Targets for health in Europe: the debate continues

The WHO European Region covers three quarters of a billion people, in 53 Member States, and reaches west–east from the Atlantic to the Pacific. Under a recently joined Regional Director, WHO European Region (WHO EURO) is reviewing its health strategy. Stein et al have provided an update on thinking about health targets that were first proposed (38 targets) in 1984, and again (21 targets) for the Health in the 21st century strategy in 1998. In the past decade, WHO EURO member states have used national targets for national health strategies; and although headline health indices (mortality rates) were diverging, recently there have been improvements in all parts of the region—even against the trend of the economic downturn (figure 1). But this time, following consultation, the new targets are proposed only for the WHO European Region itself (i.e. at supranational level), whereas the progress of member states will be ‘monitored’ within the entire region. Do member states disagree with the concept of national targets? Are they concerned about differences between the member states? Are they anxious should they fail?

A difficulty for choosing to present targets at only European level is ‘skewed federalism’, an idea first described in relation to the regional health system in Italy. Although the higher tier (WHO region) holds responsibility for achieving targets, the funds and policy levers are at a lower political level (WHO member states); and the total can only be the sum of the parts. The European Union (now almost two-thirds of the population of the WHO European region) has a similar challenge in its new Innovation Partnership for Active and Healthy Ageing, which has set a (single) target to increase the healthy life span by 2 years by 2020. The European Union (EU) staff budget for public health is not larger than that of WHO EURO, and small when compared with the healthcare budget of even a single Member State. For both organisations, their prime tool is not direct spending, but coordination across countries, and promoting good practice based on innovation and research. But the EU has the advantage of being able to fund some of this coordination, and also introduce directives for legislation within Member States. For example, regulation on tobacco, food, alcohol and road transport would contribute to achieving the target through reducing chronic disease.

The WHO regional targets are of concern to the citizens of Europe as well as its policy-makers—to the ‘silent majority’ whose health is achieved and maintained through prevention of disease, the minority who are patients within medical and social care and the healthcare workers who provide services. In the everyday life of a health decision-maker, for example, the needs of a child with epilepsy, or someone receiving social care, must be balanced against other prevention interventions, such as for healthier eating, which potentially help majorities of the population. Will the targets be related to cost-effective interventions for prevention as well as for treatment, and assist public choices for funding, policy and legislative priorities? How will disparities between social groups be addressed?

New areas of data collection are opening up. WHO proposes to collect data on ‘wellbeing’, although more discussion will be needed before accepting this reconceptualisation of health. Electronic medical records and population study cohorts (mainly financed with public money) are

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Figure 1 Expectation of life at birth, European countries, 1980–2010. Source: WHO/Europe, European HFA Database, January 2012
becoming important for surveillance, both evaluation of therapeutic effectiveness and broader outcomes of medical care. But European data sets remain underdeveloped; they are not clearly linked with health strategies and policies and there is a lack of comparable information on national policies and implementation—which does not assist democratic review of the impacts of governmental action. Attention should also be given to better data-sharing, for example, through pan-European ‘research infrastructures’.  

Perhaps the biggest challenge for targets is gathering reliable and timely data. WHO has put much effort into assisting countries in standardised reporting, and built systems such as the Health for All database and the European Health Interview Survey that are of great value. However, the European Commission has taken a divergent line on health databases, first through including health data in EUROSTAT, and more recently, in a new electronic platform HEIDI-WIKI of the Directorate for Health and Consumers. Will the extension of the EU’s influence through its European Neighbourhood Policy (linking with countries to the east and south) lead to dominance of EU systems across the whole region? What is the place of other international data-gatherers, such as OECD and the Council of Europe? And what synchronisation can there be with EU-funded projects developing more focused data sets at subnational level?

Intergovernmental bodies need to renew their strategies as the world changes. This year, the WHO World Health Report 2012 is to focus on conducting and translating health research. As WHO EURO member states rapidly convert from analogue to digital health record systems, governments could require this substantial spending to provide information for public health research as well as for clinical and administrative needs. The new European health targets also offer a framework for building evidence on the impacts of health policy and practice.

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References

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