Monitoring health in central and eastern Europe and the former Soviet Union

Dr. McKee is professor of European Public Health at the European Centre on Health of Societies in Transition, London School of Hygiene and Tropical Medicine, London, UK

Published Online First: 9 November 2005

Since the political transition in central and eastern Europe and the former Soviet Union, much has been written about the health situation in this region. There is now a much better understanding of the factors underlying the stagnation in mortality that occurred in central Europe in the 1980s (Chenet et al. 1996) as well as the reasons for its improvement in the 1990s (Dolea et al. 2002). Similarly, there is a much clearer appreciation of the immediate causes of the continuing mortality crisis in many of the countries of the former Soviet Union, and in particular the key role played by alcohol (Shkolnikov et al. 2001). Rather less is, however, known about measures other than mortality. For example, while it has been shown that older Russian women experience high levels of poor self-reported health, so that despite living longer than their male counterparts, they have almost the same expectation of healthy life (Andreev et al. 2003), we know very little about why this is the case. And while it is straightforward to track trends in individual causes of death, where appropriate using sophisticated analytic methods to disentangle age, period and cohort effects (Varasovszky et al. 1997), in many countries little is known about what has happened to the risk factors that might explain these changes. This lack of information poses a major problem. Life expectancy in the eight central European countries that joined the European Union in 2004 still lags far behind that in their western European neighbours. On present trends it will take twenty or more years for the gap to close (McKee et al. 2004). If this process is to be accelerated, it will be essential to implement policies that tackle the underlying causes of the diseases that are killing people prematurely. The problem is even greater in many parts of the former Soviet Union, where life expectancy continues to decline (McMichael et al. 2004). In many cases there is clear evidence about what is likely to work. Yet without good information on levels of exposure, how will we know if we are succeeding? Furthermore, experience from western countries shows how, when health promoting policies are introduced, it is often those who are already advantaged who benefit most (Mackenbach et al. 2003). Without adequate information on the distribution of risk factors, and how it is changing, there is a danger that health inequalities that have already grown since transition will widen further (Leinsalu et al. 2003).

Compared with many parts of the world, this region has many advantages, although on closer inspection, there are also some problems. There are functioning systems for recording births and deaths and for monitoring population through censuses. Many work well but some have major weaknesses, especially in areas afflicted by conflict (Bozicevic et al. 2001), and there is evidence of a deterioration in some places, especially in central Asia (Rechel et al. 2005). This region has inherited a network of sanitary-epidemiological facilities that should, in theory, be able to provide the basis for an effective surveillance system. Yet in many countries these facilities have suffered from a long period of under-investment, with outdated equipment and few people trained in modern epidemiological methods. As a consequence, in many places the service has become essentially corrupt.

What needs to happen? To begin with, it is important to recognise that there is enormous diversity in this region. Some countries, such as Hungary, have invested substantially in developing a modern public system (McKee 2005). Elsewhere, it has not been seen as a priority. As a consequence, even if a decision was taken today to develop an effective surveillance system, some countries would not be in a position to do so. It is, however, straightforward to identify what is needed.

The elements of a comprehensive health surveillance system flow from a consideration of the pathways from health to disease. One element looks at trends in disease, assessed both

Soz.-Präventivmed. 50 (2005) 341–343
0303-8408/05/050341-3
DOI 10.1007/s00038-005-5036-8

through fatalities, from mortality records, and the occurrence of disease, with sentinel surveillance and systems for notifying events such as infections or congenital malformations. Another looks at the determinants of disease, assessed by, for example, regular health and lifestyle surveys. Then there is monitoring of the course of disease, utilising disease and cancer registers.

There are many examples where individual elements have been put in place. Many countries have participated in a series of international monitoring activities, such as the World Health Organization's MONICA and CINDI programmes and the Health Behaviour in School-aged Children surveys (HBSC). The three Baltic States have benefited from the series of FINNBALT surveys that have tracked changing lifestyles during the transition (Kasmel et al. 2004). The Lifestyles, Living Conditions and Health surveys, conducted in eight former Soviet republics, also provide valuable comparative information on a range of health-related behaviours (Gilmore et al. 2004), as illustrated by the paper by Cockerham et al. in the precedent issue of SPM (2005). While its main purpose was not to monitor health, the successive waves of the Russian Longitudinal Monitoring Survey have provided a valuable means of tracking health and lifestyles during the transition (Cockerham 2000). In Hungary, an imaginative collaboration between the School of Public Health and the national Public Health Service has created a system of sentinel surveillance, making it possible to assess the extent of previously unrecorded illness in the population using explicit case definitions (Szeles et al. 2005). Also in Hungary, important findings from the 2002 health behaviour survey are now being reported, with two examples reported in this and a following issue of SPM (Szanto et al. 2005; Konerding et al. 2005). A report in a former issue of SPM describes one of the many innovations that are being developed in the region, a telephone-based risk factor surveillance programme (Schmid et al. 2005).

Unfortunately, among these achievements, there have been some setbacks, most notably the ill-conceived application of data protection legislation that has damaged the operation of some long-standing cancer registries (Rahu & McKee 2003) and which has limited the scope to examine, for example, the health needs of minorities, such as the already disadvantaged Roma population (Koupilová et al. 2001).

Over the past 15 years, many countries in this region have made a successful transition to modern market economies. However, economic growth will not be sufficient on its own to improve health (McKee & Suhrcke 2005). Elsewhere, the situation is much less hopeful. Yet almost everywhere there is a need for a renewed effort to build the systems that will make it possible for countries to monitor and enhance the health of their populations.

Martin McKee

References

Andreev EM, McKee M, Shkolnikov VM (2003). Health expectancy in Russia: a new perspective on the health divide in Europe. Bull WHO 81: 778–88.

Bozicevic I, Oreskovic S, Stevanovic R, Rodin U, Nolte E, McKee M (2001). What is happening to the health of the Croatian population? Croatian Med J 42: 601–5.

Chenet L, McKee M, Fulop N, et al. (1996). Changing life expectancy in central Europe: is there a single reason? J Publ Health Med 18: 329–36.

Cockerham WC (2000). Health lifestyles in Russia. Soc Sci Med 51: 1313–24.

Cockerham WC, Hinote BP, Abbott P, Haerpfer C (2005). Health lifestyles in the Ukraine. Soz Praventiv Med 50: 264–271.

Dolea C, Nolte E, McKee M (2002). Changing life expectancy in Romania following the transition. J Epidemiol Comm Health 56: 444–9.

Gilmore A, Pomerleau J, McKee M, et al. (2004). Prevalence of smoking in 8 countries of the former Soviet Union: results from the living conditions, lifestyles and health study. Am J Public Health 94: 2177–87.

HBSC: http://www.hbsc.org/countries.html

Kasmel A, Helasoja V, Lipand A, Prattala R, Klumbiene J, Pudule I (2004). Association between health behaviour and self-reported health in Estonia, Finland, Latvia and Lithuania. Eur J Public Health 14: 32–6.

Konerding U, Kohlmann T, Alte D, John U (2005). Subjective health complaints in West Pomerania: results of the Study of Health in Pomerania (SHIP). Soz Praventiv Med 50 (in press).

Koupilová I, Epstein H, Holcík J, Hajioff S, McKee M (2001). Health needs of the Roma population in the Czech and Slovak Republics. Soc Sci Med 53: 1191–204.

Leinsalu M, Vagero D, Kunst AE (2003). Estonia 1989–2000: enormous increase in mortality differences by education. Int J Epidemiol 32: 1081–7.

Mackenbach JP, Bos V, Andersen O, et al. (2003). Widening socioeconomic inequalities in mortality in six Western European countries. Int J Epidemiol 32: 830–7.

McKee M (2005). A decade of experience in eastern Europe. In: Foege W, Black R, Daulaire N, eds. Leadership and management for improving global health. New York: J. Bass, J. Wiley: 167–86.

McKee M, MacLehose L, Nolte E (eds.) (2004). Health policy and European Union enlargement. Buckingham: Open University Press.

McKee M, Suhrcke M (2005). Health and economic transition. Int J Epidemiol (in press).

McMichael AJ, McKee M, Shkolnikov V, Valkonen T (2004). Mortality trends and setbacks: global convergence or divergence? Lancet 363: 1155–9.

Rahu M, McKee M (2003). Effect of Estonian law on prospects for public health research. Lancet 362: 2122.

Soz.-Präventivmed. 50 (2005) 341–343

Rechel B, Shapo L, McKee M (2005). Are the health Millennium Development Goals appropriate for Eastern Europe and Central Asia? Health Policy 73: 339–351.

Schmid T, Zabina H, McQueen D, Glasunov I, Potemkina R (2005). The first telephone-based health survey in Moscow: building a model for behavioural risk factor surveillance in Russia. Soz Praventiv Med 50: 61–2.

Shkolnikov V, McKee M, Leon DA (2001). Changes in life expectancy in Russia in the 1990s. Lancet 357: 917–21.

Szanto Z, Susanszky E, Kopp M (2005). Relationships between unfavourable health status and smoking cessation attempts in Hungary. Soz Praventiv Med 50: 323–331.

Szeles G, Voko Z, Jenei T, et al. (2005). A preliminary evaluation of a health monitoring programme in Hungary. Eur J Public Health 15: 26–32.

Varasovszky Z, Bain C, McKee M (1997). Alcohol related mortality in Poland and Hungary: differences and similarities. J Epidemiol Comm Health 51: 167–71.

Address for correspondence

Martin McKee, CBE, MD, MSc, FRCP, FRCPI, FFPHM, FMedSci
European Centre on Health of Societies in Transition
London School of Hygiene and Tropical Medicine
Keppel Street
London WC1E 7HT
UK
Tel.: +44 20 7927 2229
Fax: +44 20 7927 2229
e-mail: martin.mckee@lshtm.ac.uk

Soz.-Präventivmed. 50 (2005) 341–343