02

Progress towards the Health 2020 targets

Key messages

Within only a few years of the development of the Health 2020 policy, increasing numbers of countries are adopting and using its principles and approaches to improve citizens' health and well-being.

The WHO European Region is on track to achieve the Health 2020 target to reduce premature mortality from cardiovascular diseases, cancer, diabetes mellitus and chronic respiratory diseases by 1.5% annually until 2020. Most of the progress in the Region is the result of improvements in countries with the highest premature mortality.

Alcohol consumption, tobacco use and overweight and obesity remain major public health problems in the Region. Europe has the highest rates of alcohol and tobacco use in the world and WHO estimates show rises in the prevalence of overweight and obesity between 2010 and 2014 in almost all countries.

Despite high overall coverage for measles vaccination in the Region, immunity gaps in the population persist, resulting in ongoing endemic transmission and some countrywide outbreaks.

The gaps between the highest and lowest reported values for the Health 2020 indicators linked to the social determinants of health –

infant mortality, life expectancy, primary school enrolment and unemployment – have shrunk. Preliminary data suggest that this positive trend has continued since 2010, although absolute differences between countries remain large.

Out-of-pocket payments as a proportion of total expenditure on health at the regional level (24%) have not changed since 2010. In 2012, this proportion was below the 15% threshold critical for preventing catastrophic levels of health expenditure in only 12 of the 53 countries in the Region.

Introduction

This chapter reports on progress towards the Health 2020 targets at the regional level since the agreed 2010 baseline. Its structure follows the Health 2020 monitoring framework, developed for this purpose *(3)*, which defines targets, quantifications for those targets and core indicators for each of the three main Health 2020 areas: burden of disease and risk factors; healthy people, well-being and determinants; and processes, governance and health systems (see Table 1.1). The framework also contains additional indicators: countries are encouraged to use these for more informative monitoring at the national level but they do not track progress at the regional level. This chapter therefore reports on regional progress towards the Health 2020 targets only through the core indicators, but in some instances additional indicators are described to provide a more comprehensive overall picture.

As noted in the section on progress towards the Health 2020 targets in Chapter 1, targets and indicators already part of existing WHO or other policy frameworks were excluded (with one exception) from the Health 2020 monitoring framework. This chapter is therefore not a comprehensive overview of all public health areas of relevance to the European Region as it focuses solely on the areas and topics addressed in that framework.

This chapter uses indicators from WHO sources as a matter of preference. The data give a snapshot of the situation at the time of writing; WHO databases are updated regularly, so some of the regional averages and the maximum and minimum values presented will change in due course, as countries continue

to report to WHO. Further, data coverage at the regional level is not yet complete for several Health 2020 core indicators for the first few years since the 2010 baseline, which hinders the drawing of conclusions on progress towards the Health 2020 targets. More details about the indicators and data sources used and data availability can be found in Annex 1.

Target 1: reduce premature mortality in Europe

This Health 2020 target has three quantifications, which relate to premature mortality from major NCDs, vaccine-preventable diseases and external causes. A summary of progress and full descriptions of its related indicators are presented for each quantification.

Summary of progress: premature mortality from NCDs

The first quantification is an average annual reduction of 1.5% in combined premature mortality from four major NCDs until 2020. The core indicators linked to this are:
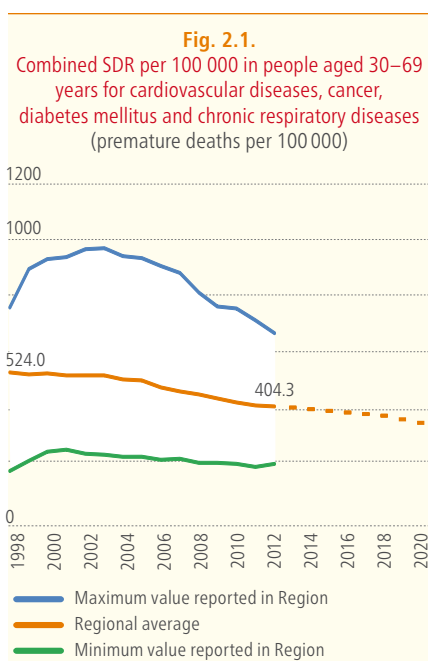
- overall premature mortality rate (from 30 to under 70 years) for four major NCDs (cardiovascular diseases, cancer, diabetes mellitus and chronic respiratory diseases);
- prevalence of current tobacco use among people aged 18 years and over;
- total per capita alcohol consumption among people aged 15 years and over;
- prevalence of overweight and obesity in people aged 18 years and over.

The average annual rate of reduction of premature mortality from the four major NCDs over the first three years of observations (2010–2012) is 2.0%. The Region is, therefore, currently on track to achieve the goal. The number of countries in the Region for which data are available for 2011 and 2012 is suboptimal, however (35 and 28 out of 53, respectively); this means that the reduction rate since 2010 should only be regarded as a preliminary estimate.

Alcohol consumption, tobacco use and overweight and obesity are among the major public health problems in the European Region. Country-reported data allowing assessment of developments in these risk factors at the regional level since 2010 were not available at the time of writing. Nevertheless, during the period 2005–2010 total alcohol consumption decreased by 10% in the Region, and this trend is expected to continue for several years. WHO estimates suggest that between 2010 and 2012 prevalence of tobacco use decreased in almost all countries for which data are available, but most are not on track to reach the global NCD target of a 30% relative reduction in current tobacco use by 2025 *(4)*. Alarmingly, WHO estimates for the prevalence of overweight and obesity show a rise between 2010 and 2014 in all 51 countries in the Region for which data are available.

Europe on track to reduce premature mortality

The average standardized death rates (SDRs) for premature mortality from the four major NCDs across the Region fell from 524 to 404 deaths per 100 000 people between 1998 and 2012, an average annual reduction of 1.8% (see Fig. 2.1). The rate of reduction accelerated during the period, from 0.8% in 1998–2005 to 2.6% in 2006–2012. To achieve the target of an average annual reduction of 1.5% from the 2010 baseline regional average to 2020, the SDR will need to decrease from 420 per 100 000 people to 361 per 100 000 (illustrated by the dashed line in Fig. 2.1). The average annual rate of reduction for 2010–2012 is 2.0%, indicating that the Region is on track to achieve the Health 2020 target. With available data from only 35 and 28 countries in the Region for 2011 and 2012 respectively, however, this should be regarded as a preliminary estimate, which will need to be assessed again once the remaining data are received.

Fig. 2.1 shows that the rate of decline in premature mortality from the four major NCDs since the mid-2000s has been much steeper in countries reporting the highest SDRs than in those reporting the lowest, where it remained virtually unchanged through the 2000s. Thus, progress in the regional average is due almost entirely to improvements in countries that started out with the highest levels of premature mortality. Caution is needed, however, in interpreting the maximum and minimum SDR trends because these represent the highest and lowest values reported in the

Fig. 2.1.
Combined SDR per 100 000 in people aged 30–69 years for cardiovascular diseases, cancer, diabetes mellitus and chronic respiratory diseases (premature deaths per 100 000)

Notes: International Classification of Diseases, tenth revision (ICD-10) codes used: cardiovascular dis eases: I00–I99, cancer: C00–C97, diabetes mellitus: E10–E14, chronic respiratory diseases: J40–47. The dashed line represents a trend of 1.5% annual decline in premature mortality to 2020 in accordance with the Health 2020 target, calculated using the average annual growth rate formula: $SDR_{time2} = SDR_{time1} \times (1+i)^n$, where i = growth rate of −1.5% and n = number of years.

Source: European detailed mortality database *(7)*.

Region in a given year and do not necessarily refer to the same country each year. They may, in some cases, reflect gaps or delays in national reporting, especially in recent years.

Cardiovascular diseases and cancer: leading causes of premature mortality

The Health 2020 indicators for premature mortality include deaths from cardiovascular diseases, cancer, diabetes mellitus and chronic respiratory diseases; these NCDs are largely responsible for deaths in people aged 30–69 years and are, to a great extent, preventable. Separate analysis of the relative contribution of each cause aids understanding of the overall premature mortality trend (see Fig 2.2).

Cardiovascular diseases include all the diseases of the heart and circulatory systems such as coronary heart disease, angina, heart attack, congenital heart disease and stroke. Ischaemic heart disease and strokes, in particular, were the leading causes of death in the Region in 2010 (8). Over half of premature mortality from the four major NCDs is due to cardiovascular diseases. Thus, the accelerated reduction in cardiovascular-related deaths from the mid-2000s has also driven the downward trend of overall premature mortality in the entire Region. This reduction may be a result of better preventive measures, such as people leading healthier lifestyles, and of improved life-saving measures for people who have suffered a heart attack or stroke.

Although the death rate for cancer has fallen gradually since the mid-2000s, the proportion of overall premature mortality from this cause has increased as the death rate from cardiovascular diseases has dropped faster. In 1998, cancer accounted for just over one third (37%) of premature mortality, and this has risen consistently to 43% in 2012.

Chronic respiratory diseases and diabetes mellitus account for the smallest share of premature deaths, at about 6% combined. Their contribution to premature mortality has remained unchanged over time (see Fig. 2.2).

Fig. 2.2.
SDR per 100 000 in people aged 30–69 years for cardiovascular diseases, cancer, diabetes mellitus and chronic respiratory diseases (premature deaths per 100 000)

- Cardiovascular diseases
- Cancer
- Chronic respiratory diseases
- Diabetes mellitus
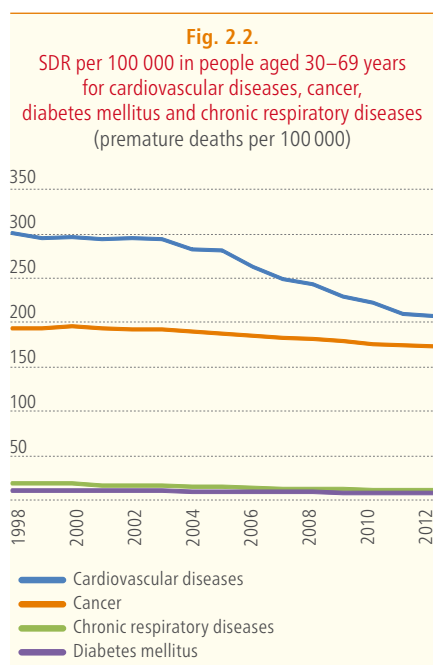
Note: ICD-10 codes used: cardiovascular diseases: I00–I99, cancer: C00–C97, diabetes mellitus: E10–E14, chronic respiratory diseases: J40–47.

Source: European detailed mortality database (7).

Countries not on track to reach global NCD target despite declining tobacco use

Between 2010 and 2012 prevalence of tobacco use among adults decreased in 39 of the 41 countries for which WHO estimates are available; the average reduction[1] was 1.8% *(9)*. Additional WHO analyses, however, show that only 11 countries in the Region are likely to meet the 30% reduction target of the global NCD monitoring framework by 2025 *(4)*: in most countries the degree to which the trend is declining is insufficient to reach the target *(10)*.

In 2012 the European Region had the highest regional average rate of tobacco use at 30%, although the rate varies considerably between countries. It also had the highest regional average rate of tobacco use among women. The highest and lowest national rates for smoking any tobacco product were 59% and 19% among men and 36% and 1% among women (see Fig. 2.3). It should be noted that these data are estimates, produced by WHO for the 2014 global status report on NCDs *(9)*. At the time of writing, no recent country-reported data were available to assess the developments since the Health 2020 baseline of 2010; trend data were only available for the period 2000–2008 *(11)*. These show a clear declining trend, however, and the 2010 and 2012 estimates suggest that this is continuing. This downward trend in tobacco use has contributed to a reduction in premature mortality and an increase in life expectancy over recent decades, particularly among men *(12)*.

The European Region's high rate of tobacco use means that it has one of the highest proportions of deaths attributable to tobacco use globally. WHO analyses in 2012 (based on 2004 data) showed that the proportion in adults over 30 in the Region was 16%. In contrast, the proportions in the African and Eastern Mediterranean regions were 3% and 7%, respectively; the global average is 12%. Almost one in five premature deaths in the European Region among those aged 30–44 years and one in three among those aged 45–49 years is attributable to tobacco use. Among NCDs, 85% of the deaths caused by cancer of the trachea, bronchus and lung and 16% of the deaths caused by ischaemic heart disease are attributable to tobacco use,
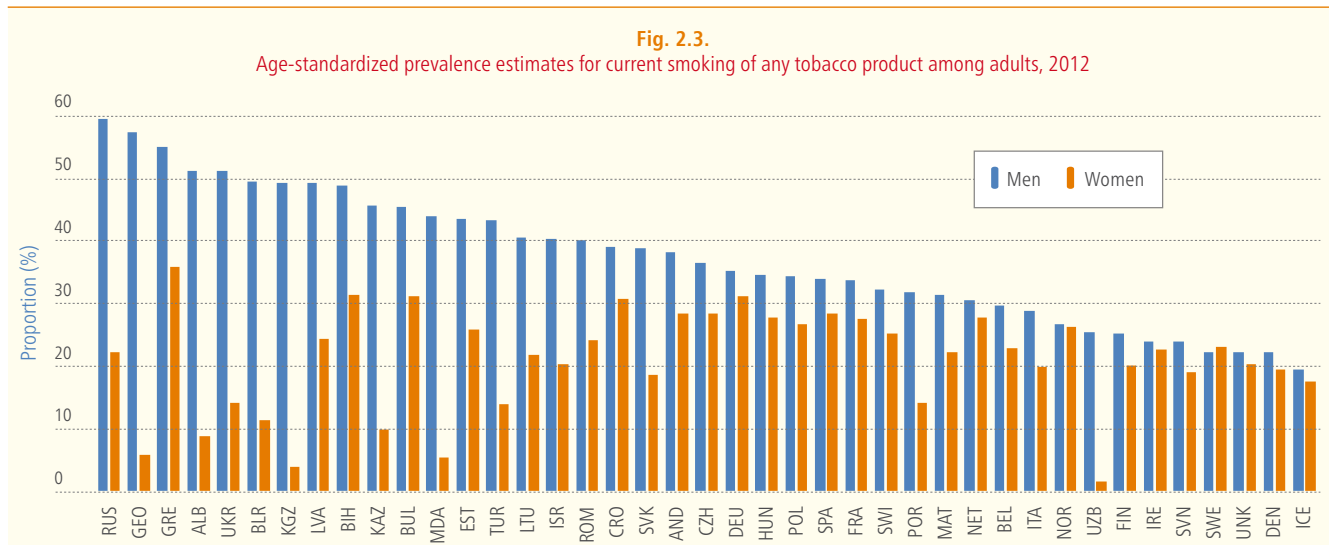
---

[1] Average unweighted reduction, calculated without taking the countries' population sizes into account.

as are 26% of tuberculosis deaths and 24% of all lower respiratory infection deaths among communicable diseases *(13)*.

The WHO Framework Convention on Tobacco Control, which entered into force in February 2005, is the world's first global public health treaty, designed to tackle the health, social, environmental and economic consequences of tobacco consumption and exposure *(14)*. There is ample evidence for the effectiveness of actions in different policy areas *(15, 16)*. For example, the scientific literature indicates that that just a few months after the implementation of smoke-free laws, the hospitalization of myocardial infarctions can decrease by 20–40% *(17)*.

European Region has highest levels of alcohol consumption and related harm

Alcohol intake in the European Region is the highest in the world, resulting in a higher prevalence of alcohol dependence and alcohol-use disorders than in other WHO regions (see Table 2.1). Nevertheless, levels of alcohol consumption vary greatly between European countries, ranging from 0.32 to 14.37 litres per capita annually (see Map 2.1). Similarly, levels of harmful alcohol use among the population aged 15 years and over differ widely

Fig. 2.3.
Age-standardized prevalence estimates for current smoking of any tobacco product among adults, 2012

Note: WHO uses standard methods to calculate estimates to maximize cross-country comparability. These data may therefore differ from the official statistics of Member States.

*Source:* Global status report on noncommunicable diseases 2014 *(9)*.

between countries, with 0.4% and 8.3% the lowest and highest levels in the Region in 2010 *(18)*. Unfortunately, regional data on alcohol consumption trends since 2010 are not yet available, but during 2005–2010 total alcohol consumption decreased by 10% in the European Region and this trend is expected to continue for several years *(19)*.

Table 2.1.
Per capita total alcohol consumption, prevalence of alcohol dependence and prevalence of alcohol-use disorders in WHO regions, 2010.

WHO region	Per capita (15+ years) total consumption (litres of pure alcohol)	Prevalence of alcohol dependence (%)	Prevalence of alcohol-use disorders (%)
Africa	6.0	1.4	3.3
Americas	8.4	3.4	6.0
Eastern Mediterranean	0.7	0.2	0.3
Europe	10.9	4.0	7.5
South-East Asia	3.5	1.7	2.2
Western Pacific	6.8	2.3	4.6
Global	6.2	2.9	4.1

Source: WHO Global Information System on Alcohol and Health *(18)*.

Map 2.1.
Recorded pure alcohol consumption, litres per capita, 15+ years

> 12
9–12
6–9
3–6
≤3
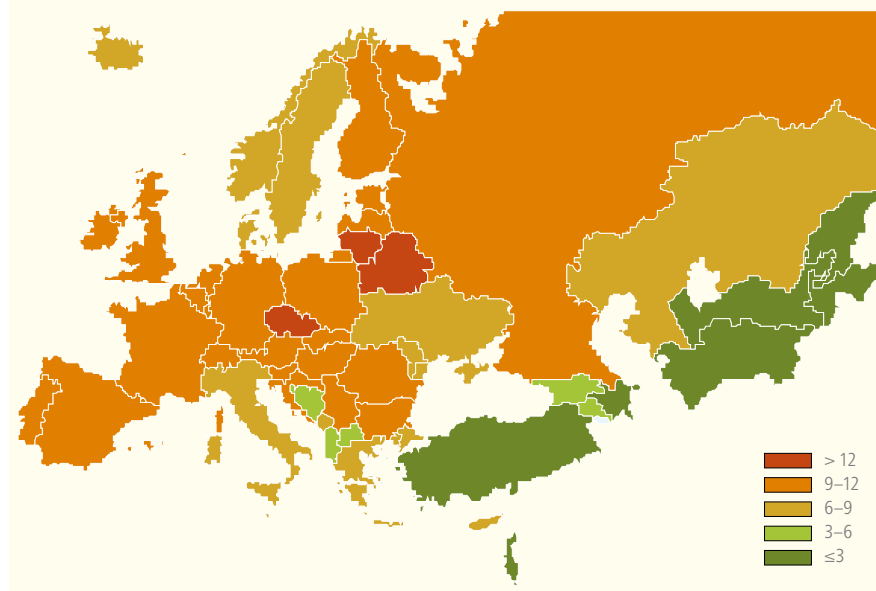
Note: data from latest available year, 2009–2012.
Source: European Health for All database *(11)*.

Europe has been at the forefront of action to reduce the harm done by alcohol: the European Region was the first to approve an alcohol action plan in 1992 and the European action plan to reduce the harmful use of alcohol 2012–2020 was endorsed by Member States in 2011. This includes a range of evidence-based policy options to reduce the harmful use of alcohol *(20)* (see Box 2.1). A strong body of evidence demonstrates the effectiveness and cost–effectiveness of policies such as interventions to regulate alcohol prices, limit alcohol availability and reduce drink–driving *(21, 22)*.

Prevalence of overweight and obesity alarmingly high and on the rise

In 2014 the prevalence of overweight – a body mass index (BMI) of 25 or above – in 51 countries in the European Region ranged from 44.9% to 66.9%, while the prevalence of obesity – a BMI of 30 or above – ranged from 13.6% to 29.5% (see Fig. 2.4). Estimates for 2010 were also produced by WHO for the 2014 global status report on

Box 2.1.
Alcohol and health in the European Region

Background
The Region has experienced a generally decreasing trend in alcohol consumption – a major risk factor for premature mortality – since 1990, but still has the highest rate of all WHO regions.

Policy action taken
In response to this, the European action plan to reduce the harmful use of alcohol 2012–2020 was endorsed by Member States in 2011. Within this plan's framework a joint European Commission/WHO survey was carried out in 2012 to monitor the policy situation in all European Union (EU) member states, accession and candidate countries, Norway and Switzerland (35 countries in total). It asked whether various policy areas had been strengthened, weakened or remained unchanged over the previous five years. Results below reflect the answers of all countries included in the survey except the five EU candidate countries.

Outcomes
The most positive developments were reported in awareness-raising (23 of 30 countries), drink–driving policies and countermeasures (22 countries) and monitoring and alcohol research (21 countries). Importantly, two thirds of the countries reported strengthening of action to control the availability of alcohol – one of the most effective interventions recommended by WHO to reduce harmful drinking. By 2012, 23 countries had a national policy on alcohol, and of the seven countries without policies, six were in the process of developing one. Those with a national policy indicated that it was multisectoral, with health, social affairs, transport/road safety, education, law enforcement, criminal justice and finance/taxation the most commonly represented sectors. All but one country reported having carried out some form of national awareness-raising activity in the previous three years; these addressed drink–driving (24 countries), alcohol and youth (21 countries) and alcohol and health (19 countries).

In 2011 two countries prohibited below-cost selling (selling for a price less than the production cost), two prohibited volume discounts, such as two-for-one offers, and five reported an additional levy imposed on specific products, such as alcopops and other ready-to-drink mixtures. In 2012 legislation was passed in one country to set a minimum unit price for alcohol, setting a floor price below which a given quantity of pure alcohol cannot be sold. The trend of declining alcohol use in the Region is encouraging: this increase in national policies will spur the trend further and ultimately reduce premature mortality caused by alcohol use *(23)*.

NCDs *(9)*: in all cases the prevalence for the 51 countries for which estimates could be produced is higher in 2014 than in 2010. Recent, regular country-reported data on overweight and obesity are lacking at the regional level.

Looking at the global picture, the prevalence of overweight and obesity is highest in the Region of the Americas (61% overweight and 27% obese in both sexes) and the European Region (58.6% overweight, 23% obese) and lowest in the South-East Asia Region (22% overweight, 5% obese). In the European, Eastern Mediterranean and Americas regions, over 50% of women are overweight and roughly half of these are also obese (25%, 24% and 30%, respectively). While men in the European Region are more likely than women to be overweight, women are more likely to be obese *(9, 24)*.

Obesity is one of the greatest public health challenges of the 21st century. Its prevalence has tripled in many countries in the European Region since the 1980s. In addition to causing various physical disabilities and psychological problems, excess weight drastically increases a person's risk of developing several NCDs, including cardiovascular diseases, cancer and diabetes mellitus *(25)*. Several WHO Regional Office for Europe programmes work on tackling the obesity epidemic in the Region, including those focusing not only on physical activity and diet but also on socioeconomic determinants, cardiovascular diseases, diabetes mellitus, cancer and child and adolescent health.

Fig. 2.4.
Age-standardized prevalence estimates for overweight and obesity in adults aged 18 years and over, 2014
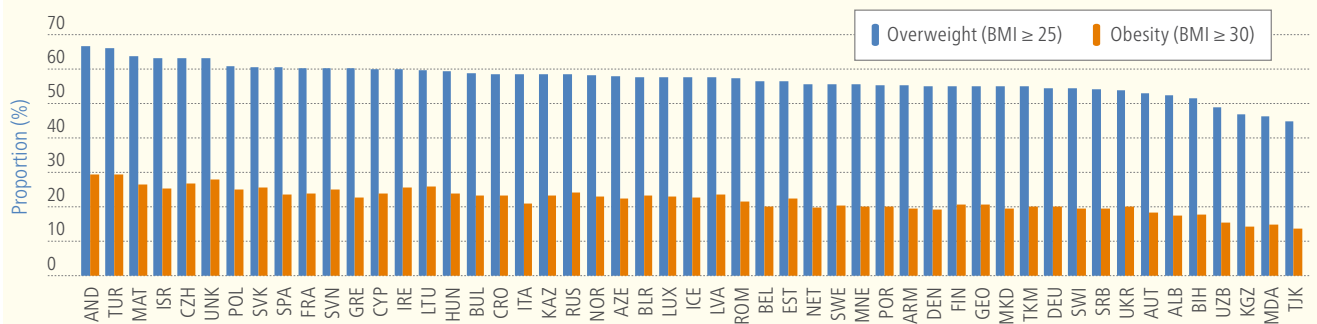
Note: WHO uses standard methods to calculate estimates to maximize cross-country comparability. These data may therefore differ from the official statistics of Member States.

Source: Global status report on noncommunicable diseases 2014 *(9).*

The European Region was the first to develop a dedicated strategy for physical activity. In the Vienna Declaration on Nutrition and NCDs *(26)*, alongside the European food and nutrition action plan for 2015–2020 *(27)*, Member States called for a strategy to encourage physical activity across all population groups with a view to promoting well-being using a whole-of-society approach and tackling the burden of obesity and NCDs. Recently published 2010 WHO estimates underline the necessity of such a policy, showing that about 20% of men and 25% of women in the European Region are insufficiently physically active *(9)*. The sixty-fifth session of the WHO Regional Committee for Europe is expected to consider the strategy in September 2015.

WHO also supports policy action by compiling information about the effectiveness of interventions targeting overweight and obesity: for example, in publications of the Health Evidence Network (HEN) *(28)*. The data presented in this section suggest that the potential gains in improved health and reduced premature mortality from tackling overweight and obesity in the Region are substantial.

## International study shows overweight in 23% of 11-year-olds

An additional indicator for this Health 2020 target quantification is the prevalence of overweight and obesity among adolescents. The Health Behaviour in School-aged Children (HBSC) study, in which 36 European countries or subnational regions, the United States of America and Canada participate *(29)*, reported in 2012 that 11–33% of 11-year-olds were overweight or obese, based on self-reported data for weight and height. The average prevalence of overweight and obesity was 23% among 11-year-olds, 19% among 13-year-olds and 16% among 15-year-olds. In all participating European countries and regions, boys had higher rates of overweight and obesity than girls, often substantially so *(29)* (see Fig. 2.5).

The HBSC study focuses on adolescents. To monitor changes in overweight in children of primary school age, the WHO Regional Office for Europe established the Childhood Obesity Surveillance Initiative (COSI) (see Box 2.2).

As with adults, the two main risk factors for overweight and obesity in adolescents are an unhealthy diet and a lack of physical activity. The HBSC study showed that in 2009/2010 the proportion

Box 2.2.
COSI

COSI was established in 2007 to monitor changes in overweight in children of primary school age. Anthropometric results of COSI round 2 (2009/2010) explored changes in BMI and overweight among children within and across nine countries from school years 2007/2008 to 2009/2010. Using cross-sectional nationally representative samples of 6–9-year-olds, the study derived BMI, anthropometric Z-scores and overweight prevalence from measured weight and height. The Z-score system expresses the anthropometric value as several standard deviations or Z-scores below or above the reference mean or median value (30). Significant changes between rounds were assessed. At round 2, the prevalence of overweight and obesity ranged from 18% to 57% among boys and from 18% to 50% among girls; the prevalence of obesity ranged from 6% to 31% among boys and from 5% to 21% among girls. Southern European countries had the highest overweight prevalence. Between measurement rounds, the absolute change in mean BMI (range: from −0.4 to +0.3) and BMI-for-age Z-scores (range: from −0.21 to +0.14) varied statistically significantly across countries. The highest significant reduction in BMI-for-age Z-scores was found in countries with higher absolute BMI values and the highest significant increase in countries with lower BMI values *(31, 32)*.

of adolescents eating breakfast every school day and eating fruit daily decreased with age, while soft drink consumption increased with age *(33)*. It also showed that the proportion of 11-year-olds reporting participation in moderate to vigorous physical activity for at least one hour daily ranged from 10% to 43% for boys and from 7% to 31% for girls. Physical activity rates for the 13- and 15-year-old respondents were even lower *(29)*.

These figures imply that increasing physical activity among children and adolescents is an important area for policy action to tackle overweight and obesity. A recent survey conducted by the WHO Regional Office for Europe showed that more than 90% of countries reported having policies specifying requirements for a minimum level of physical education hours in schools and for the equipment needed for kindergartens and schools with exercise facilities. Only 20% of countries responding, however, reported having policies requiring bicycle lanes leading to schools and just 35% reported having measures to facilitate walking to schools. These results underscore the difficulty of developing intersectoral policies, which require the integration of education with urban planning and transport policies, to create more supportive and safer environments for children to be more active physically in all settings of daily life *(34)*.

Fig. 2.5.
Prevalence of overweight and obesity among adolescents aged 11 years, 2009/2010
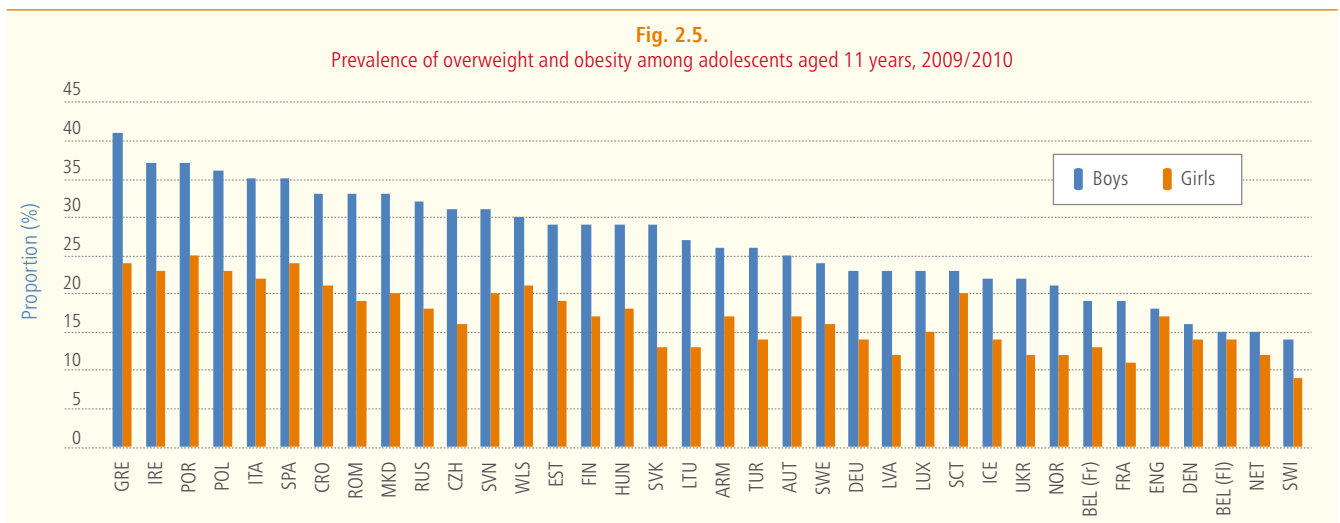
Note: overweight and obesity allocated based on the WHO growth reference for school-aged children and adolescents aged 5–19 years to monitor growth.
The findings show the proportions with a BMI greater than one standard deviation above the average WHO reference BMI for their age.

Source: Currie et al. *(29)*.

Summary of progress: vaccine-preventable diseases

The second quantification for Health 2020 target 1 is sustained elimination of selected vaccine-preventable diseases, for which the core indicator is the percentage of children vaccinated against measles, poliomyelitis (polio) and rubella. As children today are usually vaccinated against measles, mumps and rubella in combination, this chapter reports only on measles and polio vaccination.

Average vaccination coverage for measles in the European Region increased from 93.4% in 2010 (Health 2020 baseline) to 93.7% in 2011 and 94.6% in 2012. Although overall coverage is steadily increasing, several countries have ongoing endemic transmission, and some have experienced nationwide outbreaks. More action is therefore needed to achieve the target of eliminating measles, particularly focusing on closing immunity gaps in the population by improving subnational and second-dose coverage rates and by reaching specific population groups.

Average vaccination coverage for polio in the Region was 94.7% in 2010, 94.4% in 2011 and 95.4% in 2012. Constant vigilance is needed as polio outbreaks in other WHO regions and suboptimal immunization coverage in some areas in the European Region still pose a threat.

### Measles cases increase despite improved overall vaccination coverage

Vaccination coverage for measles increased steadily in the European Region from 81% in 1990 to about 95% in 2012 (see Fig. 2.6 and Map 2.2). From 93.4% in 2010, it grew to 93.7% in 2011 and 94.6% 2012. Nevertheless, after a historically low incidence rate in 2007–2009, measles has resurged: over half the countries in the Region reported measles cases for 2013, amounting to a total of 31 685 cases. Nine countries, in both the western and eastern parts of the Region, reported over 1000 cases each.

While national-level coverage with a first dose of measles- and rubella-containing vaccines is generally high throughout the Region, subnational and second-dose coverage rates are still unacceptably low in many countries. Most outbreaks occurred

in the general population; some, however, affected particular groups, such as communities that refuse vaccination on religious grounds. In 2013 over a third of cases across the Region were aged 20 years and over. This shows that adults who were not immunized when measles vaccination programmes were first implemented have emerged as a susceptible group in many countries *(35)*. The European Vaccine Action Plan 2015–2020 is a regional interpretation of the Global Vaccine Action Plan developed to address the specific needs and challenges related to immunization in the Region *(36)*.

Polio transmission outside Europe underlines need for constant vigilance

Overall vaccination coverage for polio in the Region rose from about 87% in 1990 to 94.7% in 2010, 94.4% in 2011 and 95.4% in 2012 (see Fig. 2.6). In June 2013 the European Regional Commission
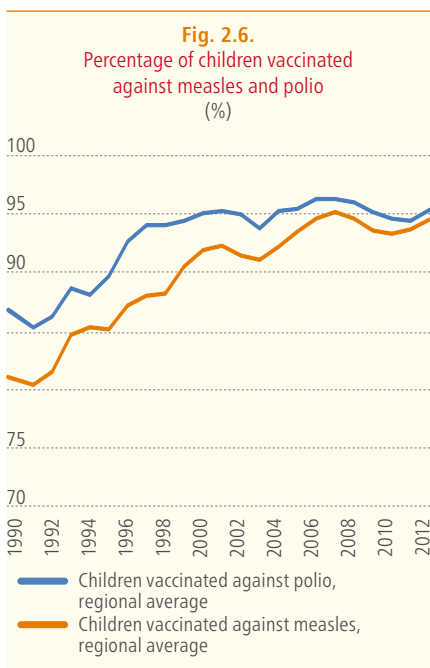
Fig. 2.6.
Percentage of children vaccinated against measles and polio
(%)

Children vaccinated against polio, regional average
Children vaccinated against measles, regional average

Note: shows percentage of children vaccinated against measles (1 dose) by their second birthday and percentage of infants fully vaccinated against polio (3 doses) by their first birthday in the given calendar year.

Source: European Health for All database *(11)*.
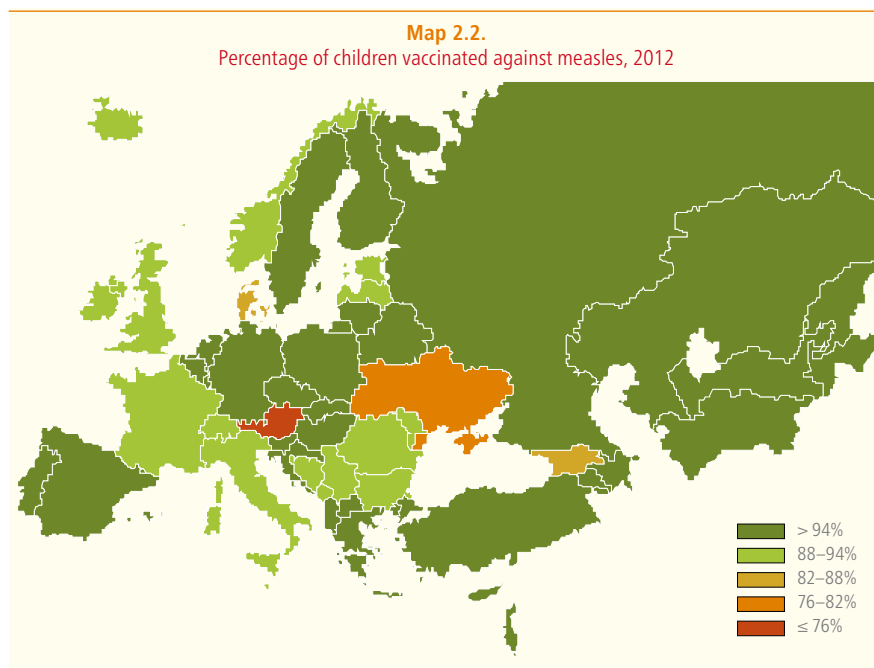
Map 2.2.
Percentage of children vaccinated against measles, 2012

> 94%
88–94%
82–88%
76–82%
≤ 76%

Note: shows percentage of children vaccinated against measles (1 dose) by their second birthday..
Source: European Health for All database *(11)*.

for the Certification of Poliomyelitis Eradication (RCC) assessed the risk of continued transmission following importation of poliovirus in each of the 53 countries in the Region: it deemed that 18 countries were at intermediate risk and four at high risk. Moreover, the presence in environmental samples and the transmission of wild poliovirus were detected in one country. Surveillance was enhanced; in 2014, after a six-month absence of transmission, RCC concluded that wild poliovirus transmission in this country had stopped. These developments, as well as polio outbreaks seen in previously polio-free areas in other regions in 2013, serve as a stark reminder of the need for constant vigilance to maintain the European Region's polio-free status *(35)*. Polio outbreak simulation exercises (POSEs) can be a good way to strengthen polio outbreak preparedness (see Box 2.3).

Box 2.3.
Polio outbreak preparedness in the European Region

Background
Significant progress has been made since the Global Polio Eradication Initiative began *(37)*. Nevertheless, wild poliovirus remains endemic in three countries (Afghanistan, Nigeria and Pakistan) and importation-related outbreaks continue to occur in polio-free areas, most recently in the Syrian Arab Republic, so polio-free areas of the world need to remain vigilant. The European Region, which has been certified polio-free since 2002, experienced an importation-related outbreak in 2010. Although the risk of poliovirus transmission after importation is low within the Region, RCC noted that national poliovirus response action plans were incomplete or absent in many countries and recommended that those plans be tested to ensure their preparedness in case of future outbreaks.

Policy action taken
To meet this recommendation a series of POSEs was carried out to explore countries' coordination and planning capacities in response

to detecting a poliovirus outbreak. The exercises took place around the Region in 2012–2013 and included participants from Armenia, Azerbaijan, Bosnia and Herzegovina, Georgia, Montenegro, Serbia, Ukraine and the United Kingdom of Great Britain and Northern Ireland. Participants were encouraged, as part of the exercise, to analyse and update their national response plans to improve detection of poliovirus importation and to increase preparedness. POSEs addressed elements of the response plans – such as their coordination, communication and collaboration at both national and international levels – and facilitated participants' identification of strengths and challenges to improve their countries' responses.

Outcomes
The POSEs demonstrated that the participating countries were generally prepared for a potential introduction of poliovirus but that the level of preparedness needed improvement. Strengths and weaknesses were revealed for each country and useful

information to address shortcomings was presented. Country reports to RCC in 2013 and 2014 indicated that much has been done since the initial POSE was carried out. For example, paediatricians and epidemiologists have defined common strategies for immunizing traditionally underserved population groups, including training mediators within those groups, mapping their settlements and developing promotional materials in local dialects and languages. Continuing education for all health professionals has also been established.

POSEs have helped familiarize participating countries with each other's preparedness plans and promoted better understanding and cooperation between countries and international organizations. The experiences and lessons learnt are transferable to other vaccine-preventable diseases and have been endorsed by RCC to be extended to other countries and subnational areas *(38)*.

Summary of progress: external causes

The third quantification for Health 2020 target 1 is the reduction of mortality from external causes, for which the core indicator is SDRs from all external causes and injuries (ICD-10 codes V01–V99, W00–W99, X00–X99 and Y00–Y98).

The mortality rate from all external causes and injuries in the Region has been declining since 2002. In 2010 (Health 2020 baseline) the rate was 60.9 per 100 000 people; in 2011 it was 60.2 per 100 000. The 2011 regional average, however, is based on data from a limited number of countries and thus needs to be reassessed when the majority of countries have reported mortality data to WHO.

Mortality from external causes and injuries declining since 2002

The mortality rate from all external causes and injuries in the Region shows a steady decline since the early 2000s. In recent years this decline seems to have stagnated; in 2010 the rate was 60.9 per 100 000 people; in 2011 it was 60.2 per 100 000. It should be noted, however, that the regional average for 2011 is based on data from a limited number of countries (see Table A.2 in Annex 1), so this should be regarded as a preliminary figure to be reassessed when the majority of countries have reported mortality data to WHO.

In particular, male mortality rates from external causes and injuries have declined in recent years, reducing the gap between men and women to 72.6 in 2010 and 71.9 in 2011. Although this is a positive development, the male–female gap in absolute terms is still considerable (see Fig. 2.7).

### Men comprise 75% of people dying in road traffic accidents

An additional indicator for this Health 2020 target quantification breaks down the overall mortality rates by cause, including motor vehicle traffic accidents and suicides, among others. The data show that mortality rates are consistently higher for men than for women across specific external causes of death (see Table 2.2). Of people dying in motor vehicle traffic accidents in the Region, 75% are men and more than half are aged 15–44 years (54%) (39). Although road traffic injuries cause relatively fewer deaths among

older people, this group is especially vulnerable: people's ability to cope with difficult traffic situations declines gradually with age and they become more fragile physically *(40)*.

In 2010, 92 500 people died from road traffic injuries, 25% fewer than those reported in 2007. During this period, the number of registered vehicles increased by 6%, suggesting that road safety interventions have had mitigating effects despite increased exposure *(39)*. Injury prevention is on the agenda of many governments: a 2013 study by WHO and the European Observatory on Health Systems and Policies concluded that numerous evidence-based policies in road safety exist within Europe, but that their implementation varies considerably. Where implemented successfully, these policies appear to have led to a marked reduction in road traffic injury mortality *(42)* (see Box 2.4). Indeed, intercountry differences in mortality from road traffic accidents are considerable (see Table 2.2), showing that in many countries there is still extensive room for improvement.

Suicide remains important health problem despite declining trends

Mortality from suicide and self-inflicted injury shows a downward trend in the Region, with mortality rates declining from 19.8 per

Fig. 2.7.
SDRs from all external causes and injuries, overall and by sex
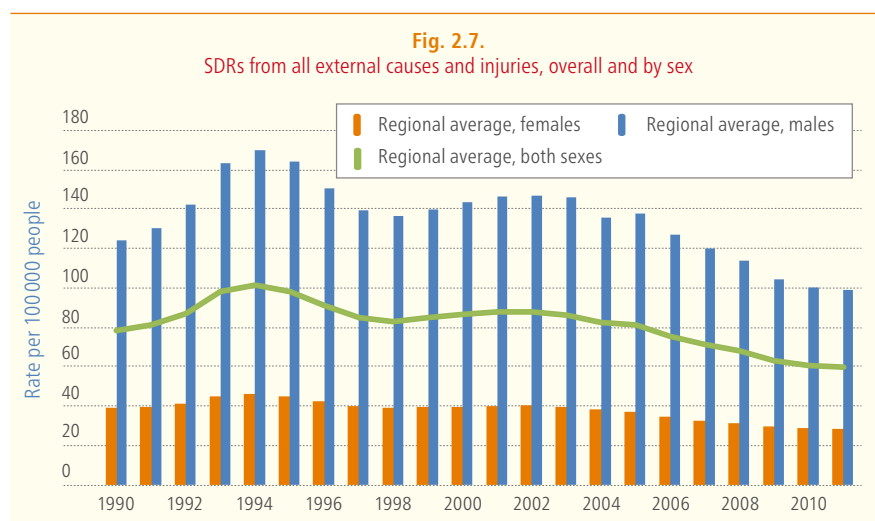
Source: European Health for All database *(11)*.

Table. 2.2.
SDRs from external causes of death per 100 000 people, by sex

Location	Motor vehicle traffic accidents		Accidental falls		Accidental poisoning		Accidental poisoning by alcohol		Suicide and intentional self-harm		Homicide and assault	
	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males
Regional average	4.3	14.4	3.1	7.5	3.0	11.0	0.9	3.9	4.8	21.3	1.8	5.6
Armenia	2.1	11.9	0.1	1.2	0.2	0.6	0.0	0.1	1.2	4.4	0.8	2.7
Austria	2.7	7.9	3.9	8.9	0.1	0.3	0.0	0.0	6.0	20.6	0.4	0.6
Belarus	–	–	3.8	19.1	2.7	16.1	–	–	8.5	46.9	3.7	8.0
Belgium	3.4	11.5	6.8	9.7	1.3	2.5	0.1	0.4	9.2	24.9	0.7	1.4
Bosnia and Herzegovina	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.0
Bulgaria	2.7	7.7	1.2	4.5	0.6	1.7	0.2	0.5	3.1	14.6	0.7	1.7
Croatia	2.3	15.5	11.7	17.8	1.5	3.8	0.2	0.7	6.1	25.3	0.6	1.7
Cyprus	2.8	15.3	1.9	3.7	0.4	2.9	0.0	0.0	1.0	6.0	1.4	1.0
Czech Republic	2.7	9.0	3.1	7.3	2.3	4.9	1.1	2.9	4.3	23.9	0.7	0.9
Denmark	1.5	5.1	4.4	6.6	1.9	6.1	0.2	0.2	4.7	14.6	0.4	1.1
Estonia	3.0	11.9	2.4	8.8	6.7	33.6	3.8	15.5	4.5	26.7	1.6	7.9
Finland	2.2	7.0	7.9	19.5	5.6	19.5	2.5	10.4	7.0	25.0	1.3	2.4
France	2.4	9.5	3.7	6.8	1.5	3.0	0.2	0.8	7.4	22.9	0.4	0.8
Georgia	0.6	2.5	0.1	0.3	0.3	0.7	0.0	0.3	0.6	4.5	0.2	0.5
Germany	1.8	5.7	4.7	7.4	0.3	1.0	0.1	0.2	4.8	14.8	0.5	0.5
Greece	4.2	17.1	1.4	4.2	0.7	3.7	0.0	0.0	1.3	6.2	0.5	2.5
Hungary	3.2	10.1	8.2	15.6	0.6	1.7	0.1	0.3	8.2	34.5	1.0	1.7
Iceland	0.7	6.3	5.4	6.5	1.3	2.0	0.0	0.0	4.6	18.2	0.0	0.6
Ireland	2.1	6.0	3.9	5.5	3.5	8.7	1.6	2.7	4.5	17.3	0.2	1.4
Israel	2.5	7.4	0.9	2.2	0.0	0.1	0.0	0.0	2.4	9.5	1.0	3.5
Italy	2.5	10.8	1.8	4.0	0.3	1.0	0.0	0.1	2.2	8.9	0.4	1.1
Kazakhstan	–	–	1.7	5.7	7.3	26.1	–	–	7.6	40.8	3.6	16.2
Kyrgyzstan	9.1	27.8	0.8	4.4	4.4	22.6	2.6	15.5	4.0	17.2	3.0	12.7
Latvia	4.0	12.7	2.6	12.9	2.9	14.0	1.9	9.5	5.0	36.6	2.8	9.5
Lithuania	3.7	15.7	3.1	14.2	5.9	26.9	3.4	15.5	9.1	51.4	2.7	7.5
Luxembourg	3.5	7.3	4.1	10.2	3.0	3.5	1.5	1.4	5.9	13.1	0.0	0.9
Malta	2.2	6.5	3.0	7.7	0.0	0.5	0.0	0.0	0.0	9.2	1.0	0.0
Montenegro	4.4	10.1	0.3	4.5	0.0	0.3	0.0	0.0	8.5	25.5	1.1	3.1
Netherlands	1.7	4.7	5.3	7.1	0.4	1.2	0.1	0.1	5.6	12.7	0.6	1.1
Norway	1.4	4.4	4.0	7.3	3.5	8.7	0.3	1.1	5.6	14.1	0.3	0.8
Poland	3.9	15.6	4.9	11.7	1.0	5.6	0.6	4.6	3.4	26.7	0.6	1.4
Portugal	3.5	12.9	1.2	3.0	0.1	0.3	0.0	0.1	3.3	13.0	0.5	1.3
Republic of Moldova	5.9	18.3	2.0	7.8	4.4	14.3	2.2	8.2	5.4	26.9	3.5	7.8
Romania	4.8	16.4	2.1	10.0	2.4	7.2	0.8	3.8	3.7	20.8	1.3	3.1
Russian Federation	–	–	2.8	10.6	9.3	38.7	–	–	6.6	39.5	5.6	20.5
Serbia	2.7	10.1	1.5	4.2	0.3	0.9	0.1	0.2	6.1	22.3	0.9	2.2
Slovakia	3.3	11.1	3.4	12.5	1.0	3.5	0.7	2.7	3.0	19.4	0.9	1.3
Slovenia	2.4	10.7	11.5	22.8	1.3	4.5	0.4	1.8	6.1	29.3	0.4	0.4
Spain	1.7	7.0	1.9	3.6	0.6	2.0	0.1	0.1	2.6	9.1	0.4	1.0
Sweden	1.2	3.8	3.2	6.6	1.9	6.2	0.4	1.8	5.9	16.4	0.6	1.4
Switzerland	1.4	5.2	8.1	12.2	1.1	3.1	0.2	0.5	6.2	16.5	0.5	0.5
The former Yugoslav Republic of Macedonia	3.1	9.5	3.3	4.1	0.5	1.4	0.0	0.2	3.1	8.3	1.2	3.0
Turkey	3.0	10.4	4.6	6.6	0.3	0.5	0.0	0.1	0.8	2.5	0.5	2.0
Ukraine	–	–	1.8	8.5	5.0	23.6	–	–	5.7	32.5	2.4	7.3
United Kingdom	1.5	4.8	3.4	5.4	1.8	4.3	0.5	0.9	2.9	10.1	0.2	0.4

Note: data from latest available year, 2009–2012; regional averages for 2011. Countries for which no data are available for this time period are not included.

Source: European mortality database *(41).*

100 000 people in 1994 to 12.6 in 2010 and 2011 *(11)*. Nevertheless, it is still an important health problem: six of the 20 countries with the highest suicide rates in the world are in the European Region. Young adults are particularly at risk, with suicide accounting for 17.6% of all deaths among people aged 15–29 years in high-income countries. It is ranked the second leading cause of death after road traffic accidents both globally and in Europe among this age group *(43)*. Older people are also at high risk for suicide, and the overall suicide rate in the European Region is higher than in other regions, illustrating the need to address suicide prevention actively in this age group *(44, 45)*. Mortality rates from suicide and intentional self-harm for all ages differ widely between countries, with the highest rate in the Region among men an alarming 51.4 per 100 000 people (see Table 2.2). A 2014 WHO report proposes practical guidance on strategic actions that governments can take

---

Box 2.4.
Reducing road traffic accidents in the Russian Federation

Background
Developments over time in mortality from transport accidents in the Russian Federation have shown a mixed picture, with upward and downward trends at different periods. Nevertheless, comparisons with other parts of the European Region showed an increasing gap, which required action.

Policy action taken
A federal road safety improvement target programme for 2006–2012 was implemented to reduce transport-related mortality. Key components included:

- improvement in driver training standards;
- modernization of the road infrastructure;
- introduction of mechanisms to improve compliance with traffic regulations;
- strengthened enforcement of legal measures in cases of misconduct;
- reductions in the time interval between the crash and the arrival

of emergency services to the crash scene;
- improved speed and coordination of the medical response.

Outcomes
Male and female mortality rates decreased by an average of 26.2% and 29.4% respectively between 2005 when the programme was introduced and 2013, suggesting a positive impact. Declining trends were observed in all age groups. In working-age adults aged 20–39 years the observed reduction in mortality rates was 20.8% for men and 22.2% for women. Among people aged 60 years and over the reduction was greater, at 35.5% for men and 39.9% for women.

Pedestrians are frequently victims of transport accidents; thus, the programme also had a significant impact on pedestrian mortality. Owing to a reduction in mortality of 45.7% in men and 45.2% in women, pedestrian fatalities as a proportion of all transport-related fatalities declined from 40.1% to 29.5% in

men and from 49.2% to 38.2% in women. Since pedestrians are frequently older people, this suggests that the programme had a greater effect on mortality in this age group.

Subnational variations in mortality due to different levels of infrastructure development and traffic intensity in various regions (oblasts) were striking. In 2013 the variation was 14-fold in death rates in men (ranging from 5.8 to 82.2 per 100 000 people) and 30-fold in women (ranging from 0.9 to 30.3 per 100 000) among the regions. Between 2005 and 2013 mortality from transport accidents decreased in 69 out of 82 regions.

The significant initial reductions begun to slow down after 2010, however: during 2010–2013 mortality decreased by only 1.1% among women, while it increased by 3.1% among men. To ensure the sustainability of the positive changes achieved in the Russian Federation, a follow-up programme for 2013–2020 has been approved.

on the basis of their resources and existing suicide prevention activities. In particular, it recommends effective evidence-based and low-cost interventions, even in resource-poor settings *(46)*.

Target 2: increase life expectancy in Europe

Summary of progress

The quantification for this Health 2020 target is a continued increase in life expectancy at the current rate (the annual rate for the period 2006–2010), coupled with reducing differences in life expectancy in the Region. The core indicator is life expectancy at birth.

Average life expectancy at birth in the Region has been increasing since the 1990s. At the time of writing, insufficient information was available to enable assessment of the rate of change in life expectancy at the regional level since the Health 2020 baseline in 2010. Differences between countries in the Region and between men and women have decreased over time. This positive trend seems to have continued in the period 2010–2011, although the limited data availability does not permit sound conclusions. Nevertheless, the gaps remain considerable.
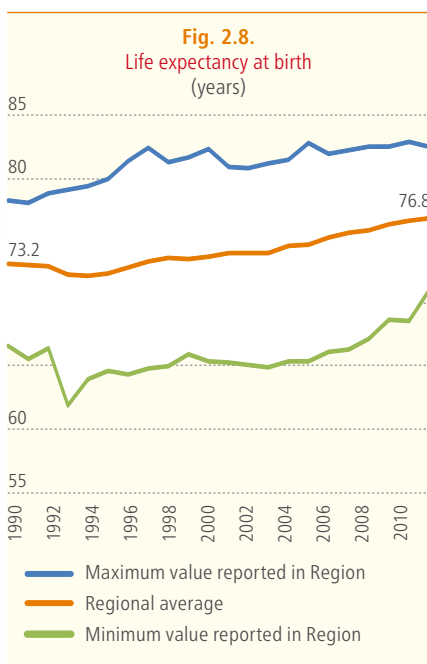
Gap in life expectancy at birth between countries still more than a decade

The Health 2020 target stipulates a continued increase in life expectancy at the annual rate for 2006–2010. The average annual increase in this period was 0.26 years, indicating accelerated progress compared to the previous period (1990–2005), when it was only 0.09 years. Average life expectancy at birth in the European Region was 76.6 years in 2010 and 76.8 years in 2011 (Fig. 2.8). At the time of writing, the regional average for 2012 could not yet be calculated reliably because data for that year were available for only a minority of countries. This will therefore be reported in the Regional Office's 2015 edition of core health indicators. Assessment of the longer-term time trend shows that in 1993 the average life expectancy in the Region took a sharp downturn;

Fig. 2.8.
Life expectancy at birth
(years)

Legend:
— Maximum value reported in Region
— Regional average
— Minimum value reported in Region

Source: European Health for All database *(11)*.

this was related to the social and economic crisis following the break-up of the USSR *(47)*.

The gap between the highest and lowest life expectancy figures for most years since the early 1990s has been 16 years on average. In 2009 and 2010, however, it was reduced to about 14 years, and it fell to only 11 years in 2011. This gap is considerably smaller than in previous years, but since only 25 countries had reported 2011 life expectancy data at the time of writing this should be interpreted with caution: minimum and maximum values will be updated when the remaining countries report their data to WHO.

The regional averages for male and female life expectancy show similar rates of increase since 1990 (see Fig. 2.9). Assessment of the gap in life expectancy by sex since 1990 shows that women consistently live on average about 8 years longer than men. The greatest difference of around 8.5 years occurred in the years 1994 and 1995; this is probably explained by the effects of the crisis after the dissolution of the USSR *(48)*. Since 2002 the gap has reduced to 7–8 years, mainly due to steeper gains in male life expectancy in the Commonwealth of Independent States (CIS).

The reduction in differences in average life expectancy in the Region between countries and between men and women is a positive sign; nevertheless, the remaining gaps are still large.
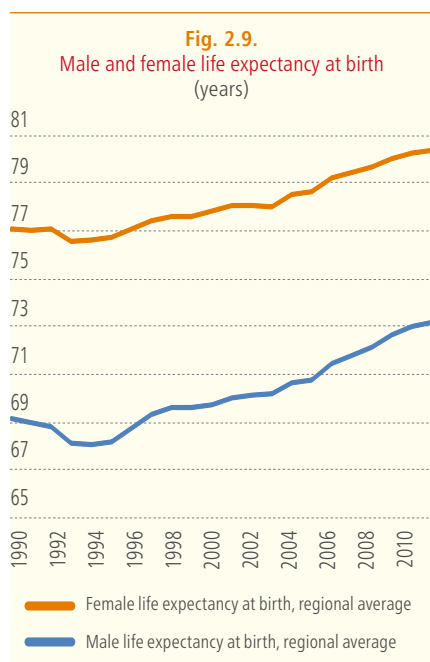
Life expectancy above average at birth and below at age 65 in some countries

An additional indicator for this Health 2020 target quantification is life expectancy at ages 1, 15, 45 and 65 years; this subsection looks at life expectancy at age 65. In some countries both male and female life expectancy is above the regional average at birth but below it at age 65. In some countries both male and female life expectancy at birth and at age 65 are lower than the regional average, while in others life expectancy for only one sex is lower (see Table 2.3). Life expectancy at age 65 at the regional level shows an upward trend, having increased from 15.7 years in 1993 to 18.0 in 2011 *(11)*.

A 2014 study looked into the causes of increases in life expectancy at age 60, primarily in high-income countries, and concluded that

Fig. 2.9.
Male and female life expectancy at birth
(years)

— Female life expectancy at birth, regional average

— Male life expectancy at birth, regional average

Source: European Health for All database *(11)*.

improvements were mainly the result of reductions in tobacco use (for men) and in cardiovascular disease mortality (for both men and women). The different timing of trends in tobacco smoking behaviour in men and women in high-income countries (known as the tobacco epidemic *(49)*) is likely to explain the different patterns seen in this study between the sexes. The increase in obesity and consequent diabetes mellitus type II prevalence could limit future rates of improvement in older age mortality, as could the increasing prevalence of dementia due to the ageing population *(12)*.

Table. 2.3.
Male and female life expectancy at birth and at age 65

Country	Life expectancy at birth		Life expectancy at age 65		Country	Life expectancy at birth		Life expectancy at age 65	
	Male	Female	Male	Female		Male	Female	Male	Female
Regional average	73.1	80.3	15.9	19.6	Latvia	68.9	79.0	13.7	18.6
Albania	73.7	78.9	14.9	17.8	Lithuania	68.0	79.0	13.6	18.5
Andorra	77.4	84.2	—	—	Luxembourg	79.2	83.9	18.2	21.7
Armenia	71.3	77.8	14.3	17.0	Malta	78.8	83.1	17.8	21.1
Austria	78.4	84.0	18.2	21.8	Montenegro	73.3	78.0	15.2	17.3
Azerbaijan	71.3	76.3	14.5	16.3	Netherlands	79.5	83.2	18.2	21.3
Belarus	64.8	76.6	11.8	16.9	Norway	79.7	83.6	18.5	21.2
Belgium	77.5	83.0	17.6	21.3	Poland	72.7	81.2	15.5	20.0
Bosnia and Herzegovina	74.2	79.0	15.6	17.4	Portugal	77.4	83.9	17.9	21.7
Bulgaria	70.8	77.9	14.0	17.4	Republic of Moldova	67.2	75.1	12.8	15.8
Croatia	74.0	80.7	15.0	18.8	Romania	70.2	77.6	14.1	17.3
Cyprus	80.1	83.9	19.0	21.1	Russian Federation	63.1	75.0	12.0	16.6
Czech Republic	75.1	81.3	15.8	19.4	San Marino	77.6	84.4	18.3	24.2
Denmark	78.0	82.1	17.5	20.3	Serbia	72.4	77.5	14.1	16.5
Estonia	71.3	81.4	14.8	20.1	Slovakia	71.8	79.4	14.1	18.1
Finland	77.5	84.0	17.9	21.9	Slovenia	76.6	83.2	16.9	21.1
France	78.4	85.4	19.0	23.5	Spain	79.4	85.5	18.8	22.9
Georgia	70.2	79.0	14.5	18.4	Sweden	79.7	83.7	18.4	21.3
Germany	78.7	83.4	18.3	21.3	Switzerland	80.4	85.0	19.2	22.7
Greece	78.6	83.2	18.6	20.7	Tajikistan	71.2	76.3	14.5	17.8
Hungary	71.7	78.8	14.4	18.2	The former Yugoslav Republic of Macedonia	73.0	77.3	14.0	16.1
Iceland	79.9	83.9	18.7	21.1	Turkey	74.5	80.0	15.7	19.1
Ireland	78.5	83.0	17.8	21.0	Turkmenistan	62.5	69.8	12.4	14.9
Israel	80.4	84.1	19.4	21.7	Ukraine	66.2	76.2	12.8	16.8
Italy	79.8	85.0	18.7	22.5	United Kingdom	78.8	82.7	18.4	21.0
Kazakhstan	63.7	73.5	11.9	15.6	Uzbekistan	68.2	73.0	13.0	15.0
Kyrgyzstan	65.5	73.7	12.8	15.7					

Note: data from latest available year, 2004–2012 (with one exception from 1998); regional averages for 2011.
Source: European Health for All database *(11)*.

Target 3: reduce inequities in Europe

Summary of progress

The quantification for this Health 2020 target is a reduction in the gaps in health status associated with social determinants within the European population. The core indicators include:

- infant mortality per 1000 live births;
- proportion of children of official primary school age not enrolled;
- unemployment rate;
- life expectancy (described in the section on target 2);
- national and/or subnational policy addressing the reduction of health inequities established and documented.

Since 1990 infant mortality has fallen in countries with the highest rates, reducing the gap between countries. Data reported for the past few years do not have sufficient coverage to determine whether this positive trend has continued since 2010.

The difference between the highest and lowest proportions of children of official primary school age not enrolled in school in countries in the Region is decreasing: it was 15.2% in 2010, 12.7% in 2011 and 10.6% in 2012 (the lowest value in 2012 was 0.2%, while the highest was 10.7%).

Unemployment rates across the Region vary considerably, with highest and lowest values of 31% and 0.5% in 2012. While the difference between the highest and lowest values in the Region has been decreasing since 2005, in recent years the rate of reduction has slowed, making the difference 31.3% in 2010 to 30.8% in 2011 and 30.5% in 2012.

The proportion of countries in the Region with a standalone policy on health inequities increased from 58% in 2010 to 67% in 2013.

Gap between highest and lowest infant mortality rates has shrunk

The infant mortality rate is defined as the number of deaths of infants aged under 1 year per 1000 live births. The maximum values reported in the Region outline an erratic pattern while

the minimum values are more or less constant (Fig. 2.10). This is largely explained by the fact that data coverage for countries is not complete, especially for those with the highest infant mortality rates. The regional averages for earlier years are based on data from most countries; the 2011 average, however, is based on data for only 27 countries. Those that have not yet reported for 2011 are also among those with higher infant mortality rates; this may explain the sharp decline in the highest reported value in the Region in 2011. In general, however, it can be concluded that the highest rates have fallen significantly over time, thus reducing the gap between countries. The difference between the lowest and highest infant mortality rates in 1990 amounted to 40 infant deaths per 1000 live births; in the 2000s it had declined to a range fluctuating between 20 and 30.

The regional average infant mortality rate has fallen by over half over 22 years, from 15.4 deaths per 1000 live births in 1990 to 7.0 in 2011 (see Fig. 2.10), representing an average annual rate of decline of 3.7%. In comparison, Millennium Development Goal 4 requires a two thirds reduction in under-5 mortality over a 25-year period, which is equivalent to a 4.4% average annual rate of decline. Furthermore, the pace of decline diminished in the latter half of the reporting period: the average annual reduction in 2001–2011 was, at best, 3.3% compared to 4.5% in 1998–2000. The pace cannot be measured reliably as of 2010, owing to delayed reporting by countries, but the trend indicates that infant mortality in the Region will decrease further.
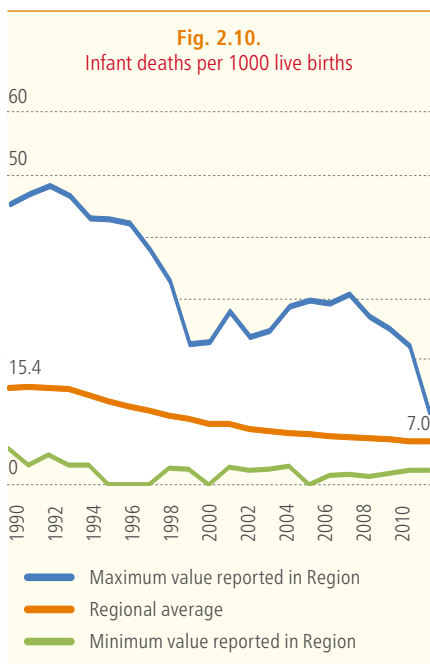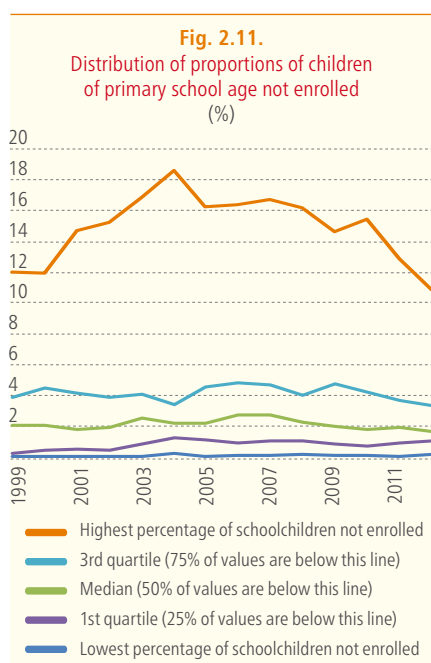
Experience across the Region – and indeed the world – shows that lower levels of infant mortality are strongly associated with a larger share of neonatal deaths (deaths occurring at 0–27 completed days) and that declines in neonatal deaths are slower than those in postneonatal deaths (occurring between 28 days and 11 months) (50). To monitor the transition to low infant mortality across the Region, well functioning civil registration systems that accurately record infant deaths are required, especially in the first days after birth. While the level of infant mortality is likely to be underestimated due to either misclassification of early neonatal deaths as stillbirths or civil registration systems failing to capture deaths occurring in the first hours or days following birth (51), the reporting bias is assumed to be largely constant. The direction and the magnitude of change described above therefore probably

Fig. 2.10.
Infant deaths per 1000 live births

Source: European Health for All database (11).

reflect reality. Annex 1 offers more information about quality issues and problems related to infant mortality data.

Wide variation in proportion of children not enrolled in primary school

The difference between the highest and lowest proportions of children of official primary school age not enrolled in the Region is decreasing: it was 15.2% in 2010, 12.7% in 2011 and 10.5% in 2012. Nevertheless, differences between countries remain large, with proportions in 2012 ranging from 10.7% to 0.2%. Distribution across the Region shows an unbalanced picture: the proportion was below 3.3%in 75% of countries, and 3.3–10.7% in 25% of countries (Fig. 2.11).

The positive relationship between education and health is widely acknowledged. It appears to be reciprocal: better education results in better health (through better jobs, higher income and increased health literacy) and better health enables people to invest more time, money and energy in education (53). Tackling inequities in education is therefore vital for addressing health inequities. The global initiative on out-of-school children set up by the United Nations Children's Fund (UNICEF) and UNESCO Institute for Statistics reported a lack of systematic analyses to identify the barriers to achieving universal primary education, partly due to a lack of adequate tools and methodologies to identify out-of-school children and monitor progress. The initiative worked with several countries in the European Region on improving inclusion rates in education (54) (see Box 2.5).

Differences in unemployment rates decreasing, but recent changes small

Rates of unemployment across the Region vary considerably: the lowest value in 2012 was 0.5% and the highest 31%. Although the difference between the highest and lowest values in the Region has been decreasing since 2005, in recent years the rate of decline has slowed, with a difference of 31.3% in 2010, 30.8% in 2011 and 30.5% in 2012 (Fig. 2.12). In 2012, according to the International Labour Organization Department of Statistics (ILOSTAT), differences between men and women in the developed economies and countries of the EU were small (unemployment rates

Fig. 2.11.
Distribution of proportions of children of primary school age not enrolled
(%)

- Highest percentage of schoolchildren not enrolled
- 3rd quartile (75% of values are below this line)
- Median (50% of values are below this line)
- 1st quartile (25% of values are below this line)
- Lowest percentage of schoolchildren not enrolled

Source: United Nations Educational, Scientific and Cultural Organization (UNESCO) Institute for Statistics (52).

Background

According to Turkey's 2008 demographic and health survey, 7.5% of 6–10-year-olds and 4.63% of 11–13-year-olds were not enrolled in school. Turkey was one of 25 countries in which UNICEF and the UNESCO Institute of Statistics started the global initiative in 2010 to accelerate the reduction in the number of out-of-school children and strengthen monitoring systems for these children.

Policy action taken

To overcome barriers and bottlenecks leading to exclusion from education, the Turkish government implemented several social policies and programmes such as distributing free textbooks and providing free lunches for those children living in rural areas at long distances from schools. It also began to provide assistance for student housing, transportation and boarding; educational materials; scholarships for children in low-income and/or rural households; free transportation for children with disabilities; and monthly payments for caring for disabled children. An expansion of pre-primary education was implemented to reach more children, and the education sector began using an e-school management information system, transitioning to a performance-based budgeting and management system. Other strategies were also enacted to increase school enrolment, such as a project to improve the work and social lives of seasonal agricultural workers and work targeting children in need of protection.

Outcomes

Hundreds of thousands of children have benefited from free lunches, stipends to meet housing costs, free bus services and many other services targeted at increasing school enrolment. According to national education statistics, the net enrolment rate for the 2013–2014 school year was 99.5% in primary education. For children aged 10–13 years the net enrolment rate in lower secondary education – after adjustment, for example, for primary schoolchildren falling in that age group because of repeated classes – was 99.9%. The proportion of children in Turkey who benefit from pre-primary education and who successfully complete basic education has greatly increased, which may be attributed to the comprehensive reforms and efforts made to address education challenges (55,56).

of 8.6% for men and 8.5% for women). In central and south-eastern European (non-EU) countries and the CIS, the rates for men were higher than for women (8.2% versus 7.7%) *(57)*.
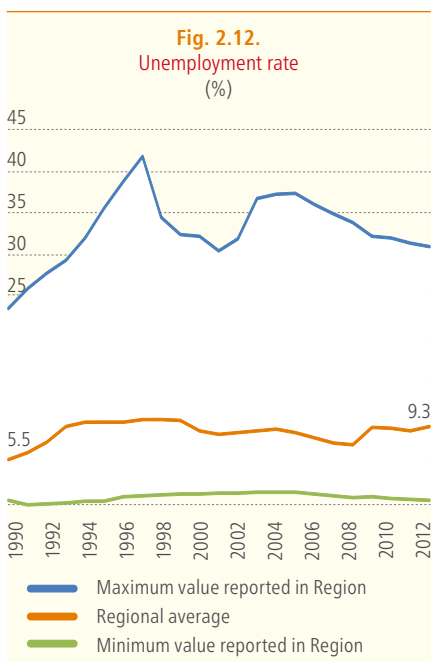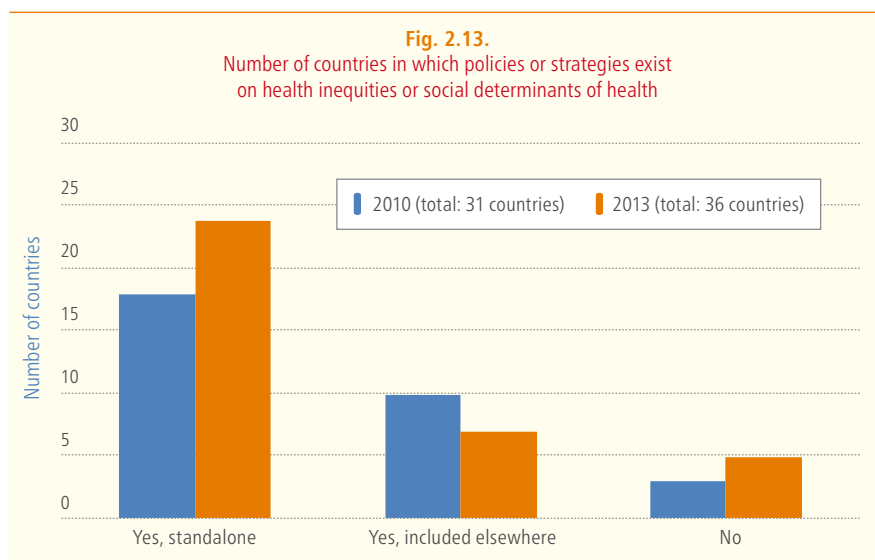
The effects of the economic crisis on the labour market disproportionately affect young people. ILOSTAT estimates that youth unemployment rates for 2012 are 18% for the developed economies and EU countries and 17.5% for central and south-eastern European (non-EU) and CIS countries. According to these projections the rates will be 16% and 18%, respectively, in 2018, implying that major improvements in the situation are not to be expected within the next few years. Importantly, in countries for which information exists, the proportion of young people neither in employment nor in education or training has continued the steep upward trend recorded since the start of the crisis *(57)*. These high and/or rising rates are a major concern for policy-makers, as this group is neither engaged in employment nor investing in skills development.

Unemployment has a direct effect on health (it is associated with an increased mortality risk and with risk behaviours, including heavy drinking) and an indirect effect through the

Fig. 2.12.
Unemployment rate
(%)

- Maximum value reported in Region
- Regional average
- Minimum value reported in Region

Source: European Health for All database *(11)*.

financial consequences of being unemployed, which leads to psychological distress and an increase in mental disorders *(58)*. The evidence suggests that employment has a beneficial effect on health, although the relationship between the two is complex. In particular, employment has a protective effect against depression and on general mental health *(59)*. Employment is an important element of healthy ageing strategies; thus, ensuring a higher employment rate among people aged 50 years and over is an important goal of many European governments. Current employment rates in the EU range from 47.5% to 82.0% for people aged 55–59 years, from 13.9% to 64.2% for people aged 60–64 years and from 3.8% to 27.0% for people aged 65–69 years *(60)*. These figures illustrate that significant policy action is required to achieve adequate employment levels among older people, contributing to active and healthy ageing.

Policies to tackle inequities exist in 31 countries in 2013

The trend of countries adopting standalone policies to address the reduction of health inequities is increasing (see Fig. 2.13). Among 36 reporting countries in 2013, 31 (86%) had a policy or strategy addressing inequities and/or social determinants, of which 77% were health-specific policies.

Fig. 2.13.
Number of countries in which policies or strategies exist on health inequities or social determinants of health

Source: Qualitative indicators for monitoring Health 2020 policy targets *(61)*.

Background

Member States agreed on a set of targets and indicators and a monitoring process for the Health 2020 policy at the sixty-third session of the Regional Committee in 2013, and set 2010 as a baseline. Some of the indicators in the Health 2020 monitoring framework relate to the development and implementation of national policies, an area for which no routine data collection process exists. To this end, WHO conducted a country survey in April 2014 to obtain information on these qualitative indicators.

Action taken

The WHO Regional Office for Europe developed a web-based system, in both English and Russian, in which countries reported on the following three indicators:

• national and/or subnational policy addressing the reduction of health inequities established and documented;
• establishment of a process for target-setting documented;
• evidence documenting:
  (a) establishment of national health policies aligned with Health 2020;
  (b) implementation plan;
  (c) accountability mechanism.

The survey required the submission of documentation providing evidence to support the responses given, such as a policy document, strategy document or parliamentary decree.

Outcomes

Responses were received from 37 countries (70% of countries in the Region), representing different geographical subregions, languages and population sizes. One country submitted data for 2010 but not 2013, six submitted data for 2013 but not 2010, and responses for both years were submitted by 30 countries. Four countries submitted the questionnaire only; 33 also submitted documentation as evidence of their policies. All responses provided answers to the full questionnaire *(61)*.

Overall, the most common elements reported in 2010 to reduce health inequities focused on integrating and improving the health of disadvantaged groups and on having a healthy start in life (87% and 77% of the responses, respectively). In 2013 the focus on disadvantaged groups and a healthy start remained (86% and 75%, respectively), but an increasing and diversified emphasis on tackling poverty (81%), improving the physical environment (81%) and enhancing human rights (75%) was also reported. The broadening of the focus of policies from the more traditional approaches applied in 2010 is encouraging. This suggests that Health 2020 implementation is gathering momentum and generating new action at the national and subnational levels *(61)*. Data for this indicator were collected by means of a survey of countries by the WHO Regional Office for Europe (see Box 2.6).

Other core indicators linked to this target

The core indicators of life expectancy at birth and GINI coefficient (income distribution) are also linked to this target. The indicator on life expectancy is described in the section on target 2; the GINI coefficient is not described in this report due to insufficient data availability (see Annex 1 for more details).

Target 4: enhance the well-being of the European population

Summary of progress

The Health 2020 core indicators linked to this target are related to subjective and objective well-being. The indicator for subjective well-being is life satisfaction and those for objective well-being include:

• availability of social support;
• percentage of population with improved sanitation facilities;
• unemployment rate (described in the section on target 3);
• proportion of children of official primary school age not enrolled (described in the section on target 3).

The average self-reported life satisfaction score – measured on a scale of 0 to 10, with 10 the best possible life – ranges from 7.8 to 4.2 in countries in the European Region. Understanding and interpreting such subjective well-being data, however, requires additional research and developmental work.

The proportion of people aged over 50 years in the Region who feel that they have social support ranges from 43% to 95%.

Considerable proportions of the population in rural areas in the Region still lack access to improved sanitation facilities and piped water on their premises. In nine countries less than 50% of the population in the rural areas had access to piped water in 2012.

Life satisfaction scores vary: more work needed to understand the differences

The average self-reported life satisfaction score in countries in the European Region ranges from 7.8 to 4.2. Of 50 countries for which data are available, 23 have an average score above 5.9; the remaining 27 score 5.9 or lower (see Fig. 2.14). Life satisfaction was scored from 0 to 10 on the Cantril Self-Anchoring Striving Scale, with 10 the best possible and 0 the worst possible life for respondents.
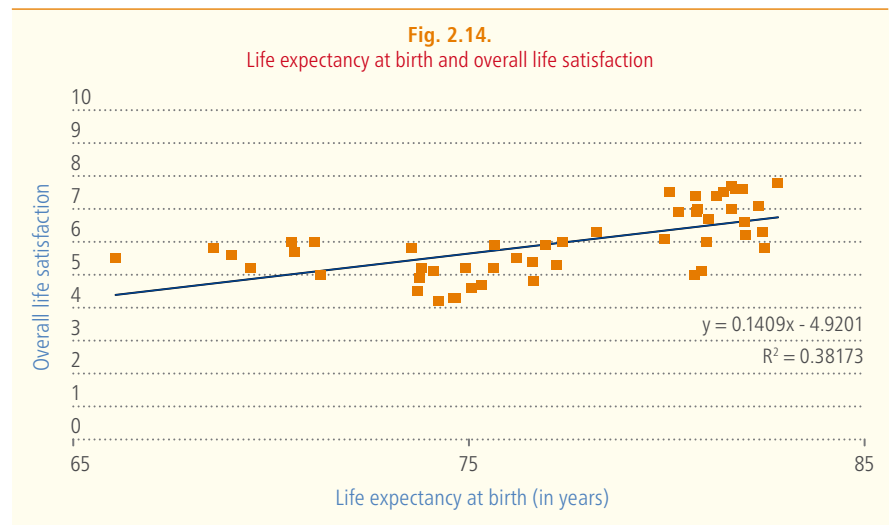
Life satisfaction is accepted as a measure of subjective well-being, which relates to what people feel and report themselves. Other elements commonly described in subjective well-being are emotional well-being (such as positive and negative affect) and positive functioning (such as sense of purpose and meaning). The Health 2020 monitoring framework currently has no indicators related to these aspects, but the WHO expert groups on the development of indicators and on the measurement of well-being for Health 2020 recommended considering additional indicators to capture them *(62)*. Understanding and interpreting such subjective well-being measures is challenging: the opportunities and pitfalls involved are addressed in detail in Chapter 3. A relationship between life satisfaction and health indicators such as mortality and life expectancy, however, has been described repeatedly *(63, 64)* (see Fig. 2.14).

The life satisfaction data in this report were gathered by Gallup World Poll and published by UNDP as part of its *Human development report 2014 (65,66)*. The data are not age-standardized; this limits comparability because of differences in the age structure of countries' populations.

Highest rate of older people with social support more than twice the lowest

The proportion of people aged over 50 years in countries in the European Region who state that they have relatives or friends they can count on when in trouble ranges from 43% to 95%. This proportion is 80% or higher for 68% of countries, and below 70% for 14% (Fig. 2.15).

Social connectedness is a measure of objective well-being. Its importance for health and well-being has been well established: it is therefore a common element in existing well-being frameworks

Fig. 2.14.
Life expectancy at birth and overall life satisfaction

$y = 0.1409x - 4.9201$
$R^2 = 0.38173$

Notes: each dot represents a country in the European Region. The Gallup World Poll poses the Cantril Scale question in the following way *(65)*. "Please imagine a ladder, with steps numbered from 0 at the bottom to 10 at the top. Suppose we say that the top of the ladder represents the best possible life for you, and the bottom of the ladder represents the worst possible life for you. On which step of the ladder would you say you personally feel you stand at this time, assuming that the higher the step the better you feel about your life, and the lower the step the worse you feel about it? Which step comes closest to the way you feel?" A single linear regression model was applied to the data: the equation in the graph describes the resulting regression line. The better the fit of the linear regression model, the closer R^2 is to 1. Data on life satisfaction from latest available year, 2007–2012; data on life expectancy from latest available year, 2004–2012 (with one exception from 1998).

Sources: life satisfaction: Gallup World Poll (through the United Nations Development Programme (UNDP)) *(65, 66)*;
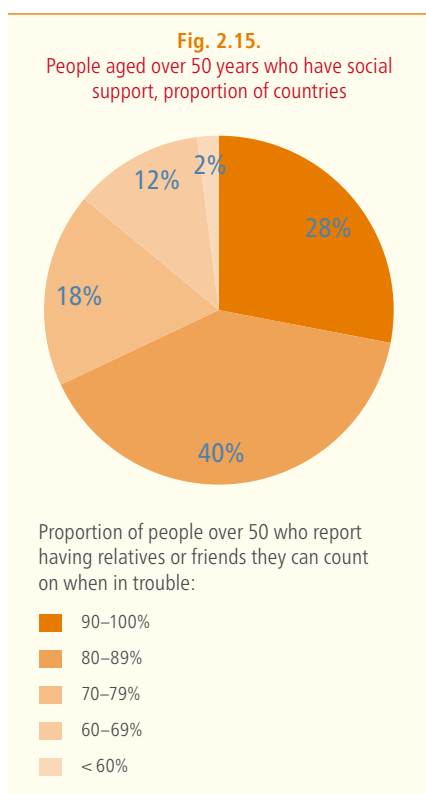life expectancy: European Health for All database *(11)*.

(62). Work by the Organisation for Economic Co-operation and Development (OECD) shows an influence of education and economic status on social network support: people with secondary or tertiary education can count on someone for help in an emergency more often than those with only primary education. Similar differences apply between upper and lower income quintiles (68). The social connectedness data used in this report were gathered by Gallup World Poll and published by HelpAge International as part of its Global AgeWatch Index 2014 (65, 67).

Many rural homes still lacking piped water and improved sanitation facilities

Large differences exist between rural and urban areas in the European Region in access to piped water on premises and improved sanitation facilities. In 2012 the proportion of the population in rural areas with access to piped water on premises was below 75% in 14 countries and below 50% in nine countries. In urban areas this proportion was below 90% in seven countries and below 80% in two (Fig. 2.16 and 2.17). The total regional proportion of the population with piped water on premises has remained practically static since the Health 2020 baseline of 2010. In rural areas the figure was 71% in 2010, 2011 and 2012; in urban areas it was 96% in 2010 and 97% in 2011 and 2012 (69).

In 2012 the proportion of the rural population with access to improved sanitation facilities (flush or pour-flush to piped sewers, septic tanks or pit latrines, ventilated pit latrines, pit latrines with slab and composting toilets) was below 85% in six countries and below 70% in one. In urban areas it was below 90% in three countries and below 80% in one (Fig. 2.18 and 2.19). As with the situation for piped water hardly any change has occurred in the total proportion of the regional population with access to improved sanitation facilities since the 2010 baseline. In urban areas this was 94% in 2010, 2011 and 2012; for rural areas it was 88% in 2010 and 89% in 2011 and 2012 (69).
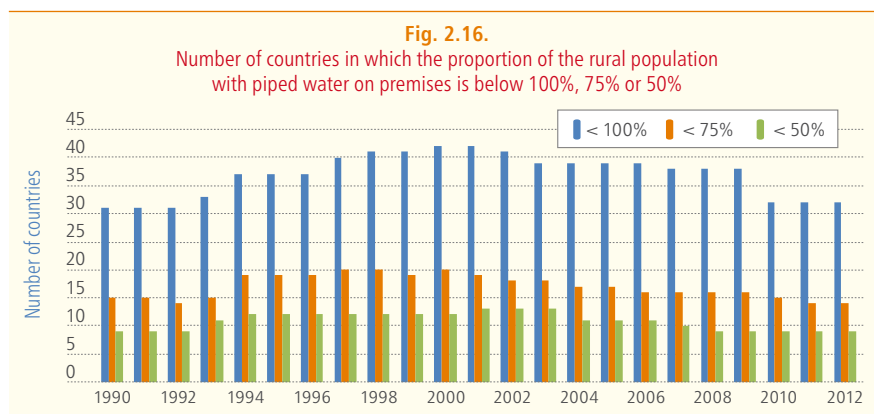
Overall, more than 90% of the population of the European Region has access to improved sources of drinking-water and sanitation facilities, as defined by the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation. Nevertheless, 67 million people lack access to basic sanitation in terms of

Fig. 2.15.
People aged over 50 years who have social support, proportion of countries

Proportion of people over 50 who report having relatives or friends they can count on when in trouble:

- 90–100%
- 80–89%
- 70–79%
- 60–69%
- < 60%

Note: data from 2013 or latest available year.

Source: Gallup World Poll (through HelpAge International) (65, 67).

functing toilets and safe means to dispose of human faeces.
Moreover, about 100 million people lack access to piped drinking-
water on premises and more than 6 million still rely on surface
water as their primary source, posing severe risks to health.
As illustrated in Fig. 2.16–2.19, rural dwellers are the most
disadvantaged. This also is true for the least wealthy. The
data show that progress has stalled; in fact, in some countries
proportions of the population with access to piped water
on premises have decreased, and the Region is not on track
to meet the Millennium Development Goal 7c target on
sanitation *(34)*.

Fig. 2.16.
Number of countries in which the proportion of the rural population
with piped water on premises is below 100%, 75% or 50%

Note: the total number of countries for which data are available may differ between years.
Source: WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation *(69)*.

Fig. 2.17.
Number of countries in which the proportion of the urban population
with piped water on premises is below 100%, 90% or 80%
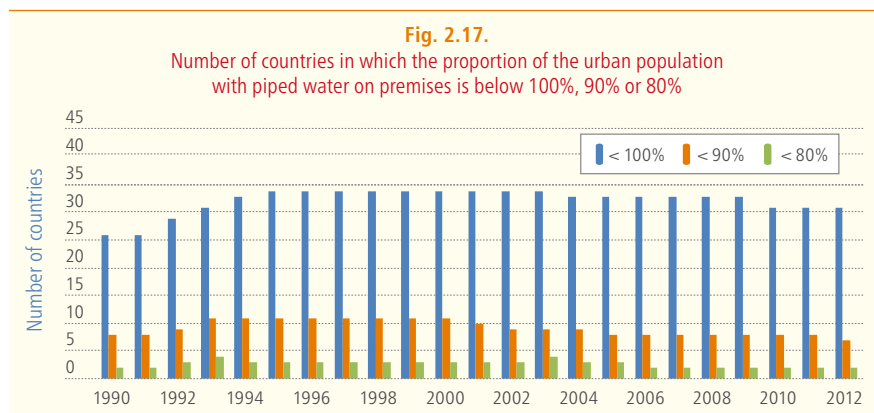
Note: the total number of countries for which data are available may differ between years.
Source: WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation *(69)*.

Diseases related to inadequate water, sanitation and hygiene represent a significant health burden, primarily from diarrhoea. In low- and middle-income countries in the Region, inadequate water, sanitation and hygiene accounts for 10 diarrhoea deaths a day. Children aged under 5 years are particularly vulnerable to diarrhoea, a leading cause of malnutrition and death. Inadequate water, sanitation and hygiene also cause other diseases, such as legionellosis and soil-transmitted helminth infections. Moreover, chemicals in drinking-water – such as arsenic, fluoride, lead and nitrates – can cause NCDs (34). Safe and sustainable water supply and sanitation facilities are essential for good health, and a safe and clean environment is important for well-being. Action on these basic provisions is clearly still needed in the Region to ensure a healthy environment for all.
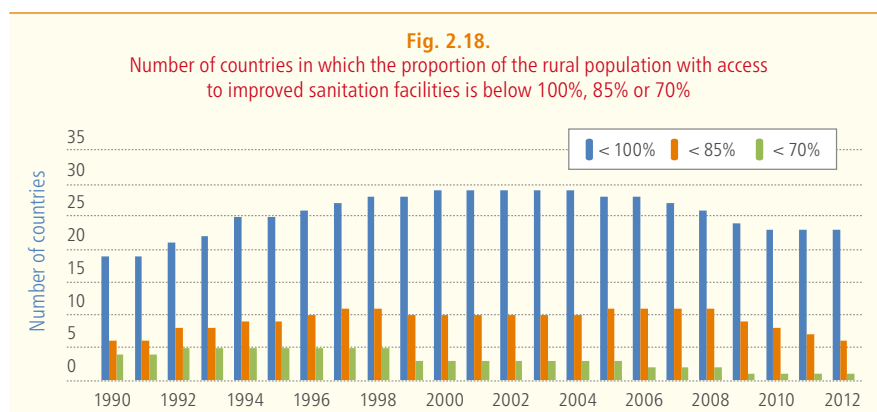
Fig. 2.18.
Number of countries in which the proportion of the rural population with access to improved sanitation facilities is below 100%, 85% or 70%

Note: the total number of countries for which data are available may differ between years..
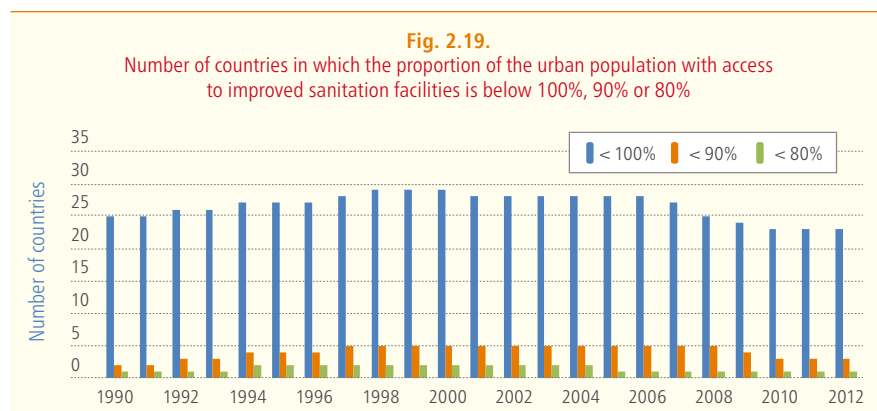*Source:* WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation *(69)*.

Fig. 2.19.
Number of countries in which the proportion of the urban population with access to improved sanitation facilities is below 100%, 90% or 80%

Note: the total number of countries for which data are available may differ between years..
Source: WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation *(69)*.

Other core indicators linked to this target

The core indicators of GINI coefficient (income distribution), unemployment rate and proportion of children of official primary school age not enrolled are also linked to this target. The GINI coefficient is not described in this report due to insufficient data availability (see Annex 1 for more details). The other two indicators are described in the section on target 3.

Country experience of monitoring well-being

Iceland is a country with considerable experience of well-being measurement. For example, a dedicated module on well-being, which included the WHO-Five Well-being Index and the Satisfaction with Life Scale *(70, 71)*, was developed and incorporated in the country's regular health interview survey (see Box 2.7).

Target 5: universal health coverage and the right to health

Summary of progress

The quantification for this Health 2020 target is moving towards universal coverage.[2] The core indicators include:

- total expenditure on health as a percentage of GDP;
- private household out-of-pocket payments (OOPs) as a proportion of total health expenditure;
- percentage of children vaccinated against measles, polio and rubella (described in the section on target 1).

While average total expenditure on health as a percentage of GDP at the regional level has remained unchanged at about 8.3% since the Health 2020 baseline of 2010, public spending has

---

[2] According to the WHO definition (76), universal coverage is equitable access to effective and needed services without financial burden.

fallen in many countries. Health systems need adequate levels of public funding to promote financial protection and stable revenue flows to maintain service quality and accessibility.

Average OOPs as a proportion of total expenditure on health at the regional level have also remained unchanged since 2010, at about 24%. In 2012 their level was below the 15% threshold critical for preventing catastrophic levels of health expenditure in only 12 of the 53 countries in the Region.

Moving towards universal health coverage still requires considerable action

Total expenditure on health as a proportion of GDP – one of the Health 2020 core indicators adopted by Member States – differs considerably between countries in the European Region, ranging from 2.0% to 12.4% in 2012. The regional average has been more or less stable, however, at around 8.3%, since the 2010 baseline (Fig. 2.20).

When assessing progress towards universal health coverage, looking at public expenditure on health is important: health

---

Box 2.7.
Linking health and well-being measures with public policy outcomes in Iceland

Background
Following the collapse of the banking system in 2008, Iceland was one of the OECD countries that went into recession with negative growth in gross domestic product (GDP). In 2007–2009 unemployment rates increased from 2% to 7% (11), the GDP index fell considerably and the national currency lost more than half its value. The collapse resulted in a reconsideration of national values, with increased interest in adopting not only economic but also social and well-being indicators for public policies.

Policy action taken
To limit the negative consequences of the economic crisis on health and well-being a series of actions was undertaken. In 2009 a proactive policy called "Iceland 2020" was created to increase well-being by the year 2020. Another action – "Welfare Watch" – systematically monitors the social and financial consequences of the crisis for families and individuals in Iceland and proposes solutions. Social indicators were developed, including health and well-being factors. In 2014 a new ministerial committee on public health, chaired by the prime minister, was established; it involves ministers of health, education and culture, and social affairs and housing. Other ministers also participate as needed.

Outcomes
With the development of the public health policy and action plan, major emphasis is put on including health and well-being in all policies and on the creation of a health and well-being impact assessment. One of the main activities is providing support to local governments around the country to become health-promoting communities, encouraging them to monitor health and well-being regularly, linking those measures with their policies. Recent evaluations of the consequences of the economic crisis have shown that measures of adult well-being indicate a rise again after a small decline just after the collapse. Among adolescents, an increase in well-being was detected between 2000 and 2010 as adolescents were spending more time with their parents and found it easier to get emotional support from them after the collapse (72–75).

systems need adequate levels of public funding to promote financial protection and stable revenue flows to maintain service quality and accessibility. Most countries experienced some fluctuation in public spending in the years following the financial and economic crisis, especially in 2009, 2010 and 2012. Public spending on health fell in many countries between 2010 and 2013, both as a share of GDP and per person; in some countries this was a continuation of a long-standing trend. Overall, most reductions were small, but a few countries experienced large or sustained reductions, so that their levels of public spending on health per person were lower in 2012 and 2013 than in 2007 *(77)*.

Ensuring an adequate level of public financing for the health system – through general tax revenues and/or taxes earmarked for health – is essential for progress towards universal health coverage. Many countries in the Region that have traditionally relied heavily on earmarked payroll taxes to finance health care now realize that a mixed public revenue base is more conducive to achieving higher levels of coverage without unduly burdening the labour market *(77, 78)*.
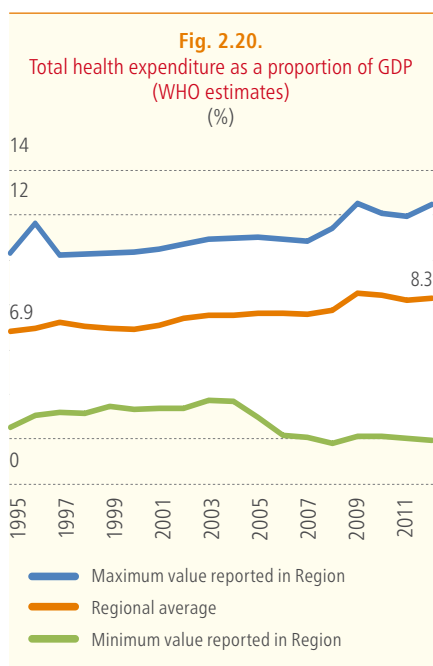
Low levels of public spending on health typically result in high levels of OOPs. The OOP proportion of total spending on health is thus an important proxy indicator of financial protection. International analysis suggests that once the OOP share falls below 15% of total spending on health very few households experience catastrophic or impoverishing levels of health expenditure *(79)*. In 2010 and 2011 only 13 of the 53 countries in the Region had an OOP share below 15%; in 2012 only 12 countries were below this threshold (Map 2.3) and one had a value just slightly above 15%. Between 2010 and 2012 the OOP share grew in 22 countries, although the magnitude of growth was usually small *(11)*. On average, the OOP proportion of total health expenditure in the Region has remained stable since 2010, at about 24% (see Fig. 2.21).

These figures highlight the need for policy action to reduce OOPs in most countries. Reducing OOPs requires a comprehensive approach that aligns all dimensions of health financing policy – revenue collection, pooling, purchasing and coverage decisions – for greater financial protection, equity and efficiency (see Box 2.8

Fig. 2.20.
Total health expenditure as a proportion of GDP (WHO estimates)
(%)

- Maximum value reported in Region
- Regional average
- Minimum value reported in Region

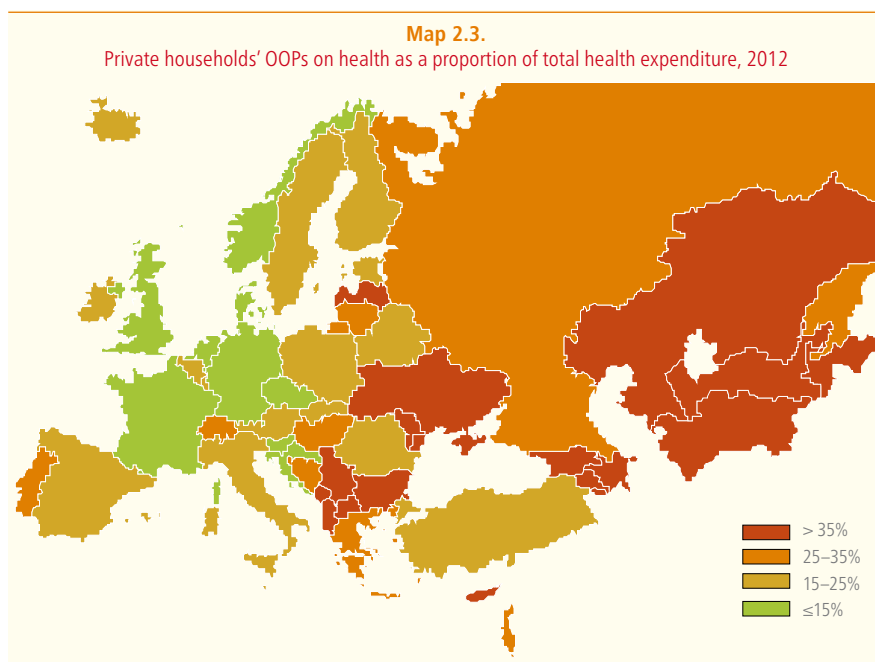*Source:* European Health for All database *(11)*.

for an example of policy action from Georgia). Medicines are usually the main driver of OOPs and a key source of catastrophic and impoverishing health expenditure. Weak pharmaceutical policies and inappropriate use of medicines are also leading sources of inefficiency in many health systems. Stronger pharmaceutical policies can thus safeguard timely and equitable access to medicines and improve financial protection, while at the same time promoting more efficient use of resources *(79)*.

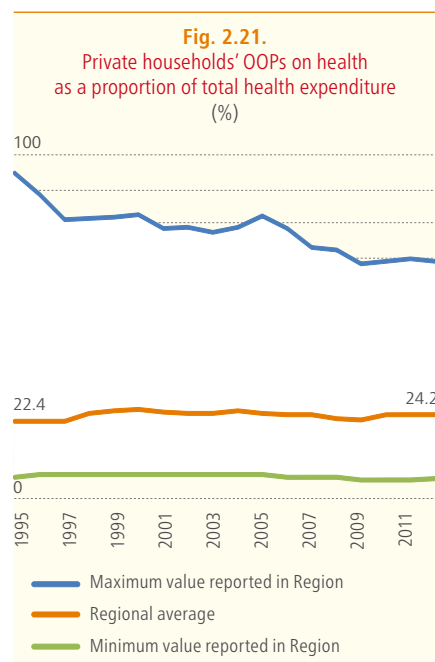## Other core indicator linked to this target

The core indicator of percentage of children vaccinated against measles, polio and rubella is also linked to this target; it is described in the section on the second quantification for target 1.

Maternal mortality still varies widely, despite a general decline

An additional indicator for this Health 2020 target quantification is maternal deaths per 100 000 live births. The steady decline in maternal mortality in the Region has been impressive: maternal deaths per 100 000 live births decreased by 59% between 1990 and

Map 2.3.
Private households' OOPs on health as a proportion of total health expenditure, 2012

> 35%
25–35%
15–25%
≤15%

Source: European Health for All database *(11)*.

Fig. 2.21.
Private households' OOPs on health as a proportion of total health expenditure
(%)

Maximum value reported in Region
Regional average
Minimum value reported in Region

Source: European Health for All database *(11)*.

2013. Several countries in the Region have achieved remarkable success in their progress towards the related Millennium Development Goal: in the same period Belarus was able to reduce its maternal mortality ratio by 96%, Israel by 84%, Poland by 81%, Romania by 80%, Bulgaria by 78%, Estonia by 78% and Latvia by 77% *(81)*. Nevertheless, intercountry differences in the Region are still substantial (Map 2.4). This implies that action is still needed to improve health system performance in maternal health – in particular, action to reduce existing inequities.

Target 6: national targets or goals set by Member States

Summary of progress

The quantification for this Health 2020 target is the establishment of processes for the purpose of setting national goals (if not

---

Box 2.8.
Substantial progress in moving towards universal health coverage in Georgia

Actions taken and achievements so far
In 2013 Georgia extended publicly financed coverage of primary care, emergency care and some elective inpatient services to people who were previously insured. Before the reform, only half of the population had access to publicly financed benefits. To fund this significant expansion the government doubled the level of public spending on health in absolute terms between 2012 and 2013, increasing the health share of its budget from 5.2% in 2012 to 6.7% in 2013 (80). The government also took back the purchasing function from private insurance companies: its universal health coverage programme is currently administered by the Social Services Agency of the Ministry of Labour, Health and Social Affairs. The programme covers 89% of the population; the remaining 11% is covered by voluntary private health insurance. A recent survey showed high

levels of satisfaction among programme beneficiaries and health service providers. Preliminary analysis also suggests a welcome increase in the use of health services and a reduction in OOPs.

Challenges ahead
The government now faces the challenge of maintaining this higher level of public spending on health and ensuring that public resources are used as efficiently as possible to address unmet need and strengthen financial protection. This is likely to involve action on several fronts, including:

• more efficient methods of paying providers and better monitoring of provider performance to improve the scope and quality of primary care and keep people out of hospital;
• efforts to improve equitable access to cost-effective medicines at lower

cost – especially those essential medicines for chronic conditions that are not yet part of the universal health coverage benefits package;
• a strategy to ensure that user charges do not prevent people from accessing the programme's benefits and to harmonize entitlements across the population.

Important role for health information
In the last five years Georgia has invested in boosting health information through national health accounts, monitoring of financial protection, two health utilization and expenditure surveys and a health system performance assessment. Continuing to generate data and improving routine health information systems will play an important role in developing effective policies to sustain Georgia's remarkable recent achievements.

already in place). The core indicators linked to this target quantification are:

- establishment of a process for target-setting documented;
- evidence documenting: (a) establishment of national policies aligned with Health 2020; (b) implementation plan; (c) accountability mechanism.

In 2010 nearly 40% of countries in the Region had defined targets to monitor the progress of health and well-being; by 2013 this had increased to 56%.

The proportion of countries with policies aligned with Health 2020 increased from 58% in 2010 to 75% in 2013. In 2010 26% of countries had adopted a policy implementation plan; by 2013 this proportion had increased to 50%. Finally, 45% of countries reported an accountability mechanism in 2010 and the proportion increased to 72% in 2013. These results show that Health 2020 implementation has rapidly gained momentum in the European Region.

Map 2.4.
Maternal deaths per 100 000 live births

> 30	
12–30	
7–12	
3.5–7	
≤ 3.5	
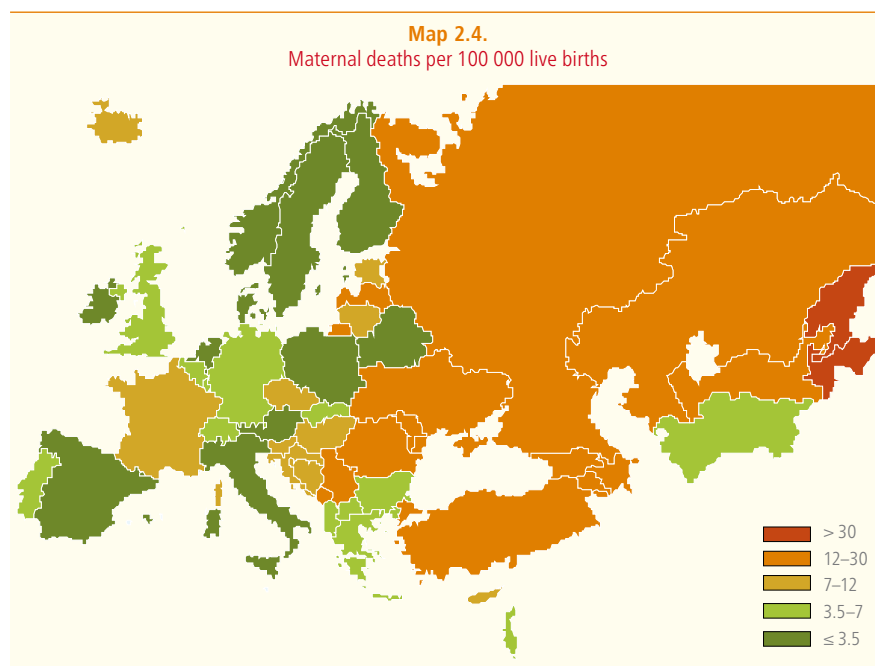
Note: the map represents the average value per country based on the three most recent years for which data were available. See Table A.4 in Annex 1 for information on the data underlying this map.

Source: European Health for All database *(11).*

Goals and targets set for health and well-being in over 50% of countries

Countries are increasingly setting national goals, targets and specific indicators to monitor their progress in improving health and well-being. In 2010 nearly 40% of countries had defined targets and an additional 35% had defined indicators without specific targets; in 2013 the proportion with defined targets increased to 56%. The number of countries planning to establish targets and indicators also increased between 2010 and 2013 (Fig. 2.22) *(61)*. This growing trend is an affirmation that the Region is progressing towards implementing the Health 2020 vision (see Box 2.9 for an inspiring example of national target-setting in Austria).

Implementation of health policies aligned with Health 2020 increasing

More and more countries are completing the three essential steps in the process of creating national health policies aligned with the overall Health 2020 vision: policy development and implementation and establishment of accountability mechanisms. Policy development is increasing rapidly in the Region: 58% of countries reported having a policy aligned with Health 2020 in 2010 and 67% of those were comprehensive health-specific policies. In 2013, one year after the adoption of Health 2020, the proportion of countries with aligned policies increased to 75%,

Fig. 2.22.
Number of countries with a process for target-setting for health and well-being, 2010 and 2013
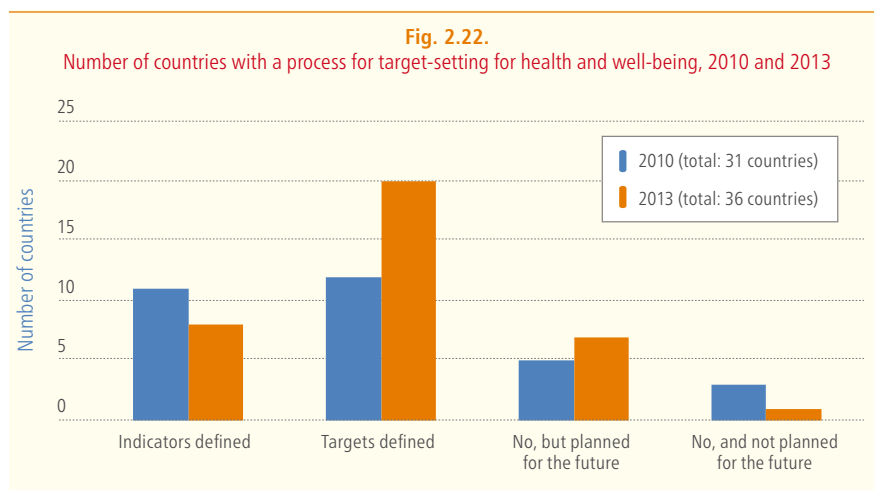
Source: Qualitative indicators for monitoring Health 2020 policy targets *(61)*.

of which 85% were comprehensive and health-specific (Fig. 2.23). A policy is considered to be aligned with Health 2020 if it includes a comprehensive national health policy or other strategy for improving universal health coverage, reducing major causes of the burden of disease, addressing major determinants of health and well-being and strengthening health systems.

As more national policies to address health and well-being are developed, so are plans to implement such policies throughout the Region. In 2010 45% of countries had an implementation plan or were in the process of developing one, and just over half of those were adopted. By 2013 50% of countries had adopted implementation plans and another 22% were in process (Fig. 2.24).

In 2010 45% of countries reported having an accountability mechanism for the policy; in 19% of reporting countries the mechanism was adopted and in 26% it was in process. In 2013 the proportion of countries with a mechanism increased to 72% (Fig. 2.25). Accountability mechanisms include setting targets, presenting progress reports to parliament or undertaking

---

Box. 2.9.
Implementing national health targets for Austria

Background
The Federal Ministry of Health led an extensive process to develop 10 health targets for Austria. A committee with representatives of almost 40 public authorities at federal, regional and local levels; social insurance and social partners; and representatives of patients, children and adolescents, older people and socioeconomically disadvantaged people was set up to develop the health targets. The 10 targets, which cover a wide range of areas (health-promoting living and working conditions, health equity, health literacy, healthy childhood, physical activity, nutrition, psychosocial health, healthy environment and health care), were officially approved by the Federal Health Commission and the Austrian Council of Ministers in summer 2012. This initiated the second phase of the process, which is dedicated to defining more specific targets as well as implementation measures.

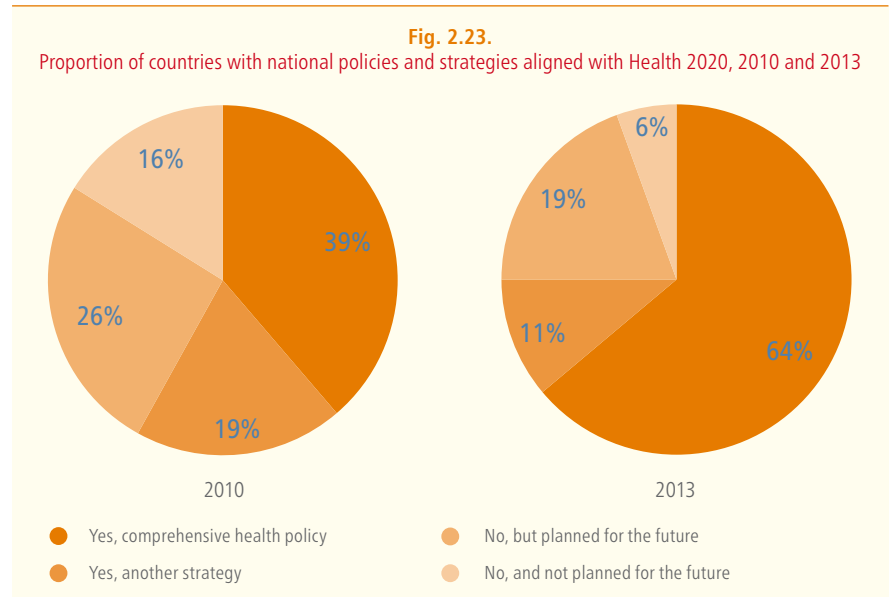**Achievements so far and future prospects**
An intersectoral working group will be established for each health target. Five working groups are in place; four have already presented a (draft) final report with specific targets and binding implementation plans including the following:

- to provide health-promoting living and working conditions for all population groups through cooperation of all societal and political areas;
- to promote fair and equal opportunities in health, irrespective of gender, socioeconomic group, ethnic origin and age;
- to enhance health literacy in the population;
- to ensure conditions under which children and young people can grow up as healthy as possible.

The working group on the target to promote healthy, safe exercises and activity in everyday life through appropriate environments continues its work. The developing committee holds regular meetings to discuss key elements of progression, important milestones and results.
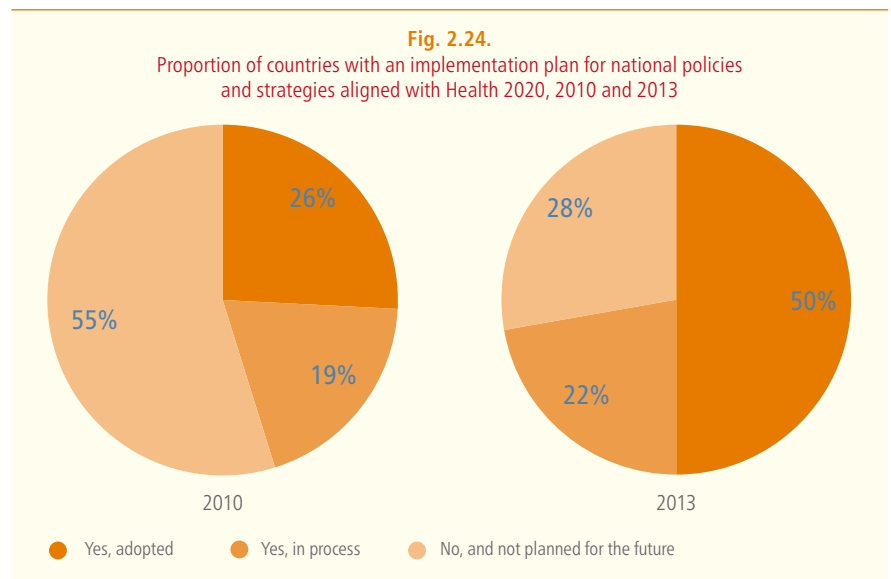
Implementation of the health targets will be monitored at different levels. As they address a broad range of health determinants, the monitoring concept is drafted accordingly, including process and outcome indicators. The progress of the implementation is monitored to ensure a high level of transparency, facilitate cooperation and allow necessary adaptations of further implementation.

an independent evaluation of the policy's implementation *(61)*. These steps in policy-making are an encouraging development towards achieving the Health 2020 vision for better health and well-being within the Region. Data for these indicators on national policies were collected by means of a country survey (see Box 2.6).
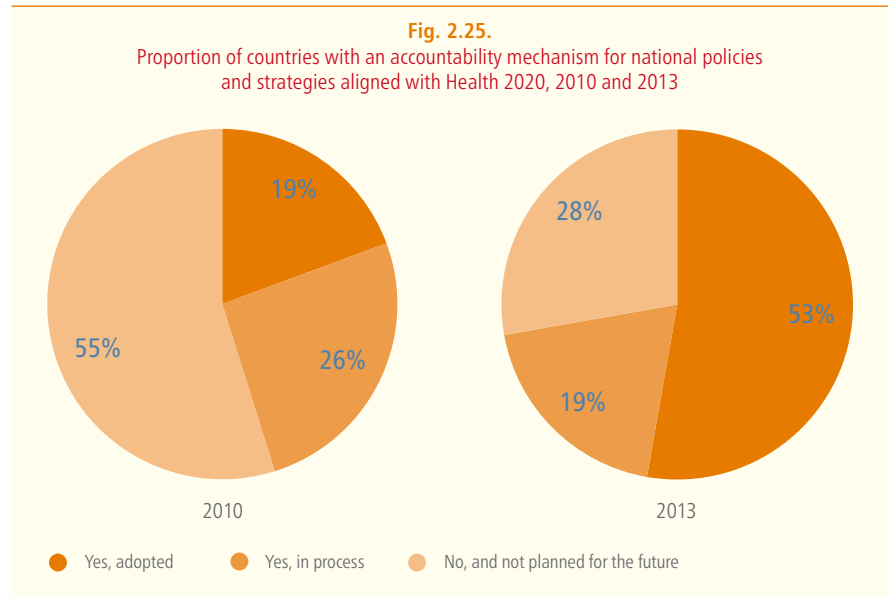
Fig. 2.23.
Proportion of countries with national policies and strategies aligned with Health 2020, 2010 and 2013

2010

2013

- Yes, comprehensive health policy
- Yes, another strategy
- No, but planned for the future
- No, and not planned for the future

Note: 31 countries provided responses in 2010 and 36 in 2013.
Source: Qualitative indicators for monitoring Health 2020 policy targets *(61).*

Fig. 2.24.
Proportion of countries with an implementation plan for national policies and strategies aligned with Health 2020, 2010 and 2013

2010

2013

- Yes, adopted
- Yes, in process
- No, and not planned for the future

Note: 31 countries provided responses in 2010 and 36 in 2013.
Source: Qualitative indicators for monitoring Health 2020 policy targets *(61).*

Fig. 2.25.
Proportion of countries with an accountability mechanism for national policies
and strategies aligned with Health 2020, 2010 and 2013

19%

55%

26%

28%

53%

19%

2010

2013

● Yes, adopted   ● Yes, in process   ● No, and not planned for the future

Note: 31 countries provided responses in 2010 and 36 in 2013.

Source: Qualitative indicators for monitoring Health 2020 policy targets *(61).*