upgrading of health care facilities. That's why facility renovations were turned into a national investment policy objective in 1998. Municipal involvement in health care appears to be a longstanding tradition in Lithuania – municipal hospitals were major providers of health care for decades, and now the best aspects of this experience are being preserved as part of present hospital reforms.



Lithuania



Malta



Poland



Slovakia



Slovenia



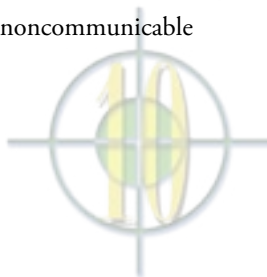
What has the Regional Office been doing in Lithuania?

The WHO Regional Office for Europe has had a liaison office in Vilnius since 1994. During 2002 and 2003, the Regional Office collaborated with Lithuania on:

- the development of a national health programme;
- the creation and adoption of (1) a national strategy and plan of action for nutrition and food safety, (2) a national strategy for drug control and addiction prevention, and (3) a national action plan for tobacco;
- HIV/AIDS;
- mental health reform; etc.

In 2004–2005, the Regional Office has agreed to provide Lithuania support in:

- development of a public health strategy
- strengthening of the national policy on health system quality
- mental health, specifically suicide prevention
- health promotion and the prevention of noncommunicable diseases
- tobacco control
- prevention of traumas and accidents.



SOURCES OF INFORMATION ABOUT LITHUANIA

Web sites

Ministry of Health	http://www.sam.lt
Lithuanian Health Information Centre	http://www.lsic.lt
Government of the Republic of Lithuania	http://www.lrv.lt
European Committee Parliament of Lithuania	http://www.euro.lt
President of the Republic of Lithuania	http://www.president.lt
Department of Information and Informatics	http://www.iid.lt
Lithuanian Department of Statistics	http://www.std.lt
Lithuanian Development Agency	http://www.lda.lt
European Commission Delegation to Lithuania	http://www.eudel.lt
Lithuania on Line	http://www.on.lt



Lithuania



Malta



Poland



Slovakia



Slovenia

MALTA



MALTA

AREA

300 km²

The smallest country in the EU-25

POPULATION

400 000

Equal to Luxembourg

THE PEOPLE

Maltese

LANGUAGES

Maltese, English

FORM OF GOVERNMENT

Parliamentary republic
Unicameral parliament (*Il-parlament*)
Head of state – the President of Malta,
appointed by the parliament

MAIN RELIGION 98% Roman Catholic

INDEPENDENCE 1964

GDP PER CAPITA €10 085 = *44% of the EU-15 average*
In purchasing power parity (PPP):
€11 900 = *53% of the EU-15 average*

REGIONAL DIVISIONS

No formal administrative regions.
However, there are 68 local councils with
limited jurisdiction over local issues.

CURRENCY Maltese lira (1 lira = €2.3)

HUMAN DEVELOPMENT INDEX
0.86 *EU-15 lowest: 0.89, highest: 0.94*

UNEMPLOYMENT RATE
6.5% *EU-15 average: 9%*

MEMBER OF CE, Commonwealth, EBRD, ILO, IMF,
OSCE, UN, WTO

Sources: 1, 3, 4, 5, 6, 7, 15, 16, 38.



Malta



Poland



Slovakia



Slovenia

HEALTH

SAHHA

THE TEN HEALTH QUESTIONS

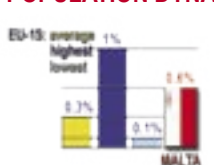


What are the demographic essentials for Malta?

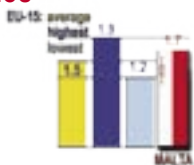
POPULATION PROFILE

Sex ratio	0.98 females/males	<i>EU-15 average: 1.4</i>
Urban concentration	90%	<i>EU-15 average: 80%</i>
Age structure	0–14 years 20%	<i>EU-15 average: 18%</i>
	65+ years 12%	<i>EU-15 average: 17%</i>
Median age	37 years	
Dependency ratio	47%	<i>EU-15 average: 49.5%</i>

POPULATION DYNAMICS



Annual growth rate

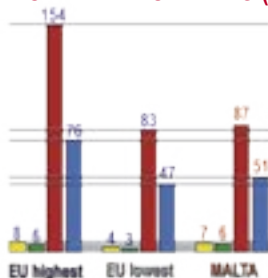


Fertility rate



Birth rates, live births /1000 population

PROBABILITY OF DYING (per 1000 population)



- *Before age 5, male*
- *Before age 5, female*
- *Between age 15 and 60, male*
- *Between age 15 and 60, female*

LIFE EXPECTANCY AT BIRTH

Total population	78 years
Male	76 years
Female	80 years

EU-15 average: 79
EU-15 average: 75.5
EU-15 average: 82

HEALTHY LIFE EXPECTANCY

	At birth (in years)			At age 60 (in years)		% of total life expectancy lost	
	Total	Male	Female	Male	Female	Male	Female
Malta	71	70	72	15	18	8	10
EU-15 highest	73	72	75	17	20	9	11
EU-15 lowest	69	67	71	15	17	8	9

Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health. The last two columns present this idea in yet another way, as the percentage of a lifetime that is spent living in less-than-full health.

Points to remember *demographic trends*

The past decade has seen:

- a slowing of population growth
- a steady decline in the fertility rate.

Sources: 1, 3, 5, 6, 9, 16, 17, 33, 34.

What do the Maltese suffer from?

**When analysing the causes of death and disease burden, WHO has divided all countries into different mortality strata according to the level of mortality for children younger than 5 and for males aged 15 to 59. According to this division, the whole of Europe falls in the developed country stratum. However, within this stratum, European countries are divided into three different groups – those with very low child and very low adult mortality, those with low adult and*



Malta



Poland



Slovakia

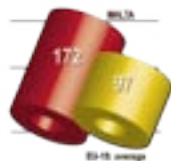


Slovenia

low child mortality, and those with low child and high adult mortality. This division reflects the great variations that exist within Europe and help place figures in a regional context – a European mortality figure that might seem quite low in comparison to figures from Africa or south-east Asia may actually be quite high in comparison to figures from the most-developed European countries. According to this classification, Malta is classified in the group of European countries with very low mortality for both adults and children. Every member state of the EU-15 falls in this same group. Throughout this chapter, data marked by * derive from this entire group, rather than from just Malta.

CARDIOVASCULAR DISEASES

- Circulatory diseases are the leading cause of death – 46% of all deaths and 8% of all hospital admissions.
- Within this category, the two major killers are:
 - *ischaemic heart disease* – responsible for 25%* of all deaths and 7%* of the disease burden; 172 people out of 100 000 died of this disease in 2002, while the average for *EU-15 was 97/100 000*; and
 - *cerebrovascular diseases* – responsible for 11%* of all deaths and 5%* of the disease burden.



CANCER (MALIGNANT NEOPLASMS)

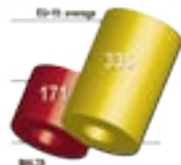
- Cancer is the second most common cause of death, 24% of the total.
- It is the third largest contributor to the disease burden: 16.5%*.
- Of all cancer deaths, 17% are from lung cancer and 13% from breast cancer.
- Each year, 2331 new cases of cancer are registered, two thirds of them among men.
- Of the new cases, 12% are non-melanocytic skin cancer, 9% breast cancer, 6% lung cancer (six times higher for men than women) and 9% colorectal cancer.
- Overall, the incidence of cancer in Malta is *lower than in the EU-15*.

NEUROPSYCHIATRIC DISORDERS

- Suicide and self-inflicted injury cause 6 deaths per 100 000 – the *EU-15 average is 10/100 000*.

UNINTENTIONAL INJURIES

- The rate of deaths from motor vehicle accidents is among the lowest in Europe, yet it is still one of the biggest contributors to the loss of potential years of life.
- There were 12 652 traffic accidents in 2000, in which 972 people were seriously injured.
- The number of road traffic accidents involving injury (per 100 000) is *171 EU-15 average: 335/100 000*.
- Overall, external causes of death (injury and poisoning) are responsible for 25.5 deaths per 100 000 (*EU-15 average: 39.5/100 000*).



RESPIRATORY DISEASES

- There are 68 cases per 100 000 – the *EU-15 average is 82/100 000*.

INFECTIOUS AND PARASITIC DISEASES

- The death rate is 5.6 per 100 000, while the *EU-15 average is 7.3/100 000*.
- Meningococcal diseases are hyperendemic in Malta, with 8 cases per 100 000 in 2001 – a rapid increase from 0.8/100 000 in 1994.
- Tuberculosis incidence is 6 cases per 100 000, compared with the *11/100 000 average for EU-15*.
- AIDS cases totalled 51 in 2001. There are 3 new cases of HIV infection per 100 000 (*EU-15 average: 4.3/100 000*), while the incidence of clinically diagnosed AIDS is 1/100 000 (*EU-15 average: 2.4/100 000*).

DIABETES

- Diabetes is highly prevalent in Malta (a pattern shared with other Mediterranean islands).



Malta



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- Ten per cent of the adults older than 35 have diabetes, and another 13% have impaired glucose tolerance.

CHILD AND ADOLESCENT HEALTH

- Infant mortality: 6.1 deaths/1000 live births
EU-15 average: 4.9/1000
- Immunization coverage: polio 95%, mumps and rubella 84%, influenza B 94%

Points to remember Always compare!

Causes of death and disease burden

	% of deaths caused*	% of disease burden*
Cardiovascular diseases	41	17
Neuropsychiatric disorders	5	27
Cancer/malignant neoplasms	27	17
Unintentional injuries	3.4	5.8
Respiratory diseases	5.6	6.5
Infectious and parasitic diseases	1.2	1.7
Respiratory infections	4.4	1.3
Perinatal conditions	<1	<1
Intentional injuries	1.3	2
Diabetes	2.3	2.1
Sense organ disorders	0	5
Total communicable diseases	6	5
Total noncommunicable diseases	89	87
Total injuries	5	8

* Data refer to the European mortality group that includes Malta and the EU-15 countries.

Points to remember

health status

It is important to consider both mortality and disease burden when looking at how a medical condition affects a population. Each measure reflects a different facet of human suffering.

Sources: 1, 6, 8, 33, 34, 35.

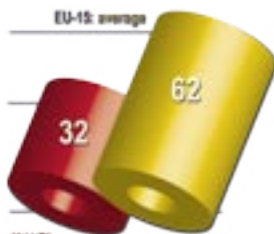
Where do the risks lie?

SMOKING

- In 1995, 34% of men and 15% of women smoked, for an adult average of 24%. *EU-15 average: men 32%, women 23%, total 28%*
- In 2001–2002, 11% of 13-year-olds and 17% of 15-year-olds smoked.
- From 1991 to 1998, the number of daily smokers aged 12–17 almost doubled.



Smoking-related deaths per 100 000 population each year



Alcohol-related deaths per 100 000 population each year

ALCOHOL CONSUMPTION

- Alcohol-use disorders are responsible for 4.3%* of the disease burden.
 - Annual alcohol consumption is 5.4 litres per person.
- EU-15 average: 9.2 litres*

OBESITY

- Within the 25–64 age group, 34% of Maltese women and 22% of Maltese men are obese.
- At age five, 13% of the boys and 11% of the girls are obese; at age ten, these figures are 19% and 24%, respectively.



Malta



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Sources: 6, 8, 11, 12, 35.



Who's who in the Maltese public health sector?

PUBLIC ADMINISTRATION

Office of the Prime Minister
Interministerial Cabinet Committee on Social Policy –
a gathering of ministers authorized to make policy decisions
Ministry of Health
Health Division – within the Ministry

INSTITUTIONS SUPERVISED BY THE MINISTER OF HEALTH

Council of Health

Multisectoral forum that advises
the Ministry on public health
system policy and legislation

Foundation for

Medical Services

Responsible for construction of the
new Mater Dei Hospital

Food Safety Commission

Interministerial

Medicines Authority

Professional regulatory bodies

Medical Council (for doctors and
dentists)

Pharmacy Council

Council for Nurses and Midwives

Council for the Professions

Complementary to Medicine

Specialist Accreditation Committee

PARLIAMENTARY COMMITTEE Social Affairs Health Committee

PROFESSIONAL ASSOCIATION

Medical Association

Association of Public Health Medicine

Dental Association

Chamber of Pharmacists

Union of Midwives and Nurses

ACADEMIC INSTITUTION Public Health Department, Faculty of
Medicine and Surgery at the University of Malta



How are services provided?



Health care in Malta is provided through two systems: statutory and private. Health care in the public sector is highly centralized and regulated.

PRIMARY HEALTH CARE

General practitioners (GPs) exist in a public–private ratio of 1.5:1. The government delivers primary health care through eight health centres that offer a full range of preventive, curative and rehabilitative services. Many private primary care practitioners also work in the government services. There are twice as many GP consultations in the private sector as in the public one.

SECONDARY AND TERTIARY CARE

Specialized ambulatory care is provided in *public* outpatient clinics and health centres. The Ministry of Health is the funder, regulator and service provider for public hospitals. The management of the public hospitals is gradually devolving from Ministry structures to management teams acquiring more responsibilities for the management of individual hospitals. Maltese who suffer chronic diseases predominantly choose the public sector hospitals and rehabilitation services.

A number of *private* hospitals have opened during the last decade, as profit-making organizations. Those citizens whose conditions require extra attention or who are not willing to wait choose the private sector. Private hospitals are subject to licensing by the Ministry of Health, which regulates facility and care standards. Around 8% of all hospital beds are in the private sector.



Malta



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Points to remember *service provision*

- There is a rich mix of the public and the private sector.
- This dual system is well accepted by the Maltese.
- The sustainability of the health care system has been a focal issue for the entire society during the last decade.
- The government acts as both third-party payer and service provider.
- Satisfaction with private primary care is high.
- There is no regulation of private general practice.

Sources: 2, 8, 32, 35.



What resources are available?

HUMAN RESOURCES

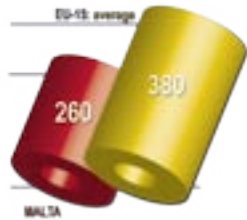
The health sector is one of Malta's largest employers, employing 7% of the total workforce. In the public health care sector, health professionals and support staff employees are civil servants.

HEALTH PROFESSIONALS (per 100 000 population)

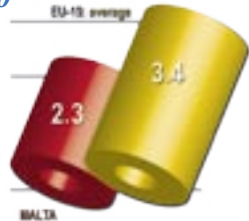
Dentists	400	EU-15 average: 640
Nurses	550	EU-15 average: 670
Pharmacists	200	EU-15 average: 790

HOSPITALS

Hospital beds (per 100 000)	496	
		EU-15 average: 611



*Physicians per
100 000 population*



Hospitals per 100 000

PHARMACEUTICALS

Medicines and medical devices have been the fastest-growing component of public health care expenditure because of increasing needs and new generations of drugs and products. The wide range of drugs on the “positive list” is available free through the statutory health care system. The private sector is involved in drug manufacturing, import, distribution and retail (through pharmacies).

Points to remember

health resources

- Health professionals' associations and unions are very strong.
- Wages in the private sector are very competitive and attractive to health professionals.
- The number of graduates in medicine and pharmacy has increased enormously.
- There has been increasing focus on human resource planning in the sector.
- There is growing interest in creating price controls for pharmaceuticals.



Who pays for what?

The statutory health care system is publicly funded and free at point of use. All Maltese are covered by national health insurance and have access to preventive, diagnostic, curative and rehabilitative services. The National Insurance Scheme is funded by the government, employers and employees through general taxation, rather than through funds earmarked for health care. This means that health care must compete with the other policy sectors when requesting allocations from the government's consolidated funds.

Private spending on health care is voluntary, so that citizens decide individually to take out private voluntary health insurance (VHI) or make out-of-pocket payments for private services. Information on private health expenditure in Malta is difficult to obtain, due



Malta



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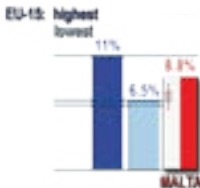


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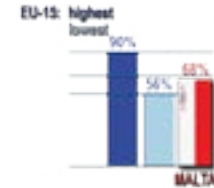
to commercial and competitive grounds and the relatively small size of the market. Around 30% of all health expenditure occurs in the private sector. The Ministry of Health does not regulate the private VHI market, and VHI products therefore vary enormously in scope and coverage.

Out-of-pocket expenditure on health consists mainly of pharmaceutical purchases and consultation fees for private GPs and specialists. Around 20% of the population has private health insurance.

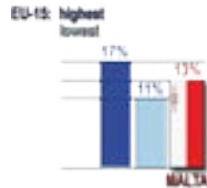
THE ECONOMIC PICTURE



Total expenditure on health, % of GDP



Government expenditure on health, as % of the total expenditures on health



Government expenditure on health, as % of the total government expenditure

Private expenditure on health (VHI and out-of-pocket fees) **31.5%** of total expenditure on health

Population below national poverty line **14.6%**

Points to remember *health care financing*

- Health care expenditure has been rising steadily.
- The public system provides comprehensive coverage and promotes equity, though it has to deal with the insufficient funding in the face of increasing demand.
- Co-payments are looked at as one possible way to counter the overuse of public health care services.
- Health care funding is a combination of public (70%) and private (30%) financing.
- Around 20% of the population has some form of VHI.

Sources: 1, 6, 32, 35, 38.



How have the Maltese been reforming their health system?

HEALTH REFORMS IN THE LAST DECADE

- Due to the gap between available funds and increasing demand (and hence costs), it is felt necessary to reform the highly equitable Maltese health care system. One possible approach considered is to link insurance contributions and health care entitlements.
- For the last two decades, primary health care has been seen as in particular need of reform.
- The Ministry of Health is currently in organizational transition. There is an even stronger and clearer need to reinforce the regulatory functions of the Ministry and its Health Division.
- Private medical clinics regulations are being revised to cover all providers, public and private, and to incorporate quality standards for care.
- In 2003, the Ministry published major reports for the first time – a national health interview survey and a national public health report.
- The pharmaceutical sector has undergone major reform during the last five years. A new Medicines Act was approved in 2002, laying the foundation for a new pharmaceutical policy and more visible regulation.

Points to remember *health system reform*

- The Ministry of Health no longer owns the debate about how to change the health system, and other ministries and Maltese society as a whole have become involved.
- There is good will in both the public and private health sectors towards the initiation of intersectoral dialogue.
- EU accession has been a major policy driver.
- Decentralization of the public health care system has been high on the agenda since the early 1990s, though the precise way to proceed is still under discussion.



Malta



Poland



Slovakia



Slovenia

What is one of the things the Maltese have learned by doing?



THE MATER DEI HOSPITAL – A NATIONAL PROJECT

In the early 1990s, Malta decided to build a state-of-the-art acute care hospital that was also a specialist research and teaching facility. The project has dominated the country's health agenda for the past decade. Mater Dei has also been the focus of capital investment in health care since the mid-1990s, and the Council of Europe has made a construction loan. The Foundation for Medical Services is managing construction and contracting for the Ministry. Meanwhile, an intensive process of planning the hospital's management and human resource structure is now concluded. A top management team has been recruited, and it has been tasked with introducing new management schemes to the current acute public hospital before Mater Dei opens in 2006. At that point, all acute services will be transferred to the new hospital. Staff conditions will soon be negotiated, and it is expected to be a useful experience for Malta's entire public health care system, since it will come just as the split between health care regulation and provision is being finalized and implemented.

What has the Regional Office been doing in Malta?



In 2004–2005, Malta and the WHO Regional Office for Europe will cooperate on:

- environment and health – preparing a national environment and health action plan for children;
- pharmaceuticals – developing a national policy that focuses on reimbursement strategies and appropriate use of medicines; and
- organization of health services – mapping existing practices to improve clinical quality of care, and developing a plan to disseminate and use evidence-based clinical practice guidelines.

In addition, the Regional Office has also trained two senior national experts in intervention epidemiology (communicable disease surveillance and response).

SOURCES OF INFORMATION ABOUT MALTA

Ministry of Health

<http://www.health.gov.mt>



Malta



Poland



Slovakia



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POLAND



RZECZPOSPOLITA POLSKA

AREA

312 677 km²

Less than two thirds the area of Spain

Almost 8% of the total EU-25 area

POPULATION

38 622 000

Approximately equal to Spain

Approximately 9% of the total EU-25 population

THE PEOPLE	Poles 98%, Ukrainians, Belarusians and Germans
LANGUAGES	Polish
FORM OF GOVERNMENT	Parliamentary democracy Bicameral parliament (<i>Sejm</i> – lower house, <i>Senat</i> – upper house) Head of state – president, directly elected
MAIN RELIGION	95% Roman Catholic
INDEPENDENCE	1918
GDP PER CAPITA	€ 5 300 = <i>23% of the EU-15 average</i> In purchasing power standards: € 7 800 = <i>35% of the EU-15 average</i>
REGIONAL DIVISIONS	16 provinces
CURRENCY	Zloty (1 zloty = €0.20)
HUMAN DEVELOPMENT INDEX	0.82 <i>EU-15 lowest: 0.89, highest: 0.94</i>
UNEMPLOYMENT RATE	20% <i>EU-15 average: 9%</i>
MEMBER OF	CE, EBRD, OECD, OSCE, UN, WB

Sources: 1, 3, 5, 7, 15, 16, 18.

HEALTH

ZDROWIE



Poland



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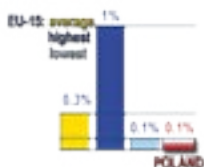
THE TEN HEALTH QUESTIONS

What are the demographic essentials for Poland?

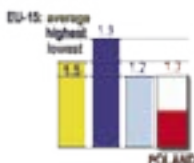
POPULATION PROFILE

Sex ratio	1.06 females/males	<i>EU-15 average: 1.4</i>
Urban concentration	63%	<i>EU-15 average: 80%</i>
Age structure	0–14 years	19% <i>EU-15 average: 18%</i>
	65+ years	13% <i>EU-15 average: 17%</i>
Median age	36 years	
Dependency ratio	44%	<i>EU-15 average: 49.5%</i>

POPULATION DYNAMICS



Annual growth rate

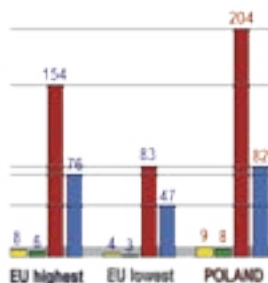


Fertility rate



Birth rates, live births /1000 population

PROBABILITY OF DYING (per 1000 population)



- *Before age 5, Male*
- *Before age 5, Female*
- *Between age 15 and 60, Male*
- *Between age 15 and 60, Female*

LIFE EXPECTANCY AT BIRTH (IN YEARS)

Total population	75	<i>EU-15 average: 79</i>
Male	71	<i>EU-15 average: 75.5</i>
Female	79	<i>EU-15 average: 82</i>
Gender difference	8.7 years	<i>EU-15 average: 6.3</i>

HEALTHY LIFE EXPECTANCY (IN YEARS)

	At birth (in years)			At age 60 (in years)		% of total life expectancy lost to poor health	
	Total	Male	Female	Male	Female	Male	Female
Poland	66	63	69	13	16	11	13
EU-15 lowest	69	67	71	15	17	8	9
EU-15 highest	73	72	75	17	20	9	11

Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health. The last two columns present this idea in another way, as the percentage of a lifetime that is spent living in less-than-full health.

Points to remember *demographic trends*

Over the past decade there has been


- an increase in life expectancy;
- a growing gender gap in life expectancy
- a decrease in the crude birth rate
- a drop in fertility rate below the replacement level.

Sources: 1, 3, 5, 6, 9, 16, 17, 33.

What do the Poles suffer from?

**When analysing the causes of death and disease burden, WHO has divided all countries into different mortality strata according to the levels of mortality for children younger than 5 and males age 15 to 59. According to this division, the whole of Europe falls into the developed country stratum. However, within this stratum, European countries are subdivided into three*

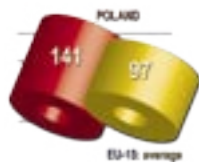




different groups – those with very low child and very low adult mortality, those with low adult and low child mortality, and those with low child and high adult mortality. This subdivision reflects the great variations that exist within Europe and help place figures in a regional context – a European mortality figure that might seem quite low in comparison to figures from Africa or south-east Asia may actually be quite high in comparison to figures from the most-developed European countries. According to this classification, Poland is in the group of European countries with low mortality for both children and adults. (The member states in the EU-15 are all in another group – that with very low mortality for children and adults.) Throughout this chapter, data marked by * are not country-specific but refer instead to the entire European group into which Poland falls.

CARDIOVASCULAR DISEASES

- Cardiovascular diseases are the leading cause of death in Poland's mortality group, resulting in 56% of all deaths.
- Of the various forms of these diseases, there are two major killers.
 - *Ischaemic heart disease* caused 141 Polish deaths per 100 000 in 2000 (*EU-15 average: 97/100 000*). For the Polish mortality group as a whole, it was responsible for 24%* of all deaths and 9%* of the disease burden.
 - *Cerebrovascular diseases* led to 103 deaths per 100 000 in 2000 (*EU-15 average: 61/100 000*). For the mortality group as a whole, these diseases were responsible for 15%* of all deaths and 7%* of the disease burden.
- Twenty per cent of the adult population suffers from hypertension.



CANCER / MALIGNANT NEOPLASMS

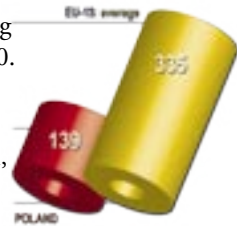
- Cancer is the reason for every tenth hospitalization.
- In 2000, it caused 216 deaths per 100 000 population.
EU-15 average: 183/100 000
- The standardized death rate from cervical cancer is more than triple the EU-15 average.

NEUROPSYCHIATRIC DISORDERS

- In the countries of Poland's mortality group, neuropsychiatric disorders cause only 1.3%* of all deaths – yet they form the second largest part of the disease burden, 19%*.

UNINTENTIONAL INJURIES

- Each year, external injuries and poisoning are responsible for 63 deaths per 100 000.
EU-15 average: 40/100 000
- In 2001 there were 139 road accidents involving injury per 100 000 population, less than half the EU-15 incidence of 335/100 000.



RESPIRATORY DISEASES

- Each year, there are 46 cases of respiratory disease per 100 000, which is somewhat lower than the average EU-15 rate of 57 per 100 000.

INFECTIOUS AND PARASITIC DISEASES

- The death rate for this group of diseases has been decreasing, dropping to the EU-15 average in the mid-1990s.
- The incidence of tuberculosis was 26 per 100 000 in 2001 (*EU-15 average: 11/100 000*).
- The incidence of new HIV infections are 1.5 per 100 000 – one of the highest among the new EU members. The country has a mature epidemic driven primarily by injecting drug use – injecting drug users account for 50% of all reported cases.



Poland



Slovakia



Slovenia

CHILD AND ADOLESCENT HEALTH

- Infant mortality in Poland has halved during the last two decades. It is now 8 deaths per 1000 live births. *EU-15 average: 4.7/1000*
- Immunization coverage is more than 96%.

ORAL HEALTH

- Oral health is deteriorating, and 60% of the children older than 12 have had at least one tooth with advanced caries.

Points to remember *Causes of death and disease burden*
Always compare!

	% of deaths caused*		% of disease burden*	
	Polish group	EU-15 group	Polish group	EU-15 group
Cardiovascular diseases	56	41	21	17
Neuropsychiatric disorders	1.3	5	19	26.5
Cancer/malignant neoplasms	16	27	8.7	16.5
Unintentional injuries	3.3	3.4	8.3	5.8
Respiratory diseases	3.8	5.6	4.1	6.5
Infectious and parasitic diseases	3.3	1.2	5.6	1.7
Respiratory infections	3.2	4.4	3.8	1.3
Perinatal conditions	2	<1	4.2	<1.0
Intentional injuries	1.7	1.3	<1	2
Diabetes	1.5	2.3	1.5	2.1
Sense organ disorders	0	0	4.2	4.7
Total communicable diseases	9	6	16	5
Total noncommunicable diseases	85	89	73	87
Total injuries	6	5	11	8

*Data refer to the European mortality groups that include Poland and the EU-15 countries, respectively.

Points to remember

health status

- It is important to consider both mortality and disease burden when looking at how a medical condition affects a population. Each measure reflects a different facet of human suffering.

Sources: 1, 6, 8, 21.



Where do the risks lie?

SMOKING

- Smokers comprise 40% of all Polish men and 25% of all women older than 15, for all adult population average of 32% (*EU-15 average rates are: men 32%, women 23%, together 28%*).
- Among young people, 10% of 13-year-olds and 21.5% of 15-year-olds smoke at least once a week.

ALCOHOL CONSUMPTION

- Alcohol use disorders are responsible for 1.7%* of the disease burden for the countries in Poland's mortality group.
- During 2000, the average Polish adult consumed 6.6 litres of pure alcohol. Since the mid-1980s, there has been a steady decrease in registered consumption that matches the average decrease in EU alcohol consumption, but serious concerns remain about the system for recording data and the scale of underreporting.

DRUGS

- Among 15- and 16-year-olds, cannabis use has been increasing more rapidly than in the other new EU countries, jumping from 2.5% in 1995 to 14% in 1999.
- Cannabis is the most popular illicit drug in the 13–15 age group.
- Up to 25% of all Poles age 18 to 50 have experimented with marijuana at least once, and the figure has been rising steadily.
- Drug use is much more common among urban inhabitants.



Poland



Slovakia



Slovenia

OBESITY

- Among Poles age 15 and older, 10% of the males and 11% of the females are clinically obese.
- For males in this age group, the mean body mass index (BMI) is 25.2, which means that the average Polish man is overweight. For females, the mean BMI is 24.4.
- A total of 31% of the adult population is reported to be physically inactive.

Sources: 6, 8, 11, 12, 18, 20, 28.



Who's who in the Polish public health sector?

PUBLIC ADMINISTRATION Ministry of Health

INSTITUTIONS UNDER THE MINISTRY OF HEALTH

Chief Pharmaceutical Inspectorate
Chief Sanitary Inspectorate
Bureau for Chemical Substances and Preparations
National Bureau for Drug Prevention
The State Agency for Prevention of Alcohol Related Problems
National AIDS Centre

PARLIAMENTARY COMMITTEES

Health Committee (in the lower chamber, *Sejm*)
Social Policy and Health Committee (in the upper chamber, *Senat*)

INSURANCE STRUCTURES National Health Fund

PROFESSIONAL ASSOCIATIONS

Polish Chamber of Physicians and
Dentists
Polish Nurses Association

ACADEMIC INSTITUTION

Eleven medical universities
Four schools of public health

PUBLIC HEALTH INSTITUTIONS

National Institute of Public Health
National Institute of Hygiene

REGIONAL INSTITUTIONS

Seventeen public health centres (under the provincial governments)



How are services provided?

PRIMARY CARE

Local government authorities (*gminas*) are responsible for the budgeting, planning, organization and supervision of primary care units. The new health system is oriented towards primary care services, and general practitioners (GPs) serve as gatekeepers. Outpatient services in specialized health care centres and hospitals are usually available only through GP referrals. For some specialists, however, including gynaecologists, psychiatrists and ophthalmologists, referrals are not necessary.

SECONDARY AND TERTIARY CARE

Hospitals are publicly owned but self-governing and self-financing administrative units. Many are on the verge of collapse because they still provide services besides the ones the health insurance system has agreed to reimburse. The main challenges for the hospital system are an inadequate supply of beds, a lack of clearly defined financing mechanisms for certain population groups, long waiting lists, under-the-table payments and corrupt relationships



Poland



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Slovenia

between hospitals, doctors and the pharmaceutical industry. Policies to address these problems are being implemented, and they include shifting long-term care out of the hospitals, strengthening outpatient care and instituting a new accreditation and registration system.



Points to remember *service provision*

- Primary health care reforms are in progress.
- The restructuring process for the hospital system continues.
- Quality remains high on the list of priorities.
- Coordination between the health services and the social services is being refined in order to meet the needs of the elderly and persons with disabilities.
- The system has been developing its capacity in response to increasing health risks
- Emergency services are looking at new ways to deal with life-threatening conditions.

Sources: 2, 8, 32.



What resources are available?

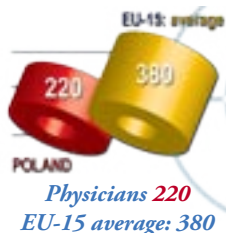
HUMAN RESOURCES

In 1999, 15% of the Polish workforce was employed in the health sector. The overall number of health professionals is decreasing, and the concentration of physicians is already one of the lowest in the new EU member states. The geographical distribution of physicians varies widely among regions, and the mix of specialties is uneven. Dentists and pharmacists are decidedly more concentrated in the largest urban areas.

Training programmes for health professionals comply with EU standards.

HEALTH PROFESSIONALS (per 100 000 population)

Dentists	300	EU-15 average: 640
Nurses	520	EU-15 average: 670
Pharmacists	610	EU-15 average: 790



HOSPITALS

The number of hospitals has been increasing over the last decade. The majority of them are public, but the number of private hospitals (both profit-making and non-profit-making) is steadily on the rise.

Some resources, particularly high-technology equipment and hospital beds, are concentrated predominantly in large cities and distributed unevenly among the provinces.

Hospital beds (per 100 000)	556	EU-15 average: 611
Annual inpatient admissions (per 100)	16	EU-15 average: 18
Average length of stay	8 days	EU-15 average: 10




During the 1990s, hospitals experienced a steady decline in the length of patient stays but an increase in admissions.

PHARMACEUTICALS

The powerful and rapidly developing pharmaceutical industry, supported by regular tax incentives, ensures the domestic production of medicines. Approximately 6000 pharmacists out of a total of 20 000 work in the private sector. Reimbursement depends on the type of drug: there is a basic list of drugs available for a flat fee equivalent to a percentage of the minimum wage, and a supplementary list of drugs for which patients pay 30% to 50% of cost. Patients with chronic disorders or war injuries are fully reimbursed.





Points to remember

health resources

- The equitable distribution of existing resources continues to be a challenge.
- Much attention is being paid to the management and optimal use of health personnel.
- There are plans to draw up a national policy on organizing and developing human resources in the health sector.
- Pharmaceutical regulation is considered an area that needs more political commitment and better organization.

Sources: 6, 8, 11.



Who pays for what?

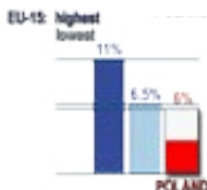
FORMS OF INSURANCE

In accordance with the National Health Fund Act of 2003, Poland has a compulsory health insurance scheme. There is one central health insurance fund, the National Health Fund, with 16 regional branches. Since 2002, citizens who are not insured by their employers or who are self-employed can purchase voluntary health insurance (VHI). VHI is also available through the National Health Fund. In addition, Poles can buy “health packages” offered by a range of private clinics and insurance companies to bolster their statutory coverage. Companies often purchase such packages for their employees.

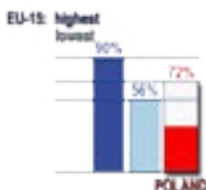
The Ministry of Finance only disburses funds from the central budget for a few very expensive services, such as transplants and particular oncology procedures. Otherwise, the main payer is the National Health Fund, and its funds do not go through the Ministry of Finance. The Fund pays for primary care, contracting GPs and specifying the capitation fees for them and other primary care providers.

Compulsory contributions are 8% of income (7.75% from general income tax and 0.25% directly from personal income); they are scheduled to increase to 9% by 2007. Poland has a substantial shadow economy, an informal sector in which incomes are not registered with the state and therefore do not contribute to social health insurance.

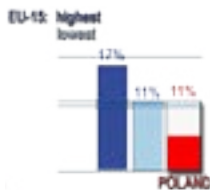
THE ECONOMIC PICTURE



Total expenditure on health, % of GDP



Public expenditure on health, as % of the total expenditures on health



General government expenditures on health as % of the total government expenditure

Population below national poverty line **18%** (2003)

Points to remember *health care financing*

- The health financing system is becoming more coherent and consistent.
- The health insurance system is still being reformed.
- The government has begun to address the issue of large hospital debts and to find an optimal balance between revenues and expenditures.
- The issue of what to do about low capital investment is being debated.
- The structural reform in health care led to unanticipated fiscal pressures, and out-of-pocket payments have increased, while public expenditure has not kept pace with GDP growth.
- In response to the financial constraints on reform, the state has recently focused on finding ways to secure health funding, mainly through new insurance schemes.

Sources: 1, 6, 13, 32.





How have the Poles been reforming their health system?

When public sector reforms began in the early 1990s, a range of ideas for how to restructure the health sector system was considered. Several major reform developments occurred during this transition period:

- The health system was gradually decentralized.
- Broad structural reforms shifted health system priorities to primary care and transformed hospitals into autonomous service providers. Universal access continued to be a fundamental feature of the system.
- The concept of family medicine (general practice) was introduced.
- The former integrated system of pharmacies, dental practices and private medical practices was dismantled.
- A series of national health policy documents was developed.

Some of the new national policies were poorly or slowly implemented, notable the policies for preventing cardiovascular diseases, cancer and trauma. As a result, the National Health Care Programme was launched in 1996 to establish reform milestones for the following decade.

During the transition period, administrative responsibilities were continually being shifted to the regional and local governments. However, this approach soon became regarded as problematic, and the government quickly moved to recentralize certain responsibilities and to introduce schemes that better addressed the public's actual health needs (see next section on health insurance).



Points to remember *health system reform*

- Poland's health sector reforms have required constant follow-up in order to keep them from being short-lived.
- The reforms have been a continual learning process, in which the reformers must figure out the best way to gather useful information and feedback before deciding how to proceed.
- Significant progress has been made in developing partnerships between the public health sector and other sectors. These cooperative efforts have given the health sector new opportunities to influence the larger societal agenda.
- There have been a wide variety of new health sector regulations, and one key reform goal is to harmonize them.

Sources: 2, 8, 32.



HEALTH INSURANCE

What is one of the things Poland has learned by doing?

In 1999, Poland created a decentralized system of 16 regional health insurance funds. One of the ideas behind the system was that it would free health care expenditure from political bargaining and personal agendas. This goal was not achieved, however; instead, the new system aggravated the problems. Soon it became obvious that the system faced major obstacles – lack of a regulatory framework, lack of the resources needed to function etc. That is why, in April 2003, the laws were amended to establish the new National Health Fund under the Ministry of Health, thereby restoring the Ministry's supervisory and governing role in funding. According to the new legislation:



Poland

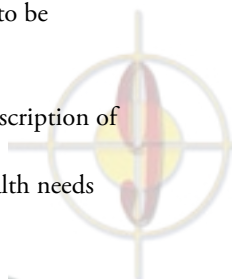


Slovakia



Slovenia

- the state is responsible for national health policy, standardization of services and the improvement of quality control;
- regional health plans and purchasing procedures are to be harmonized;
- everyone will have free access to emergency services;
- all service provision is to be documented and the prescription of drugs supervised; and
- a public hospital network will be set up based on health needs assessments.



What has the Regional Office been doing in Poland?

The WHO Regional Office for Europe has had a liaison office in Warsaw since 1992. The country hosts nine of WHO's collaborating centres and is involved in several WHO networks, including Health Promoting Schools, Health Promoting Hospitals and Healthy Cities.

In 2002–2003, the Regional Office and Poland collaborated in the areas of:

- mental health
- noncommunicable diseases
- environment and health
- environmental tobacco smoke
- food and nutrition.

The Regional Office has signed an agreement to work with Poland in 2004–2005 on:

- the stewardship role of the health system
- mental health
- health financing (hospital debts)
- environment and health (focusing on children)
- ageing and health.

SOURCES OF INFORMATION ABOUT POLAND

Web sites:

Ministry of Health	http://www.mz.gov.pl
The Sejm of Poland	http://www.sejm.gov.pl
The Senate of Poland	http://www.senat.gov.pl
President of the Republic of Poland	http://www.prezydent.pl
The Chancellery of the Prime Minister of Poland	http://www.kprm.gov.pl
Polish Official Statistics	http://www.stat.gov.pl/english
Polish search engine	http://www.poland.pl
Delegation of the European Commission in Poland	http://www.delpol.pl



Poland



Slovakia



Slovenia

SLOVAKIA



SLOVENSKÁ REPUBLIKA

AREA	49 000 km ² Approximately equal to Denmark <i>1.2% of the total EU-25 area</i>
POPULATION	5 400 000 Equal to Denmark <i>1.2% of the total EU-25</i>
THE PEOPLE	Slovaks 86%, Hungarians 10%, Roma 2%, Czechs, Ukrainians, Germans, Poles
LANGUAGES	Slovak, Hungarian

FORM OF GOVERNMENT

Parliamentary republic
Unicameral parliament (*Narodna Rada Slovenska*)
Head of state – president, directly elected

MAIN RELIGION

Roman Catholic 69%, Protestant 9%,
Orthodox 4%

INDEPENDENCE

1993

GDP PER CAPITA

€4 300 = **18% of the EU-15 average**
In purchasing power parity (PPP):
€10 300 = **45% of the EU-15 average**

REGIONAL DIVISIONS

8 regions (*kraje*)

CURRENCY

Slovak koruna €1.00 = 40 koruny
(1 koruna = €0.02)

HUMAN DEVELOPMENT INDEX

0.84 **EU-15 lowest: 0.89, highest: 0.94**

UNEMPLOYMENT RATE

17 % **EU-15 average: 9%**

MEMBER OF

CE, OSCE, UN, OECD, NATO

Sources: 1, 3, 5, 7, 15, 16, 18.

HEALTH

ZDRAVIE

ZDRAVOTNÍCTVO



Slovakia



Slovenia

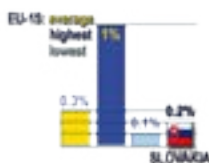
THE TEN HEALTH QUESTIONS

What are the demographic essentials for Slovakia?

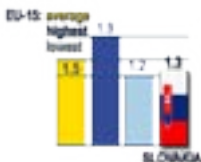
POPULATION PROFILE

Sex ratio	1.05 females/males	<i>EU-15 average: 1.4</i>
Urban concentration	58%	<i>EU-15 average: 80%</i>
Age structure	0–14 years 19%	<i>EU-15 average: 18%</i>
	65+ years 11.5%	<i>EU-15 average: 17%</i>
Median age	35 years	
Dependency ratio	43%	<i>EU-15 average: 49.5%</i>

POPULATION DYNAMICS



Annual growth rate

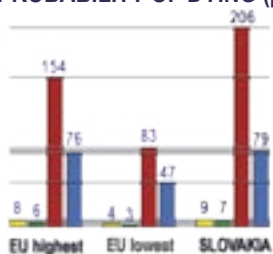


Fertility rate



Birth rates, live births /1000 population

PROBABILITY OF DYING (per 1000 population)



- Before age 5, male
- Before age 5, female
- Between age 15 and 60, male
- Between age 15 and 60, female

LIFE EXPECTANCY AT BIRTH

Total population	74 years
Male	70 years
Female	78 years

EU-15 average: 79
EU-15 average: 75.5
EU-15 average: 82

HEALTHY LIFE EXPECTANCY

	At birth (in years)			At age 60 (in years)		% of total life expectancy lost to poor health	
	Total	Male	Female	Male	Female	Male	Female
Slovakia	66	63	69	12	16	10	11
EU-15 lowest	69	67	71	15	17	8	9
EU-15 highest	73	72	75	17	20	9	11

Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health. The last two columns present this idea in another way, as the percentage of a lifetime that is spent living in less-than-full health.

Points to remember *demographic trends*

The past decade has seen:

- low birth rates, therefore slowed population growth
- sub-national variations in male life expectancy
- increased life expectancy
- ageing of the population.

Sources: 1, 3, 4, 6, 9, 16, 18.

What do the Slovaks suffer from?

** When analysing the causes of death and disease burden, WHO has divided all countries into different mortality strata according to the levels of mortality for children younger than 5 and males age 15 to 59. According to this division, the whole of Europe falls into the developed country stratum. However, within this stratum, European countries are subdivided into three different*

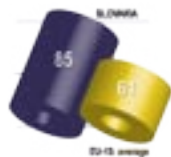


groups – those with very low child and very low adult mortality, those with low adult and low child mortality, and those with low child and high adult mortality. This subdivision reflects the great variations that exist within Europe and help place figures in a regional context – a European mortality figure that might seem quite low in comparison to figures from Africa or south-east Asia may actually be quite high in comparison to figures from the most-developed European countries. According to this classification, Slovakia is in the group of European countries with low mortality for both children and adults.

(The member states in the EU-15 are all in another group – that with very low mortality for children and adults.) Throughout this chapter, data marked by * are not country-specific but refer instead to the entire European group into which Slovakia falls.

CARDIOVASCULAR DISEASES

- Cardiovascular diseases are the leading cause of mortality in Slovakia, resulting in 55% of all deaths.
- Of the various forms of these diseases, there are two major killers.
 - *Ischaemic heart disease* caused 290 Slovak deaths per 100 000 population in 2000 (*EU-15 average: 97/100 000*). For the mortality group as a whole, it was responsible for 25%* of all deaths and 9%* of the disease burden.
 - *Cerebrovascular diseases* led to 85 deaths per 100 000 in 2000 (*EU-15 average: 61/100 000*). For the mortality group as a whole, these diseases were responsible for 15%* of all deaths and 7%* of the disease burden.
- In 2000, 41 people (out of 100 000) died of other circulatory system diseases (*EU-15 average: 14/100 000*).



CANCER (MALIGNANT NEOPLASMS)

- Cancer is the second most significant cause of death in Slovakia, resulting in 23% of the total.

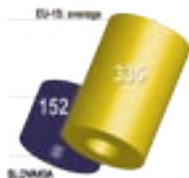
- In 2000, it caused 226 deaths per 100 000 population (*EU-15 average: 183/100 000*).
- The standard death rate from cervical cancer was 7.5 per 100 000 population in 2000, or triple the *EU-15 average (2.6/100 000)*.
- The standardized death rate from cancer of the respiratory system was 44 per 100 000 in 2000 (*EU-15 average: 37*).

NEUROPSYCHIATRIC DISORDERS

- Each year, suicide and self-inflicted injury in Slovakia cause 13 deaths per 100 000 (*EU-15 average: 10/100 000*).

UNINTENTIONAL INJURIES

- In 2000, external injuries and poisoning were responsible for 58 deaths per 100 000 (*EU-15 average: 40/100 000*).
- In 2001 there were 152 road accidents involving injury per 100 000 population, less than half the EU-15 incidence of 335 per 100 000.



RESPIRATORY DISEASES

- Each year, there are 54 deaths from respiratory diseases per 100 000 (*EU-15 average: 57 per 100 000*).

INFECTIOUS AND PARASITIC DISEASES

- The death rate for this group of diseases was 3.4 per 100 000 population in 2000 (*EU-15 average: 7.3/100 000*).
- The incidence of tuberculosis was 18 per 100 000 in 2001 (*EU-15 average: 11/100 000*).
- The prevalence of HIV/AIDS is 0.04 per 100 000 population (*EU-15 average: 0.2/100 000*). The annual incidence of new HIV infections is 0.2 per 100 000 (*EU-15 average: 4.3/100 000*). Slovakia has one of the lowest concentrations of newly registered AIDS cases in all Europe.

CHILD AND ADOLESCENT HEALTH

- Infant mortality in Slovakia is 8.6 deaths per 1000 live births (*EU-15 average: 4.7/1000*).
- Immunization coverage is between 95% and 99%.

Points to remember *Causes of death and disease burden*
Always compare!

	% of deaths caused*		% of disease burden*	
	Slovak group	EU-15 group	Slovak group	EU-15 group
Cardiovascular diseases	56	41	21	17
Neuropsychiatric disorders	1.3	4.7	19	26.5
Cancer/malignant neoplasms	16	27	8.7	16.5
Unintentional injuries	3.3	3.4	8.3	5.8
Respiratory diseases	3.8	5.6	4.1	6.5
Infectious and parasitic diseases	3.3	1.2	5.6	1.7
Respiratory infections	3.2	4.4	3.8	1.3
Perinatal conditions	2	<1.0	4.2	<1.0
Intentional injuries	1.7	1.3	<1.0	2
Diabetes	1.5	2.3	1.5	2.1
Sense organ disorders	0	0	4.2	4.7
Total communicable diseases	9	6	16	5
Total noncommunicable diseases	85	89	73	87
Total injuries	6	5	11	8

* Data refer to the European mortality groups that include Slovakia and the EU-15 countries, respectively.

Points to remember

health status

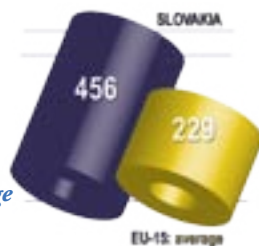
- It is important to consider both mortality and disease burden when looking at how a medical condition affects a population. Each measure reflects a different facet of human suffering.

Sources: 1, 6, 8.

Where do the risks lie?

SMOKING

- Smokers comprised 41% of all adult men and 15% of all adult women, an overall average of 32% (*EU-15 average rates are: men 32%, women 23%, together 28%*).
- Among young people, 15% of 13-year-old boys and 11% of 15-year-old girls are smokers. For the group of the 15-year-olds, these figures are respectively 31% for the boys and 28% for the girls.



Smoking-related deaths per 100 000 population each year

ALCOHOL CONSUMPTION

- During 2000, the average Slovak adult consumed 10 litres of pure alcohol (*EU-15 average: 9.2*).
- In the same year, there were 95 alcohol-related deaths per 100 000 (*EU-15 average: 62/100 000*).

DRUGS

- The prevalence of illegal drug use among 16-year-olds is less than 1%, which is lower than in the EU-15.



Sources: 6, 8, 11, 12, 18, 20, 28.



Who's who in the Slovak public health sector?

PUBLIC ADMINISTRATION Ministry of Health

INSTITUTIONS UNDER THE MINISTRY OF HEALTH

Institute of Health Information and Statistics

State Institute for Drugs Control

Several highly specialized health facilities, including the National Cancer Institute and the National Institute of Cardiovascular Disease

PARLIAMENTARY COMMITTEES

Health Committee

Social and Housing Committee

INSURANCE STRUCTURE

General Health Insurance Company

Common Health Insurance Company

Three smaller insurance companies

PROFESSIONAL ASSOCIATIONS

Slovak Medical Chamber

Slovak Chamber of Dentists

Slovak Pharmaceutical Chamber

Slovak Chamber of Paramedical Personnel

Slovak Chamber of Nurses and Midwives

ACADEMIC INSTITUTIONS

Slovak Health University

Medical faculties in Bratislava, Kosice and Martin

Several faculties of public health, nursing, social work; faculty of health management

PUBLIC HEALTH INSTITUTIONS

Public Health Office of the Slovak Republic (supervises a network of 37 regional public health offices)

REGIONAL AND LOCAL INSTITUTIONS

The regions and municipalities have a strong role in the management and organization of health services. There is a health department in each of the 8 regional parliaments.



How are services provided?

PRIMARY CARE

When Slovaks require medical attention, their first contact with the health care system is usually with one of three types of primary care doctors – general practitioners, paediatricians and gynaecologists. Primary care physicians work with nurses and paramedical staff. They belong almost entirely to the private sector – 94% of them run private solo practices, receiving payment through direct contracts with the insurance companies. Dentists, too, provide their services in private health care facilities. Slovaks have free choice of primary care providers. Polyclinics and health centres are the responsibility of the regions and municipalities.

SECONDARY AND TERTIARY CARE

Secondary outpatient care is provided on a private profit-making basis 44% of the time; the remaining 56% is provided by state specialists, who either work for a state facility or receive a salary according to a national pay scale. Until 2002, more than 90% of all hospital beds were in acute care, but the situation has recently changed. Today, hospitals are either regional (with a maximum of four specialized departments), district (with a wide range of



Slovakia



Slovenia

specialties) or highly specialized (most often affiliated with medical schools). Only the last group remains state-owned, the others being owned by their respective regions. In 2003, an amendment to the Act on Health Care made a clear distinction between health care services and the auxiliary services that support them (food, accommodation, data processing, transport etc.). Payments for services in these two categories are now based on different scales.

Points to remember *service provision*

- Geographical inequalities in the distribution of primary care are now being addressed.
- The Ministry of Health is looking at ways to increase the utilization of beds from its recent level of 70%.
- Acute hospital beds continue to be converted to social care uses.

Sources: 2, 8, 32.

What resources are available?

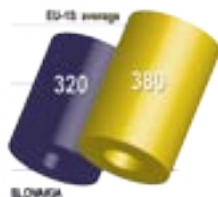
HUMAN RESOURCES

The health sector employs 5.5% of the Slovak workforce.

HEALTH PROFESSIONALS

(per 100 000 population)

Dentists	440	<i>EU-15 average: 640</i>
Nurses	700	<i>EU-15 average: 670</i>
Pharmacists	500	<i>EU-15 average: 790</i>
General practitioners	40	<i>EU-15 average: 102</i>



Physicians 320
EU-15 average: 380

HOSPITALS

Hospital beds (per 100 000) 779

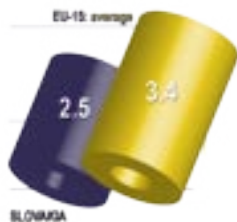
EU-15 average: 611

Annual inpatient admissions (per 100) 20

EU-15 average: 18

Average length of stay 10 days

EU-15 average: 10



Hospitals per 100 000 population

PHARMACEUTICALS

There are three reimbursement categories of drugs: full, partial and no reimbursement. The prices of medicines have risen so much that drug costs now constitute 40% of Slovakia's total health expenditure – the highest figure of all OECD countries. Domestic production has recently accounted for 18% of the pharmaceutical market.

Points to remember

health resources

- Membership in the professional associations is obligatory for all health professionals. In turn, the associations are responsible for the quality of service their members provide.
- The country has already taken the necessary steps to prepare for opening the health care employment market to workers from the rest of the European Union.

Sources: 6, 8, 11.

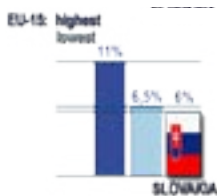
Who pays for what?

All citizens of Slovakia are covered by mandatory health insurance. Health care is financed through a mix of public and private funding. The public funds come from two main sources. One is the statutory health insurance premiums, which are 14% of a worker's assessed income (10% paid by the employer and 4% by the employee). The self-employed also pay 14%, while the state pays for the rest of the population. Together, these premiums account for 68% of the total expenditure on health. Budgetary transfers are the other main source of health

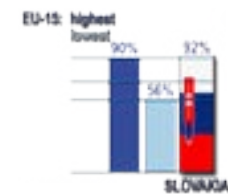
funding, providing 24% of total health expenditure. Out-of-pocket payments constitute the other 7% of health expenditure.

The General Health Insurance Company and the Common Health Insurance Company can be described as statutory institutions because the state guarantees their solvency. The country's other three insurance companies are private, in that the state does not guarantee them. All five companies sign contracts with individual health care providers, both public and private, and reimburse them for services. The current government plans to introduce a scheme that offers two types of insurance: compulsory (based on the principle of solidarity) and supplementary (insurers will have the alternative of direct payments for care). The scheme is intended to balance opportunities and obligations for both compulsory and supplementary insurance. For the time being, voluntary health insurance accounts for a very small portion of health care spending.

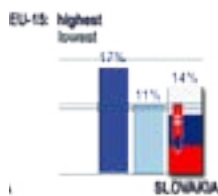
THE ECONOMIC PICTURE



Total expenditure on health, % of GDP



Government expenditure on health, as % of the total expenditures on health



Government expenditure on health, as % of the total government expenditure

Points to remember *health care financing*

- The population needs to better understand the exact range of services covered by health insurance.
- Although there are several insurers, there is no real competition among them.
- The existing organisation poses questions of defining the extent to which the state would subsidize non-contributors.

Sources: 1, 6, 13.



How have the Slovaks been reforming their health system?

THE HEALTH REFORMS OF THE LAST DECADE:

- were advanced by the government;
- focused on reducing the state's monopoly in health care;
- delegated numerous administrative, managerial and financial responsibilities to the regions and the municipalities;
- sought to use compulsory health insurance to realize citizens' constitutional right to free, universal and comprehensive health coverage;
- instituted a contractual relationship between health care providers and health insurance companies; and
- visibly shifted health system priorities from inpatient to outpatient care.



Points to remember *health system reform*

- To date, health care reform has been carried out in a fragmented manner and now Slovakia is seeking ways to consolidate the achievements and to envision the best way to complete them.
- The balance between health care revenue and expenditure is being refined.
- Responsiveness to the needs of the population has become a policy priority.
- Decentralization and the transfer of facility ownership to the regions continue.
- A comprehensive package of health care legislation has been recently submitted to the parliament, seeking to achieve a new balance between services and available resources.





What is one of the things Slovakia has learned by doing?

GOING PRIVATE

Back in 1993, early in the transition between health care systems, the Slovak government gave the green light to the de-monopolizing and privatizing of pharmacies and health care services. The privatization of the pharmaceutical sector was efficient and radical, and by 1995, all pharmacies were private. The progress in health care was more controversial. The large-scale privatization of primary care providers began in the mid-1990s and resulted in considerable unevenness in the quality of services. The Ministry of Health responded by creating a provider network in which status, obligations and funding would be the same for all providers, both public and private. The government had a definite strategy and knew exactly what it wanted to privatize, and by 2000, locally based primary care was predominately private – 83% of the GPs, 87% of the paediatricians and 83% of the gynaecologists. The situation in specialist outpatient care was a different story (34% private), and the contrast was even more marked in inpatient care (3% private). In addition, almost all spas went private, and some hospitals became private non-profit-making organizations. A second wave of privatization began in 2001, when the possibility of going private was extended to other health care facilities – local health centres, sanatoria, polyclinics, rehabilitation institutions etc. While a few problems have emerged, the direction of the general policy remains quite clear.



What has the Regional Office been doing in Slovakia?

The WHO Regional Office for Europe has had a liaison office in Bratislava since 1994. During the period 2002–2003, the Regional Office worked with Slovakia on:

- developing a drug policy
- increasing the capacity for long-term care of people with mental illness
- developing a national database and establishing health service indicators
- furthering health promotion efforts
- developing a tobacco control policy.

For 2004–2005, the two partners have agreed to collaborate on:

- improving the efficiency of hospital management
- financing health care
- upgrading nurse training modules
- conducting prevention efforts to address health risks.

SOURCES OF INFORMATION ABOUT SLOVAKIA

Web sites

Ministry of Health

<http://www.health.gov.sk>

The Slovak Republic Government Office

<http://www.government.gov.sk>

Office of the President of the Slovak Republic

<http://www.prezident.sk>

Statistical Office of the Slovak Republic

<http://www.statistics.sk>

Delegation of the European Commission in the Slovak Republic
<http://www.europa.sk>
<http://slovakia.org/news>



Slovakia



Slovenia

SLOVENIA



SLOVENIJA

AREA

20 000 km²

Two thirds the size of Belgium

0.5% of the total EU-25 area

POPULATION

2 000 000

One fifth the population of Belgium

0.5% of the total EU-25 population

THE PEOPLE

Slovenes 88%, Croatians 3%, Serbs 2%

LANGUAGES

Slovene (official), Croatian, Serbian, German

FORM OF GOVERNMENT

Parliamentary democratic republic
Unicameral national assembly (*Drzavni Zbor*)
Head of state – president, elected directly

MAIN RELIGION

Roman Catholic 70%, atheist 4%, Eastern Orthodox 2.5%, Muslim, Protestant

INDEPENDENCE

1991

GDP PER CAPITA

€10 900 = *47% of the EU-15 average*
In purchasing power parity (PPP):
€15 000 = *66% of the EU-15 average*

REGIONAL DIVISIONS

11 collective and 182 single municipalities
(*obcine*)

CURRENCY

Slovene tolar (€1.00 = 237 tolar)

HUMAN DEVELOPMENT INDEX

0.87 *EU-15 lowest: 0.89, highest: 0.94*

UNEMPLOYMENT RATE

6% *EU-15 average: 9%*

MEMBER OF

CE, OSCE, UN, NATO, WTO

Sources: 1, 3, 5, 6, 7, 15, 16.

HEALTH ZDRAVJE

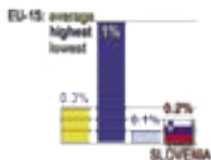
THE TEN HEALTH QUESTIONS

What are the demographic essentials for Slovenia?

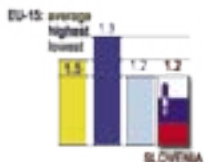
POPULATION PROFILE

Sex ratio	1.04 females/males	<i>EU-15 average: 1.4</i>
Urban concentration	50%	<i>EU-15 average: 80%</i>
Age structure	0–14 years 16%	<i>EU-15 average: 18%</i>
	65+ years 14%	<i>EU-15 average: 17%</i>
Median age	38.6 years	
Dependency ratio	42%	<i>EU-15 average: 49.5%</i>

POPULATION DYNAMICS



Annual growth rate

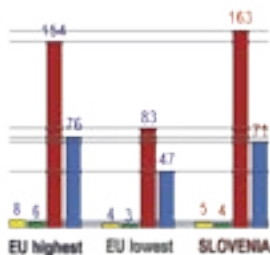


Fertility rate



Birth rates, live births /1000 population

PROBABILITY OF DYING (per 1000 population)



- Before age 5, male
- Before age 5, female
- Between age 15 and 60, male
- Between age 15 and 60, female

LIFE EXPECTANCY AT BIRTH

Total population	77 years	<i>EU-15 average: 79</i>
Male	73 years	<i>EU-15 average: 75.5</i>
Female	80.5 years	<i>EU-15 average: 82</i>
Gender difference	7 years	<i>EU-15 average: 6</i>

HEALTHY LIFE EXPECTANCY

	At birth (in years)			At age 60 (in years)		% of total life expectancy lost to poor health	
	Total	Male	Female	Male	Female	Male	Female
Slovenia	69.5	67	72	14	18	8	10
EU-15 lowest	69	67	71	15	17	8	9
EU-15 highest	73	72	75	17	20	9	11

Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health. The last two columns present this idea in another way, as the percentage of a lifetime that is spent living in less-than-full health.

Points to remember *demographic trends*

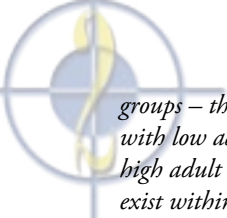
The past decade has seen:

- ageing of the population
- an increasing number of chronic conditions
- a decline in the population growth rate.
- an increase in life expectancy.

Sources: 1, 3, 4, 5, 6, 9, 16, 17, 18.

What do the Slovenes suffer from?

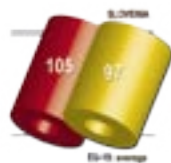
** When analysing the causes of death and disease burden, WHO has divided all countries into different mortality strata according to the levels of mortality for children younger than 5 and males age 15 to 59. According to this division, the whole of Europe falls into the developed country stratum. However, within this stratum, European countries are subdivided into three different*



groups – those with very low child and very low adult mortality, those with low adult and low child mortality, and those with low child and high adult mortality. This subdivision reflects the great variations that exist within Europe and help place figures in a regional context – a European mortality figure that might seem quite low in comparison to figures from Africa or south-east Asia may actually be quite high in comparison to figures from the most-developed European countries. According to this classification, Slovenia is in the group of European countries with very low mortality for both children and adults. Every member state of the EU-15 also falls into the same group. Throughout this chapter, data marked by * derive from this entire European mortality group, rather than just Slovenia.

CARDIOVASCULAR DISEASES

- Cardiovascular diseases are the leading cause of mortality in Slovenia, resulting in 39% of all deaths.
- Of the various forms of these diseases, there are two major killers.
 - *Ischaemic heart disease* causes 105 Slovene deaths annually per 100 000 population (*EU-15 average: 97/100 000*). For the Slovene mortality group as a whole, it is responsible for 17%* of all deaths and 7%* of the disease burden.
- *Cerebrovascular diseases* lead each year to 85 deaths per 100 000 (*EU-15 average: 61/100 000*). For the mortality group as a whole, these diseases are responsible for 10.5%* of all deaths and 5%* of the disease burden.



CANCER (MALIGNANT NEOPLASMS)

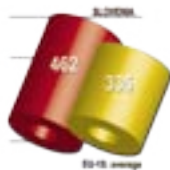
- Cancer is the second leading cause of death, responsible for 26% of all deaths in 2001.
- In 2000, cancer caused 204 deaths per 100 000 population (*EU-15 average: 183/100 000*).
- The standard death rate from cervical cancer is twice the EU-15 average.
- There has been a noticeable decline in lung cancer among men.

NEUROPSYCHIATRIC DISORDERS

- The suicide rate in Slovenia is among the highest in Europe (3.1 per 100 deaths are due to suicide).
- Suicide and self-inflicted injury cause 27 deaths each year per 100 000 population (*EU-15 average: 10/100 000*). For the last two decades, the Slovene suicide rate has been among the highest in the world.
- In the countries of the Slovene mortality group, neuropsychiatric disorders account for 26.5%* of the disease burden, more than any other factor.

UNINTENTIONAL INJURIES

- Unintentional injuries are the third leading cause of death (8% of all deaths).
- External causes of death – injuries and poisoning – are responsible for 70 deaths per 100 000 annually (*EU-15 average: 40/100 000*).
- Each year, there are 462 traffic accidents involving injury per 100 000 population (EU-15 incidence of 336 per 100 000). The mortality rate for transport accidents is 16 deaths per 100 000 (*EU-15 average: 11/100 000*).



RESPIRATORY DISEASES

- There are 61 deaths from respiratory diseases per 100 000 every year (*EU-15 average: 57 per 100 000*).

INFECTIOUS AND PARASITIC DISEASES

- The annual death rate for this group of diseases is 4 per 100 000 (*EU-15 average: 7/100 000*).
- The incidence of tuberculosis is 17 per 100 000 (*EU-15 average: 11/100 000*).
- HIV/AIDS is a low-level epidemic in Slovenia. Transmission is primarily via male–male sexual contact. In 2002, there were 1.1 new cases reported per 100 000 (*EU-15 average: 4.3/100 000*). The incidence of clinically diagnosed AIDS is 0.1 per 100 000 (*EU-15 average: 2.4/100 000*).

CHILD AND ADOLESCENT HEALTH

- Infant mortality in Slovenia is 4.9 deaths per 1000 live births (*EU-15 average: 4.7/1000*).

ORAL HEALTH

- Dental caries is on the decline in Slovenia. It affects 5% of 6-year-olds, 7% of 18 year-olds and 15% of those in the 35–44 age group.

	Points to remember Always compare!	<i>Causes of death and disease burden</i>
	% of deaths caused*	% of disease burden*
Cardiovascular diseases	41	17
Neuropsychiatric disorders	4.7	26.5
Cancer/malignant neoplasms	26.5	16.5
Unintentional injuries	3.4	5.8
Respiratory diseases	5.6	6.5
Infectious and parasitic diseases	1.2	1.7
Respiratory infections	4.4	1.3
Perinatal conditions	<1.0	<1.0
Intentional injuries	1.3	2
Diabetes	2.3	2.1
Sense organ disorders	0	4.7
Total communicable diseases	6	5
Total noncommunicable diseases	89	87
Total injuries	5	8

* Data refer to the European mortality group that includes both Slovenia and the EU-15 countries.

Points to remember	<i>health status</i>
● It is important to consider both mortality and disease burden when looking at how a medical condition affects a population. Each measure reflects a different facet of human suffering.	

Sources: 1, 6, 8, 20, 21, 36.



Where do the risks lie?

SMOKING

- Smokers comprise 28% of Slovene men and 20% of Slovene women, or 24% overall (*EU-15 average rates are: men 32%, women 23%, together 28%*).
- In 2001–2002, 5% of 13-year-olds and 30% of 15-year-olds were smokers.
- In 2003, the overall smoking prevalence among adults above 25 years of age was 24%.
- Every year there are 269 smoking-related deaths in Slovenia per 100 000 (*EU-15 average: 229/100 000*). The average mortality related to smoking is reported to be 15% for men and 12% for women.



ALCOHOL CONSUMPTION

- Among the countries in Slovenia's mortality group, alcohol problems account for 4.3%* of the disease burden.
- The reported annual consumption of pure alcohol for the average Slovene is 5.5 litres (*EU-15 average: 9.2*). However, the estimated unrecorded consumption is an additional 7.5 litres per person. For the population above 15 years of age, the reported consumption is 15 litres per person.
- Prevalence of excessive drinking in the same age groups is estimated to 13% of the whole population.
- Alcohol is reportedly a major factor for the frequency of road accidents with fatal outcome (91 deaths due to drunk driving only in 2003).

DRUGS

- Among 15- and 16-year-olds, 25% have used cannabis at least once.
- Eleven per cent of the adult population have tried an illegal drug at least once.
- A total of 14.5% of the population report having experimented with inhalants.

Sources: 6, 8, 11, 12, 18, 20, 28.



Who's who in the Slovene public health sector?

PUBLIC ADMINISTRATION Ministry of Health

INSTITUTIONS UNDER THE MINISTRY OF HEALTH

National Board of Health (advisory body to the government)
Health Council (coordinating expert body)
Directorate for Public Health
Health Inspectorate
Office for Medicinal Products

PARLIAMENTARY COMMITTEES

Committee on Social Affairs, Work, Family Matters and Health

INSURANCE STRUCTURE

National Health Insurance Institute

PROFESSIONAL ASSOCIATIONS


Medical Chamber of Slovenia
Slovenian Chamber of Pharmacy
Slovene Medical Association

ACADEMIC INSTITUTIONS

Medical Faculties in the University of Ljubljana and the University of Maribor

PUBLIC HEALTH INSTITUTIONS

One National and 9 regional Public Health Institutes (responsible for prevention programmes and data collection)





How are services provided?

PRIMARY CARE

In the public sector, primary care, both preventive and curative, is provided in 128 health care facilities. Most primary care professionals work independently, and their gate-keeping function is further strengthened. There have been attempts to delegate the responsibility for planning primary care to local governments, and today municipalities manage most centres, which are still owned by the state. There are also dispensaries for various types of care aimed at children, youth, tuberculosis patients and venereal disease patients. Family medicine/general practice is taught as a postgraduate specialty, but interest in it is low among physicians. Primary care workers in the public sector are paid on either a salary or capitation basis; financial incentives for them are still being developed. Private providers are granted primary care concessions in accordance with Ministry of Health regulations.

SECONDARY AND TERTIARY CARE

Hospitals provide about 75% of Slovenia's secondary care. The public network includes 26 general and 12 specialized hospitals. The hospital system has undergone fundamental changes as part of the decentralization reforms. The concept of the day hospital was introduced, and many resources were shifted from inpatient to outpatient care, decreasing the number of acute hospital beds. Existing public hospitals have been granted greater managerial autonomy in recent years, but they still lack sufficient resources and reliable mechanisms for quality assurance. Many hospitals are in debt, and average waiting times are quite long.

Points to remember *service provision*

- The privatization of primary care has been gathering speed
- Cooperation between primary and secondary care has great potential for future development.
- A World Bank loan is funding a new plan to reform health care management and financing, with a special emphasis on quality of care.
- Management of the health care system is still relatively centralized.
- Most hospitals are public, though primary and specialized outpatient services are often delivered in private settings.

Sources: 2, 8.

What resources are available?

HUMAN RESOURCES

5% of the total workforce is employed in the health sector.

HEALTH PROFESSIONALS

(per 100 000 population)

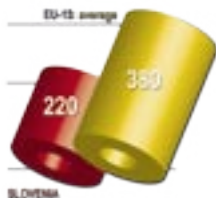
Dentists **600** *EU-15 average: 640*

Nurses **710** *EU-15 average: 670*

Pharmacists **390** *EU-15 average: 790*

General

practitioners **50** *EU-15 average: 102*



*Physicians 220
EU-15 average: 380*

HOSPITALS

Hospital beds (per 100 000) **516**

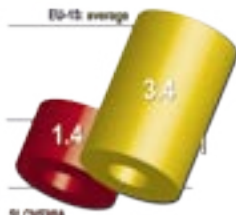
EU-15 average: 611

Annual inpatient admissions (per 100) **16**

EU-15 average: 18

Average length of stay **8 days**

EU-15 average: 10



*Hospitals per 100 000
population*

PHARMACEUTICALS

New legislation has been introduced to bring pharmaceutical packaging, labelling, advertising, inspection and authorization procedures in line with the EU *acquis communautaire*. The Slovene pharmaceutical industry is looking for ways to survive competition from imported products. Systems are being developed to improve efficiency and quality control for both new and existing products. Statutory insurance covers 75% of any medicines on the positive list; the remaining 25% is paid either by voluntary insurance or out of pocket.

Points to remember

health resources

- Health professionals still need to be more evenly distributed throughout the country.
- Health professionals' satisfaction in the public sector is an ongoing issue.
- Slovenia is currently experiencing a shortage of about 400 doctors, and medical admissions during the last few years have accordingly been increased by 15%.
- Nurses have expressed a desire to improve their on-the-job skills.
- Drug costs have been rising very rapidly.
- Consumption of prescription drugs is relatively high – and increasing.

Sources: 6, 8, 11.

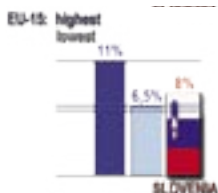


Who pays for what?

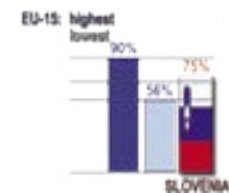
All Slovene citizens are entitled to **compulsory health insurance** benefits, some of which are subject to co-payments. Worker contributions are proportional to income and shared between employer and employee. Other individuals, such as pensioners and other special groups, pay a fixed amount. The National Employment Institute covers contributions for the unemployed, and the municipalities pay for some of the more vulnerable and socially disadvantaged persons. In 2002, 84% of the population's health expenditures were paid through the compulsory system and covered by the health insurance fund.

Voluntary complementary health insurance was introduced in 1993, and since then, practically all Slovenes (98%) have become subscribers. The National Health Insurance Institute has contracts with most private providers. People increasingly pay directly, in cash, when they consult private physicians for services that are not covered by compulsory insurance.

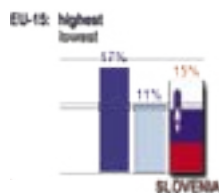
THE ECONOMIC PICTURE



Total expenditure on health, % of GDP



Government expenditure on health, as % of the total expenditures on health



Government expenditure on health, as % of the total government expenditure

Points to remember *health care financing*

- The insurance system is built up around employment-based financing.
- Pressure on the existing (and insufficient) resources is growing.

Sources: 1, 6, 13.

How have the Slovenes been reforming their health system?

THE HEALTH REFORMS OF THE LAST DOZEN YEARS:

- began when new health care legislation was adopted in 1992;
- formed part of the modernization of Slovenia's overall social structure;
- shifted from a provider-oriented to a patient-oriented system;

- encouraged privatization of part of the public health care network;
- introduced patient choice of physicians;
- focused on improving the financing and management of secondary and tertiary care;
- strengthened the government health insurance scheme;
- created an independent health insurance administration in order to separate payers and providers;
- introduced new laws, rules and amended regulations in 2002 as part of the EU accession process; and
- sought to define accurately and in depth the roles and responsibilities of the health sector's various key actors. constitutional right to free, universal and comprehensive health coverage;

Points to remember *health system reform*

- The government continues its efforts to redistribute resources in order to compensate for inequity, especially in access to health services.
- Incentives for cost-effectiveness in health care need to be increased.
- Evidence-based clinical practice is now high on the system agenda.
- Disease surveillance has become a central challenge in the public health sector.
- Slovenia has been going through a constructive process of fine-tuning reform developments.
- The system's responsiveness to patient needs has continued to improve.
- The government has tried to address inequality and improve access to health services while meeting the population's increasing expectations.



What is one of the things Slovenia has learned by doing?

PRIMARY HEALTH CARE

Slovenia has changed its approach to strengthening and upgrading primary care. The reforms of the last decade included introduction of the family doctor concept, a concept that was tried and then modified to suit the particular characteristics of the Slovene health care system. The process resulted in an enhanced definition of health professional roles and tasks – and a search for incentives to make the specialty of general practice more attractive. One essential challenge that needs to be addressed is how to develop more efficient communication between primary care and secondary/tertiary care. With current plans to reduce hospital admissions, it is hoped that some resources will be freed up and allocated to primary care, and that regional inequalities and imbalances can be addressed. An innovative move by the Health Ministry has been to link the payment of primary care physicians to shortened waiting lists, efficiency in referrals and the implementation of preventive programmes. The existence of private primary care poses further challenges – chiefly, how to take advantage of competition and how to make better use of publicly facilities by transferring them to private ownership.





What has the Regional Office been doing in Slovenia?

The WHO Regional Office for Europe has had a liaison office in Slovenia since 1993. In the period 2002–2003, the Regional Office helped the country to:

- consider what the guiding values of health care reform were
- implement a research strategy for health investment
- conduct a health impact assessment in agriculture
- develop a food safety and nutrition action plan and a national strategy for mental health
- scale up health prevention activities.

For 2004–2005, the Regional Office has agreed to provide Slovenia support in developing health system infrastructure and improving quality of care.

SOURCES OF INFORMATION ABOUT SLOVENIA

Web sites

Government of Slovenia

<http://www.sigov.si>

Governmental Public Relations and
Media Office in Slovenia
(in Slovene)

<http://evropa.gov.si>

Slovene Press Agency (STA)

<http://www.sta.si>

European Commission Delegation to Ljubljana

<http://www.evropska-unija.si>

ANNEX

ENVIRONMENTAL HEALTH RISKS

Data on environmental health risks are not included in the countries chapters because there are variations in the availability of statistics and records in this area. For instance, when reporting the availability of drinking water and sanitation, only two countries have provided information (and the figures range from 93% to 99% of the population with access to safe water and sanitation, while in EU-15 this figure is 100%). Still, in spite of certain insufficiency of data such as this, on some environmental health risk factors comparisons may be made and the general environment and health picture seen, as suggested by the table below.

	Indicators	Cyprus	Czech Republic	Estonia	Hungary	Latvia
Ambient air*	SO ₂ emissions kg/per capita per year	...	28	42	54	66
	Percentage of urban population exposed to PM ₁₀ ** above EU limits	...	73	...	100	...
Water and sanitation	Standardized mortality rate for diarrhoeal diseases, under 5 years of age (per 100 000)	...	0.2	0.0	0.6	3.1
Food safety	Incidence of Salmonellosis (cases per 100 000)	...	327	21	104	34
UV radiation	Incidence of melanoma (cases per 100 000)	...	8	5	7	4
Occupational risks	New cases of occupational diseases per 100 000	...	21	15	7	55
	Fatal occupational injuries (cases per 100 000)	2.4	1.8	2.6	1.7	2.2

Notes: * From a health viewpoint it is important to monitor what air gets into the human body, therefore to measure the ambient air - the air close to the earth which humans breathe, as opposed to atmospheric air which includes also the long-range air pollution.

Points to remember *environmental health risks*

- Ambient air quality is improving.
- Exposure to air pollutants is still a concern, especially for urban populations.
- The incidence of food-borne diseases of microbiological origin is higher than the EU-15 average in half of the ten new EU members.
- The incidence of reported occupational diseases is generally lower, while the reported occupational fatalities tend to be higher than in the EU-15.

Lithuania	Malta	Poland	Slovakia	Slovenia	EU-15 average	EU-15 highest	EU-15 lowest
41	...	36	39	14	14	51	3
...	...	100	89	100	33	100	0
1.3	0.0	0.3	0.8	1.1	0.5	3.5	0.0
37	35	51	361	86	41	104	3
3	5	6	5	7	5	26	2
35	7	73	15	23	42	454	0.3
2.4	1	1.4	1.6	1.6	1.5	3.6	0.4

** *PM10 are the suspended particulates in the ambient air (with diameter less than 10 micrometers) that enter deeply into the lungs and cause most of the health damage. EU limits as set by the EU legislation, is 40 micrograms per cubic meter PM10.*



Cyprus



Czech Republic



Estonia



Hungary



Latvia



Lithuania



Malta



Poland



Slovakia



Slovenia

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Cyprus



Czech Republic



Estonia



Hungary



Latvia



Lithuania



Malta



Poland



Slovakia



Slovenia

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GLOSSARY

Annual population growth rate (%): Indicator used in population studies to assess average change in the size of a population from one year to the next.

Dependency ratio: Indicator used in population studies to measure the portion of the population which is economically dependent on the active age group. It is calculated as the sum of 0-14 year olds and over 60 or 65 year olds, depending on the working age limit considered, divided by the number of people aged between 15 and 59 or 64, respectively. For the purpose of the World Health Report (which is the source used in this book), it is calculated as the sum of 0-14 year olds and over 65 year olds divided by the number of people aged between 15 and 64.

Disability-adjusted life years: years of healthy life lost due to premature mortality or disability.

General government expenditure on health as % of total expenditure on health: Public Health Expenditure is the sum of outlays on health paid for by taxes, social security contributions and external resources (without double-counting the government transfers to social security and extra-budgetary funds).

General government expenditure on health as % of total general government expenditure: Public Health Expenditure (PHE) is the sum of outlays on health paid for by taxes, social security contributions and external resources (without double-counting the government transfers to social security and extra-budgetary funds). General Government Expenditure corresponds to the consolidated outlays of all levels of government; territorial authorities (Central/ Federal Government, Provincial/Regional/State/District authorities, Municipal/ Local governments), social security institutions, and extra-budgetary funds, including capital outlays.

Healthy life expectancy (years), total population: Healthy life expectancy (HALE) is based on life expectancy, but includes an adjustment for time spent in poor health. This indicator measures the equivalent number of years in full health that a person (a newborn child or at age 60 years) can expect to live based on the current mortality rates and prevalence distribution of health states in the population.

Human development index: The human development index is a summary composite index that measures a country's average achievements in three basic aspects of human development: longevity, knowledge, and a decent standard of living. Longevity is measured by life expectancy at birth; knowledge is measured by a combination of the adult literacy rate and the combined primary, secondary, and tertiary gross enrolment ratio; and standard of living by GDP per capita (PPP US\$).

Infant mortality: deaths per 1000 live-born children aged less than one year.

Life expectancy: Life expectancy is the average number of years of life that a person can expect to live if they experience the current mortality rate of the population at each age.

Obesity: Obesity is the excessive accumulation of adipose tissue to an extent that health is impaired. It is usually determined using the body mass index (BMI). BMI is the standard measurement of choice for many health professionals based on a weight-to-height ratio. Overweight is defined as a BMI ≥ 25 and < 30 kg/m². Obesity is defined as a BMI ≥ 30 kg/m². Obesity correlates strongly with obesity related co-morbid conditions and mortality. The current obesity pandemic reflects the profound changes to society over the last 20-30 years that have created an environment that promotes sedentary lifestyle and the consumption of a high fat, energy dense diet.



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Per capita GDP: Gross domestic product (GDP) per capita is the per capita market value of the total final output of goods and services produced in a country over a specific period. The international dollar is a common currency unit that takes into account differences in the relative purchasing power of various currencies. Figures expressed in international dollars are calculated using purchasing power parities (PPP), which are rates of currency conversion constructed to account for differences in price level between countries.

Percentage of total life expectancy lost: Percent of total life expectancy lost is LHE expressed as a per cent of total LEX and represents the proportion of total life expectancy that is lost through living in health states of less than full health.

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

Total expenditure on health as % of GDP: Total health expenditure is the sum of Public Health Expenditure and Private Health Expenditure.

Total fertility rate: The average number of children a hypothetical cohort of women would have at the end of their reproductive period if they were subject during their whole lives to the fertility rates of a given period and if they were not subject to mortality. It is expressed as children per woman.

Total unemployment rate: Unemployed persons as a share of the total active population, as a percentage of the total active population aged 15-64.



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10 health questions about the 10



The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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Ten countries joined the 15 existing members of the European Union (EU) on 1 May 2004 – and so, after a period of accession, EU-15 became EU-25. The health status of their populations varies from country to country and, sometimes, it also differs from that of the people in the EU of 15. Likewise, there are different patterns of the development of their health systems. How does each of the new EU members compare in terms of health to the old EU members? This book offers a quick and easy way to grasp the essential features of health and health systems in the new member countries. Each chapter provides a concise overview of key health indicators in each of the ten newcomers, comparing these to EU-15 averages. It also summarizes the key aspects of the respective state's health system and describes what each has achieved after a decade of health reforms. The book is not a comprehensive in-depth study, rather, it is an easy guide to the knowledge available and is for anyone who wants to have a quick, straightforward and accurate entry point to understanding health in the ten new EU member states.

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