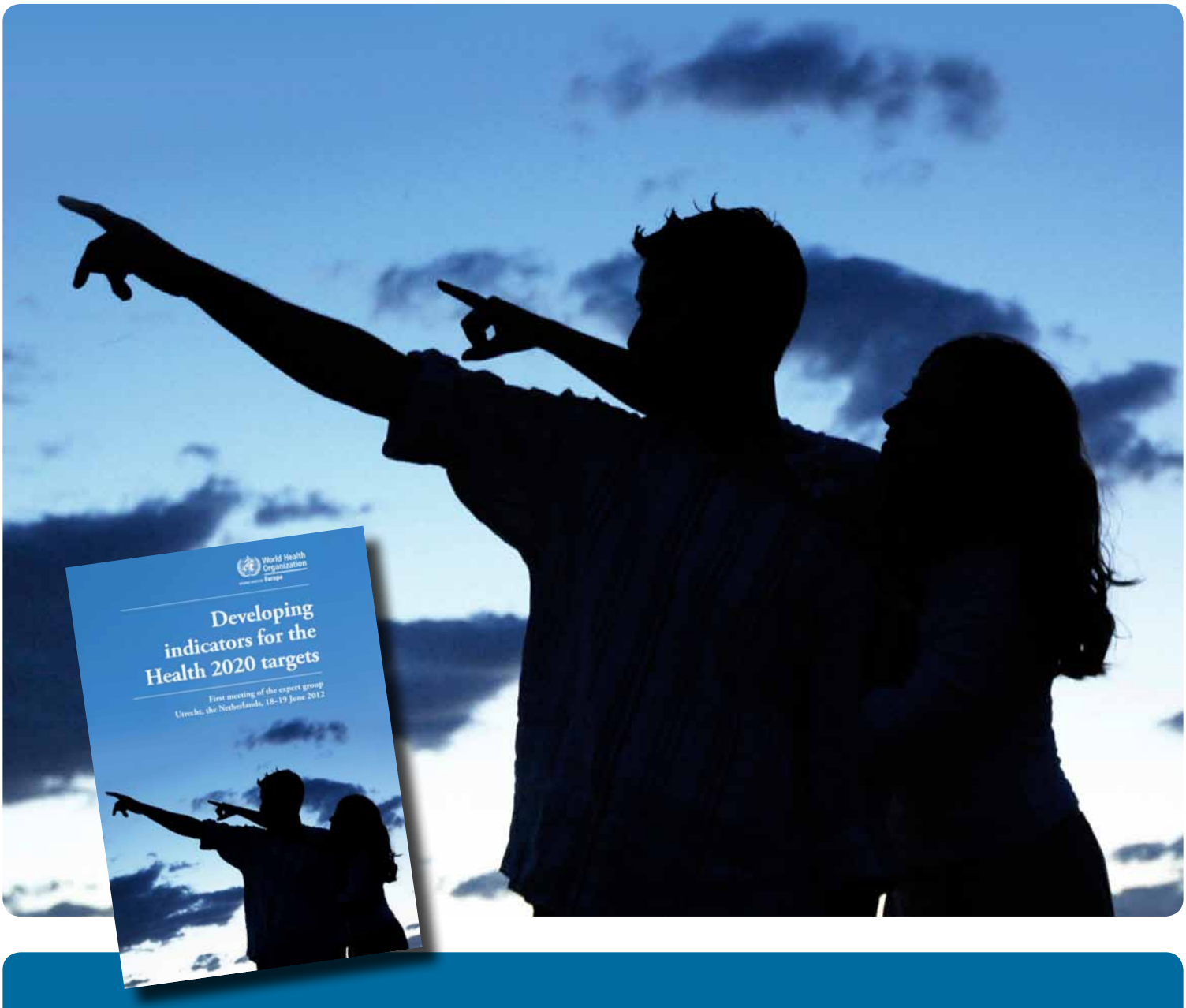
Information document

Executive summary of the European health report 2012: Moving Europe towards health and well-being



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Executive summary of the European health report 2012: Moving Europe towards health and well-being

This Information document contains an overview of the upcoming European Health Report 2012, the WHO Regional Office for Europe's flagship publication issued every three years. Details are outlined in four sections, addressing health status in Europe, European targets for health and well-being, the case for measuring well-being and an agenda to address measurement challenges.

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Overview

1. As part of its mandate to monitor and report on the health of nearly 900 million people in the WHO European Region, this report is the WHO Regional Office for Europe's flagship publication, issued every three years. The report has three purposes. First, the timing offers an excellent opportunity to provide policy-makers and public health professionals with the epidemiological evidence base underpinning the strategic objectives, targets and priorities of the new European policy framework for health – Health 2020. The report also analyses social, economic and environmental determinants of health and puts on the agenda well-being as a marker of social progress for the European Region. Finally, it identifies key challenges for health measurement for the coming decade and sets out a collaborative agenda to collect, analyse, and make use of health data Region-wide. The report contains four sections.

2. The first section introduces the report by laying out the current health status and trends in Europe, covering 53 countries, and highlights individual countries and subsets of countries. Topics covered include demographic trends; life expectancy; mortality; causes of death; burden of disease; risk factors; health determinants; and inequalities, including health system determinants. Key messages from this analysis show that people across Europe are living longer, but with changing patterns of disease burden, and with increasing inequalities in health and its determinants. Life expectancy has increased to more than 76 years for men and women combined, mainly as a result of decreases in certain causes of death and improvements in the prevalence of risk factors and socioeconomic and living conditions. Yet these improvements and the conditions that foster them have not been shared equally within and between countries – substantial differences persist and in many instances are increasing.

3. The second section presents the baseline for the overarching targets selected to monitor progress for the new European health policy, Health 2020. Specifically, it documents the intense process of consultation with representatives of Member States and the work of several expert groups, leading to the six overarching targets to be achieved by 2020. Targets are set at the regional level and are quantifiable, with indicators to mark progress towards 2020. The use of targets builds on previous European efforts such as those of Health for All and HEALTH21. With almost 30 years of experience in target setting, valuable lessons have been learnt that can also benefit Member States in their efforts to set targets at the national level.

4. The third section recognizes that a core aspect of Health 2020 is improving population well-being, specifically in the context of health. This is also enshrined in the WHO definition of health: a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". However, WHO has neither measured nor reported on well-being. In order to incorporate well-being in the work of WHO and to develop a European target and relevant indicators by 2013, this section lays out issues and processes needed to develop a common concept and approach to well-being which allows for valid measurement and yields information that is useful to policy-makers and for programme evaluation.

5. The fourth section concludes the report by identifying important measurement challenges in marking progress towards Health 2020 and by outlining an agenda to overcome these, working with partners and Member States. This also reflects the support offered to countries by the European Region to enhance health information collection, analysis and reporting at the national level, as well as working with the European Commission and Organisation for Economic Co-operation and Development (OECD) towards the establishment of a common integrated health information system for Europe, covering all 53 Member States.

Where we are: health status in Europe – the case for Health 2020

Demographic trends

6. The WHO European Region is undergoing important demographic and epidemiological changes that are shaping the needs for health promotion, disease prevention and care in the future. However, such transitions are occurring at varying speed and intensity for different country groups and populations, creating new challenges and a mosaic of health situations that requires specific approaches. This highlights some of the major challenges for health in Europe that are addressed by the Health 2020 policy. The information provided in this section identifies key elements upon which the Health 2020 policy is based, sets the agenda for action and provides a baseline for the monitoring of progress towards defined priorities and areas for policy action.

7. The population of the 53 countries of the European Region reached nearly 900 million in 2010; 44% live in the countries belonging to the European Union (EU) before May 2004 (EU15) and another 33% in countries of the Commonwealth of Independent States (CIS). However, decreasing fertility rates across the Region mean that population growth will soon plateau.

8. An estimated 73 million migrants live in the European Region, accounting for nearly 8% of the total population, with women representing 52% of the migrants. Overall, this population inflow, mostly towards EU countries, comprises an increase of 5 million in the migrant population since 2005 and accounts for nearly 70% of population growth during this period.

9. The proportion of the population of the European Region living in urban areas reached nearly 70% in 2010 and is expected to exceed 80% by 2045; as a consequence, people are being exposed to different risks and determinants of health.

Life expectancy

10. Life expectancy at birth has increased by 5 years since 1980, reaching 76 years in 2010. The largest increase of 6.5 years was observed in the EU15 subregion, while in the CIS subregion, where life expectancy is considerably lower, the average increase was only 1.5 years. Projections suggest that life expectancy will increase in the European Region to nearly 81 years by 2050, a similar pace to that between 1980 and 2010. Data from individual countries also show large inequalities in life expectancy levels and years gained, especially when analysed by sex.

11. More people in the Europe Region are living over the age of 65 years – an estimated 15% in 2010. Their remaining life expectancy after that age is on average 15.5 years. It is projected that by 2050 this age group will represent more than 25% of the total population of the Region.

Mortality

12. The overall mortality from all causes of death continues to decline in the European Region, reaching an age-standardized death rate (SDR) of 813 deaths per 100 000 population in 2010. Mortality trends by country groups show wide variations across the Region. Mortality patterns by age in the Region tend to be low or very low during early years of life up to young adulthood and then rapidly increase two-fold in EU15 countries and three-fold in the 12 countries joining the EU since May 2004 (EU12) and CIS countries, continuing this rapid increase into older ages. Child mortality indicators in the European Region are the lowest in the

world and have continued to decline since 1990. The average reported infant mortality rate in 2010 was 7.3 per 1000 live births, following a 53% reduction over the 1990–2010 period.

13. The European Region maternal mortality ratio for 2010 was 13.3 maternal deaths per 100 000 live births, with subregional variations ranging from 73% greater than the average in the CIS subregion to 36% and 62% less than the average in the EU12 and EU15 subregions respectively. Both level of education and socioeconomic status of women impact on maternal mortality. This highlights the importance of addressing gender and other social determinants of health in policies and interventions.

14. As the European population ages, mortality trends help to anticipate some of the challenges that will be faced in the future by health systems that will need to adjust in order to address them. All-cause mortality trends among people over the age of 65 years show a decrease in the European Region as a whole, reaching its lowest rate of 4549 per 100 000 in 2010: a 25% reduction since 1980.

Causes of death

15. Noncommunicable diseases produce the largest proportion of mortality, accounting for about 80% of deaths in the European Region in 2009. Cardiovascular disease accounts for nearly 50% of all deaths, followed by cancer as the second leading cause of mortality, accounting for nearly 20% of all deaths. External causes of injuries and poisoning are responsible for 9% of all deaths. Distribution patterns by subregion have been changing over time.

16. The main cardiovascular diseases are ischaemic heart and cerebrovascular diseases, which together account for 35% of all deaths in Europe. However, they vary widely between countries by age, sex and the distribution of their determinants. Risk factors are described in paragraphs 26 to 28.

17. According to the Health for All database, overall cancer incidence and mortality rates in the European Region are 379 and 168 cases per 100 000, respectively. The incidence rate has increased by 32% and the mortality rate decreased by 10% since the mid-1980s. Mortality rate reductions are observed with cancers where diagnosis, prevention and health care have improved. Among men, lung, colon, stomach and prostate cancers account for nearly 50% of cancer deaths, while among women, breast, lung, stomach, colon, cervical and ovarian cancers account for 60% of deaths.

18. Monitoring of mortality trends for the main external causes provides additional information for future projections and insights on environmental safety conditions and on some harmful behaviours in the population. For example, although they are at different levels, suicide rates have been decreasing by between 25% and 40% in all the subregions of Europe, following an increase in the mid-1990s. Recent trends indicate, however, a slower decrease coinciding with the economic downturn since 2008. Mortality from transport accidents provides information on road safety, including infrastructure conditions, protective measures and regulation. The overall European Regional trends show a 50% decrease in levels from 1990, arriving at a rate of 10 per 100 000 in 2010. This situation may be related to a decrease in road traffic accidents, particularly those involving alcohol.

19. Communicable diseases are less common in the European Region than in other parts of the world. The main concerns are related to the occurrence of tuberculosis, HIV/AIDS, other sexually transmitted diseases and hepatitis viral infections. However, recent poliomyelitis, rubella and measles epidemics in parts of Europe have also re-emphasized the need to sustain or improve public health activities, such as disease surveillance and prevention against disease

activities, including health promotion and immunization. Mortality rates for tuberculosis are decreasing in the European Region after increases in the 1990s, reaching a rate of 6 per 100 000 in 2010: a 30% reduction during this period. Co-infection with HIV presents further challenges to reducing mortality from tuberculosis, particularly in areas of eastern Europe where both infections coexist and where multidrug (including antimicrobial) resistance is present. HIV incidence trend patterns differ among the subregions. AIDS incidence is decreasing in all subregions, indicating the importance of effective treatment.

Premature mortality

20. More than 70% of mortality occurs at ages over 65 years, when disease processes have been underway for several years. Monitoring of premature mortality (deaths of people before the age of 65) is more informative for developing public health policy, programmes and interventions for delaying disease and the onset of disability. The gap between men and women shows a 50% excess risk for men reaching 60 years, and by the age of 65, risk for men is twice as high as for women.

21. Cancer has replaced cardiovascular disease as the foremost cause of premature death in 28 of the 53 countries of the European Region. Explanations are the sustained decrease in cardiovascular disease mortality and an associated increase in life expectancy, and the long latency period in developing cancers. At the country level, the pattern of premature mortality from lung cancer shows the highest rates in central Europe – particularly Hungary, Serbia and Poland – where rates are over 25 per 100 000. This pattern is associated with the prevalence of tobacco smoking that is, in turn, determined by affordability, marketing strategies and permissive public health policies. The premature mortality rates for breast cancer in the Region have been decreasing over the past decade to reach a level of 14 per 100 000: a reduction of 21% since reaching its peak in the mid-1990s.

22. Rates of premature mortality from respiratory diseases have been steadily decreasing in the European Region by 40% since the mid-1990s, to reach a rate of 16 per 100 000 in 2010. Respiratory disease mortality takes its toll on two distinct populations: children and older people. The main specific causes of death are chronic obstructive pulmonary disease (COPD), asthma, pneumonia and influenza, all of them closely associated with outdoor and indoor environmental conditions and exposures. Interventions to prevent them are known but some need intersectoral action.

23. Premature mortality from diseases of the digestive system trends in the European Region show an increasing pattern from 1990 to 2010, when the rate reached 25 per 100 000: a 30% increase during the period. Chronic liver disease and cirrhosis, and ulcers of the stomach and duodenum are the main causes of death among this group and are mainly associated with harmful intake of alcohol and processed foods. Chronic liver disease and cirrhosis have also been associated with a range of viral causes, such as hepatitis B and C infections, and toxins and drug misuse. However, the contribution of alcohol abuse, particularly when its level is heavy and sustained, is probably the most prominent.

24. Diabetes is a major public health problem in Europe because of its direct and indirect effects on those with the disease – ranging from renal, neurological and ophthalmological micro-vascular damage to vascular damage of the limbs, brain and heart – with various severe consequences. Premature mortality from diabetes trends in the European Region show a 25% reduction in the rate from 1995 to 2010, when it reached a level of 4 per 100 000. Identification of diabetes as a cause of death poses some difficulties and may thus be underestimated.

Burden of disease

25. The European Region's total burden of disease (combining mortality, morbidity and disability) distribution for 2004, the latest year with available data, shows a range between 10% and 28% of estimated disability-adjusted life years (DALYs) lost per country population. This represents an almost three-fold gap between the best country situation and the least favourable one. Total DALYs have been attributed to different leading risk factors across the European Region. This information makes it possible to identify and establish the most important areas that demand interventions – such as nutrition, physical activity and reduction of addictive substance consumption – mainly to reduce obesity, high cholesterol and blood pressure, and alcohol and tobacco use. Such interventions require intersectoral participation and the use of different cost-effective strategies.

Risk factors

26. An important element for disease prevention and control and health promotion is an understanding of the underlying causes, including risk factors and socioeconomic and health system determinants. Among the major groups of diseases causing high mortality, morbidity and disability – such as cardiovascular diseases, cancer, external causes of death, respiratory system diseases and digestive diseases, as noted above – there are two main risk factors to tackle: tobacco smoking and harmful alcohol consumption. Prevalence and consumption levels of these two factors among the European population remain high in all subregions, in spite of the availability of knowledge and technology to control them.

27. Tobacco smoking prevalence in the European Region reached 27% of the population aged 15 years and older around 2008, but has been decreasing gradually towards 25%, particularly among men. In the CIS subregion it has remained at around 30%; however, there are no recent data from the CIS as a whole. Alcohol consumption is another factor that determines the frequency of health problems, and according to WHO estimates it accounts for nearly 6.5% of all deaths in Europe. In addition to volume, the type of alcohol consumed and binge drinking consumption patterns are also relevant, due to their potential health impacts.

28. Differential access or exposure to diverse environmental factors over the course of a lifetime are known to determine the occurrence of major health problems including cardiovascular, respiratory and digestive diseases, cancer and external causes of death. Access to clean water and hygienic sanitation services, housing conditions, road safety, air quality, work environment and exposure to extreme climate conditions directly or indirectly contribute to shaping the health profile of the European population.

Health determinants, health systems and inequalities

29. The WHO Commission on Social Determinants of Health defines health equity as "the absence of unfair and avoidable or remediable differences in health among population groups". Global evidence suggests that at least 25% of health inequalities (differences found within a country's population) are caused by a lack of access to effective health services, and this percentage increases when adding in basic public health interventions. Social determinants of health contribute to another 50% of health inequalities, covering political, socioeconomic and environmental factors. These are also referred to as the "causes of the causes" of health inequities, reflecting their fundamental influence on disease causation and the systematic social patterning of health outcomes, including life expectancy. Health inequities are a major concern in Europe, given the widening gap in life expectancy between and within many countries. As one of the most important social determinants, gender norms and relations continue to shape the

way health systems are organized and services delivered, often to the detriment of girls and women or those who do not fit within accepted gender roles.

30. Prerequisites to tackle health inequities include: (a) commitment to ensure that all people have equal opportunities to improve or maintain their health; (b) assessment of health policies and programmes in relation to their specific effects on inequities in health from inputs to outcomes, using disaggregated data on different subpopulations; (c) understanding the pathways from social determinants to differential exposures, vulnerabilities, interaction with the health system, and differential health outcomes; and (d) identification of entry points and actions for change involving participation of the community and other stakeholders, drawing on the evidence base on what can be done to reduce health inequities. Action within the health sector or health system can include strategies to reshape existing programmes to enhance equitable access to care and address processes that exclude people who are disadvantaged or vulnerable. Action on the social determinants of health often requires that multiple sectors align their objectives, work together, and achieve multiple social goals. For example, early child development programmes are associated with better health, education and nutritional outcomes for children and across the life course, as well as improved incomes and contribution to greater social cohesion.

31. Distributions of wealth, education and occupation status – within or across countries – reflect how stratified a population is, and these distributions are also important social determinants of health within and across countries. The European Region is characterized overall as one of the wealthiest in the world, where the annual average income per capita was about US$ 24 000 in 2009. Although increasing since 1990, per capita income levels within the Region are still highly inequitable, ranging from about US$ 715 to US$ 105 000, with nine of the twelve countries with levels below US$ 5000 within the CIS subregion. The recent economic downturn affecting the European Region increased the average unemployment level to 8.7% of the economically active population in 2009, a reversal of the more optimistic trend over the previous decade. At the country level, the gap between low and high unemployment shows a 35-fold difference.

32. The environment represents another important health determinant. Recent assessments of the contribution of environmental factors to health have estimated that they may be responsible for as much as 13% to 20% of the burden of disease in Europe, depending on their mortality pattern classification. The impact of environmental factors on health inequalities has recently been assessed by WHO in the European Region.

33. An effective health system is a prerequisite for responding to the changing epidemiological situation and the health needs of the population through governance, health financing, human resources, and institutions that provide services covering prevention, treatment and palliative care. Progressive financing of health systems and ensuring social protection for households from catastrophic expenditure are an important component of universal coverage without financial risk. Direct or out of pocket payments (OOPs), as a percentage of total health expenditure, provide a good indicator of financial risk and the level of equity in financing. Data on this indicator are available from all 53 European Member States. Average OOPs across the European Region stand at about 23%, but the level varies from about 37% for CIS countries and around 22% for EU12 countries to less than 15% for EU15 countries. Global evidence shows that when reliance on direct payments falls to less than 15–20% of total health expenditure, the incidence of financial catastrophe routinely falls to negligible levels (with financial catastrophe defined as when households annually spend more than 40% of their income after food on paying for health services).

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

34. The strategic goals of Health 2020 are currently taking shape in collaboration with Member States. At its sixty-first session in September 2011, held in Baku, Azerbaijan, the WHO Regional Committee for Europe endorsed the proposals that Health 2020 will (a) set out an action framework to accelerate attainment of better health and well-being for all; (b) be adaptable to the different realities that make up the Region; and (c) formulate regional targets for achievement by 2020. Final approval of the regional targets will be sought at the sixty-second session of the Regional Committee in September 2012 in Malta. The targets and indicators to monitor them will be presented in full within the *European health report 2012*. The process of target setting has been informed by previous efforts and by participatory detailed discussion, written consultation and approval by representatives of governing bodies at each stage.

Previous target setting and monitoring experiences

35. European Region targets were suggested as part of the first common health policy in the Region, the European strategy for attaining Health for All. In the early 1980s, the then 32 European Member States of the WHO European Region debated European targets aligned to the new policy. The agreement on targets was a major undertaking, with more than 250 experts from across the Region working together with the WHO Secretariat. More than 20 drafts and an in-depth consultative process with Member States resulted in the presentation of 82 targets for consideration by the governing bodies of the Region. A reduced set of 38 targets was unanimously adopted in 1984 at the thirty-fourth session of the Regional Committee for Europe in Copenhagen. The first European health policy was published and included these 38 targets, together with 65 regional indicators to monitor and assess progress.

36. These European targets and indicators were reported on within the Health for All database. By 2012, the Health for All database has evolved to cover 53 countries and is widely available and used across the Region. The database includes a selection of core health statistics covering basic demographics, health status, health determinants and risk factors, and health care resources, utilization and expenditure; these data are compiled from various sources, inform the Atlas of Health in the European Region, and are updated twice a year.

37. In order to reflect the changes that have taken place in the Region since the mid-1980s, the 38 targets were revised in 1991. The WHO Regional Office for Europe supported the implementation of the targets by responding to Member States requests and aligning the organization's budgets and programmatic activities to the target areas.

38. During the 1990s, major political, economic and social changes in the Region changed the European landscape. One result of this was a dramatic increase in the number of European Member States, which now stands at more than 50. The Regional Office revisited its European health policy and regional targets. In 1998, a new set of 21 targets was identified within *HEALTH21: Health for All in the 21st century*. Adopted at the forty-eighth session of the Regional Committee in 1998, these targets were published in 1999. The focus of this second iteration remained on the construction of targets at the country and local levels, with no regional reporting.

39. The WHO European Region has approximately 30 years of experience in target setting as part of regional health policies and strategies, in the context of a Europe that has changed dramatically. Lessons learnt include the following: (a) a broad consensus needs to be developed among stakeholders; (b) targets need to be limited to a manageable number; (c) any plan should

be based on evidence of effectiveness; (d) targets need to be linked to resources; (e) technical challenges remain that require collaboration with partners and technical support to countries who ask for it. Experience in the Region has shown that setting targets and monitoring indicators can be a hugely motivating factor as countries collect and incorporate in their routine information systems the necessary data to inform health policy, even where in the past such data did not exist.

Technical issues in selecting targets and indicators

40. A well-organized mechanism is important to formulate specific, measurable, achievable, relevant and timely (SMART) targets. SMART targets are more likely to be accomplished than general goals. In order to arrive at measureable targets, concrete criteria for measuring progress must be established. For targets to be achievable, they must be realistic, while at the same time set against a defined time scale – in this case up to the year 2020 – with interim progress monitoring. Targets are considered relevant when they represent objectives towards which the policy is able to work. Every target, if achieved, should represent real progress that can be quantified.

41. Once a target area and potential indicators are identified, several approaches exist to select a target level. The counterfactual method identifies a biologically achievable or theoretical minimum or maximum value, which is compared to the existing situation based on available information. Trend analyses show where trends in rates can be used to arrive at a target in the future. Intervention study pooling and comparative risk assessments also provide methods of selecting target levels based on evidence of what works in different contexts and subpopulations. A monitoring framework and structured reporting are also needed, as well as a guide to interpret the indicators and targets. With these lessons in mind, extensive consultations with Member States and technical experts have taken place to develop regional targets in line with the development of Health 2020. The full report includes the monitoring framework.

Consultation with representatives of European Member States

42. Three meetings of the European Health Policy Forum for High-level Government Officials took place that provided detailed discussions and input to the process to identify a limited number of European targets including technical criteria, alignment with Health 2020, and agreement on a framework and shortlist. Delegations from across the European Region met in March 2011 in Andorra, in November 2011 in Israel, and in April 2012 in Belgium. A shortlist of six overarching European target areas was identified as a mechanism for accountability and solidarity across the Region, noting that Member States should be encouraged to develop their own national targets for health.

43. Member States also contributed to the technical deliberations, working closely with the WHO Secretariat, reflecting the proposal of the Standing Committee of the Regional Committee (SCRC) in May 2011. Representatives of the following Member States were nominated for this working group: Andorra (previous chair of SCRC); Poland; Sweden (current chair of SCRC); Turkey; Ukraine; the United Kingdom; and the former Yugoslav Republic of Macedonia (former SCRC Chair). The group was chaired by a representative of a Member State (Sweden) with extensive experience in this area, and co-chaired by the WHO Regional Director for Europe. Each meeting of the group resulted in clear recommendations towards narrowing down a list of potential targets and indicators in line with the three broad areas identified as part of Health 2020: (a) burden of disease and risk factors; (b) healthy people, well-being and determinants; and (c) processes including governance and health systems, for wider consultation.

44. The WHO Secretariat collated inputs and recommendations on the process to set targets, as well as potential targets for inclusion, for the various consultations with Member States described above. All technical divisions at the WHO Regional Office for Europe submitted potential targets and monitoring indicators. From an initial list of 51 proposed targets, the SCRC working group recommended that 21 proposed targets should be retained in January 2012. This shortlist was subject to extensive written and face-to-face country consultation during February and March 2012, resulting in an initial framework of 16 potential targets and associated indicators, largely drawn from existing data reporting by countries; these were further reduced to six overarching or "headline" targets. The May 2012 meeting of the SCRC, held in Geneva, provided full support to the target work, further endorsed the six overarching targets and agreed that the targets will feature in all Health 2020 documents, and confirmed that indicators will monitor progress and achievement by 2020.

Overarching targets

45. The rationale for choosing the six overarching targets – listed below – is that either they are in line with contemporary global target setting efforts, such as in the area of noncommunicable diseases, or they extend and update previous European target setting strategies and approaches already acknowledged or agreed upon by European Member States. The targets are:

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

46. With the assistance of an international expert group, the WHO Secretariat is completing the identification of indicators in advance of the sixty-second session of the Regional Committee for Europe, to be held in Malta in September 2012. With the approval of the Regional Committee, the complete European health report 2012 will detail the baseline for each target at the European level, discuss each indicator selected, assess the achievability of each and convey what it will mean if the target is reached by 2020. Different experiences from Member States across the European Region will also highlight existing efforts to address these target areas at the national level.

How we are getting there and what we value: the case for measuring well-being

47. The WHO definition describes health "not merely as the absence of disease or infirmity" but as "physical, mental and social well-being". However, for more than 60 years WHO has neither measured nor reported on well-being. Instead, it has focused its reporting on death, disease and disability. While this monitoring function is clearly a core mandate for the Organization, WHO is partnering with other institutions to describe the well-being of populations and to measure progress on the enhancement of well-being in Europe in the context of Health 2020.

48. What does well-being mean? What makes up a "good life" is one of the basic moral discussions common across all philosophical traditions. Across countries, people usually agree

on the “big picture” or the minimum ingredients of well-being, even if the identification of important areas or components remains a normative exercise. What matters to people’s lives is also surprisingly constant, indicating that what we value does not change easily. It is a multidimensional concept. Well-being and health are interactive concepts, with some common determinants, such as the health system.

Direct relevance to Health 2020

49. Discussions during the extensive consultation phase of Health 2020 with representatives from European Member States and technical experts provided qualitative evidence that across the European Region people value health and want to minimize disease. In terms of important broader determinants of health and well-being, they value social cohesion and inclusion, so that all people have a fair chance for health. People also value security and safety, which are related to health in the context of well-being. Common values across Europe increase the possibility of having a regional target for health and well-being.

50. Why is this important for health? Policy-makers, public health practitioners and people living in communities across Europe agree that well-being includes health, and that health is an essential part of – if not a prerequisite for – well-being. Health matters for well-being, and specifically several aspects of health, including physical, mental and social. Moreover, research shows that there are two-way relationships between different areas of well-being: it is clear that health influences overall well-being, but well-being is also an indicator of future health or illness.

51. Why is this important to governments and societies across Europe? The past few years have witnessed a number of national and international initiatives promoting the policy use of well-being indicators that reach beyond measuring economic performance and, within the health sector, that can supplement standard metrics of mortality, disability or disease. These initiatives are very diverse in their scope, methods, targets and key audiences. Another goal shared by some of these initiatives is to involve citizens in the definition of measures of well-being and progress.

52. Improving – or at least maintaining – well-being is part of the social contract between governments and the people they represent. Ensuring a good life is not owned by any particular sector or service, as it is a multidimensional concept with multiple determinants. Improving population well-being can be a platform to develop a common agenda, including a whole-of-government approach, across sectors and stakeholders. In addition to governments, major actors interested in well-being include civil society groups, patient groups, wellness and health promotion practitioners and the media.

What we can build on

53. Efforts that have considered measuring well-being at the population level are in practice more relevant than other efforts that focus on specific clinical subpopulations for the aim of developing targets and indicators to monitor and report on health and well-being at the European Regional level. The WHO Regional Office for Europe carried out a systematic literature review of validated tools for the measurement of well-being, to increase understanding in this area.

54. The complete report also highlights and reviews efforts led by those working with the Regional Office as partners on this common challenge, including national governments in Europe, other international organizations, WHO at the international level, private firms and efforts commissioned by the United Nations. All feature health as an important component of

well-being, or a factor directly affecting well-being; a few draw on the same data sets collected through international surveys; and some use different words – such as quality of life, subjective well-being or happiness – to discuss what makes up a good life.

What challenges do we face?

55. Despite general agreement on what makes a good life, as well as multiple tools and approaches to measure health and well-being, researchers agree that the field of measuring well-being would benefit from additional clarity and more rigorous assessment methods. Some of the challenges are a narrow conceptualization of health and well-being; limited data sources, yet a vast number of tools and indices; greater reliance on mortality or illness measures than those that assess positive health; and a lack of meaningful approaches to communicating and interpreting multidimensional concepts.

56. With strong support for an overarching target addressing health and well-being as part of the new European health strategy, Health 2020, the WHO Regional Office for Europe is working with technical partners to provide operational clarity on how health is measured in the context of well-being. In parallel, we have entered a process of intense consultation with Member States. With the approval of governing bodies, we expect to have the following results by 2013, elaborated on in the full report:

- A framework and definition of well-being that is conceptually sound – as far as possible the operational approach should draw on existing models that have been used at the population level;
- Identification of the range of domains and subsequent indicators – for example, linked to the International Classification of Functioning, Disability and Health (ICF), which is WHO's framework for measuring health and disability at both individual and population levels and complements WHO's International Classification of Diseases (ICD);
- Indicators and an approach to their measurement, identified to measure each aspect of the health domain, that are tied to an agreed target identified for monitoring progress towards the Health 2020, to improve population health in the context of well-being;
- Clarity on the way policy-makers, health professionals and other interested stakeholders across the European Region can use this information as inputs to policy-making and interventions, joined up with different sectors – for use within Health 2020, both the information content of well-being measures and the entry points need to be considered carefully, along with potential limitations to using well-being indicators;
- A recognition that there are also a large number of countries in the Region who do not currently have national efforts (whether within the Ministry of Health, other ministries or national statistical agencies) to conceptualize, collect or use information on health and well-being – any effort to improve well-being at the Regional level should consider options to support a broad range of countries, with different data and measurement starting points.

57. Improving health and well-being is a recognized as an essential component of Health 2020. A wide range of ongoing activities measuring well-being at the international level in Europe, as well as many national initiatives, provide a strong basis for the WHO Regional Office for Europe to build on work in this field; in particular, measuring health in the context of well-being and setting out a research agenda that improves both the methods for assessing and communicating measures and the policy processes to enhance the use of information that improves health and well-being.

58. The Regional Office will also support the policy use of health and well-being measures, drawing on strategies reflecting the WHO European Region's comparative advantage in several areas, including approaches to disseminating policy relevant information, working in collaboration with partner European institutions and Member States; advice on how well-being indicators should be interpreted and used in connection with standard measures of mortality, morbidity and health system performance indicators; and undertaking a more innovative role in providing evidence on the mechanisms and tools for the health sector to enhance well-being in other sectors.

Countdown to 2020: marking progress

59. Although the previous sections document a plethora of health information available in the WHO European Region, the measurement challenges remain considerable. Relevant data to measure progress are not available for all countries; definitions vary between countries and disease classifications are not homogenously applied; population coverage for vital events registration is variable and does not yet cover the whole population in all countries of the Region.

60. One of the major challenges for the implementation and impact of Health 2020 is data availability to monitor progress at the country level. The overarching or "headline" targets and their indicators have been selected for their importance in achieving Health 2020 but also for their availability. Most indicators for the targets listed are supplied by information that is either routinely or regularly collected in most European countries. However, differences in definitions, coverage of the population and data quality make comparisons problematic. WHO is committed to assisting Member States in enhancing their health information reporting and in monitoring progress with the implementation of Health 2020.

61. Key requirements for addressing the challenges that the WHO Regional Office for Europe faces are listed below, within the categories of health information, interpretation and translation. These are also the areas where the Regional Office could add value with its partners. The full report will detail a roadmap on how to address the challenges and achieve solutions, identifying collaborators, resources and processes that can support joined up action.

- Health information
  - Address the range of data sources and norms/standards – from vital statistics to household surveys – so that these contain common ways to disaggregate population data, by social strata or other types of strata, and to increase accountability.
  - Address a method for illustrating all 53 countries within meaningful subEuropean aggregations; that is, subregional trends. This is important as currently 14 Member States are not included in the EU12, EU15 and CIS subregional groupings.
  - Collect, link and make accessible data across health and other sectors, to support health in all sectors and intersectoral analysis, policy-making, monitoring and evaluation.
  - Improve surveillance and outbreak monitoring and compliance with the International Health Regulations (IHR) across the European Region, as well as connections with other regions (regarding governance for health and tackling communicable diseases).
- Interpretation
  - Improve methods for using summary measures of population health (such as DALYs), which combine information on fatal and non-fatal outcomes, thus providing a more comprehensive picture of the regional burden of disease.

  - Build better understanding of the pathways to health and well-being and their distribution in the European Region and within countries. This will also include the ability to better attribute the share and degree of impact of an intervention (from within the health sector and from other sectors) on health and reduction in health inequalities.
  - Enable measurement of well-being in the context of health and its eventual target setting. Section 3 provides a detailed roadmap which will culminate in the announcement of proposed indicators for well-being in 2013.

- Translation
  - Enhance the use of new technologies and innovations, particularly in the area of e-health. Secure and relevant information exchange within the European context needs to be supported, while staying in line with data protection laws, patients' rights, and accountability.
  - Support initiatives for the translation of evidence into policy, which can address and resolve policy questions using the best available evidence.

62. In order to respond to these challenges, WHO will support the development, updating or redesign of tools and instruments to enhance health information collection, analysis and reporting at the country level. WHO is working with the European Commission and OECD towards the establishment of a single integrated health information system for Europe, covering all 53 Member States. This work is well under way, together with the development of a health information strategy for Europe.