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Health policy in Europe: factors critical for success

Large health gains could be made if all countries in Europe adopted the health policies of the best performing country. Johan P Mackenbach, Marina Karanikolos, and Martin McKee examine the differences between countries and the reasons behind them.

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Over recent decades, policies in areas such as tobacco and alcohol control, early detection of hypertension and cancer, and child and road safety have made important contributions to improvements in population health in Europe. This progress has, however, been uneven, and some countries lag considerably behind the front runners. While some of these variations reflect differences in available resources, others reflect differences in willingness to take action, as illustrated by the fact that neighbouring countries in similar economic conditions sometimes have very different outcomes.

Major successes mirrored by large failures

Over the past 40 years, European countries have followed very different health trajectories. This can most easily be seen in the area of life expectancy, which has increased almost continuously in the Nordic countries, the United Kingdom and Ireland, and continental and Mediterranean Europe. Yet in central and eastern Europe and the former Soviet Union, it was already stagnating by 1970 and began to improve only in the 1990s or later (fig 1). The differences are due to diverging trends in rates of death from a wide range of causes, many of which have become amenable to interventions within and outside the healthcare sector, such as lung, cervical, and breast cancer; ischaemic heart and cerebrovascular disease; liver cirrhosis; maternal and infant mortality; and road traffic and other injuries.

Changes in mortality from a particular cause almost always reflect the interplay of a wide range of factors, only some of which are within the control of individuals and governments. Although it is often not possible to determine the quantitative contribution of purposive action, there is compelling evidence that declines in mortality from causes amenable to intervention are partly due to the implementation of effective health policies (box 1, web appendix). In many western European countries, lung cancer mortality is falling, particularly among men, as a delayed response to the tobacco control efforts over the past decades that reduced the prevalence of smoking. Similarly, declining mortality from cervical and, more controversially, breast cancer partly reflects the introduction of population based screening.

Lifestyle improvements (less smoking, dietary change) have contributed to falls in ischaemic heart and cerebrovascular disease, as have increased detection and treatment of hypertension and improvements in medical care. In some countries, more stringent alcohol control measures have led to reduced alcohol consumption and falling mortality from liver cirrhosis (while conversely their relaxation has been followed by increased mortality).

The falls in maternal and infant mortality can be partly attributed to improved access to contraception and safe abortion, prenatal care, prevention of cot death, and other measures related to mother and child health.

In many countries, improved road traffic safety has greatly reduced deaths from road traffic injuries despite increased road usage.

The scale of these population health advances can be gauged by looking at the numbers of deaths that would have occurred in 2009 in Europe as a whole if death rates had remained at their 1970 levels (table 1). For example, we calculate that 351 000 deaths from ischaemic heart disease and 355 000 deaths from cerebrovascular disease among men have been averted and, had this not occurred, mortality from these diseases in 2009 would have been 42% and 86% higher, respectively.
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Factors that are critical for success

Why have some countries been more successful in pursuing effective health policies than others? Here we should differentiate between the “means” and the “will” to implement health policies. Of course, there must be adequate financial resources. Although health policies vary greatly in cost—and some, such as increased tobacco and alcohol taxation, can generate income—it will inevitably be easier for wealthy countries than poor ones to introduce many policies, especially those based on service provision. It is therefore no surprise that countries with a higher national income generally perform better (fig 2A). However, some countries perform substantially better or worse than their national income seems to allow. For example, among the high income countries in Europe, Sweden does better and Belgium does worse than predicted, and among the middle income countries in Europe Albania does better and Russia does worse than predicted by its economic “means.”

In addition to financial means countries must have functioning institutions, providing, among other things, effective government (such as the ability to enact legislation and enforce the law) and a competent public health workforce. Again, these differ greatly between European countries. Many of the countries in central and eastern Europe and the former Soviet Union have relatively low levels of government effectiveness, as reported by international agencies such as the World Bank.

Differences in health policies among countries are probably also determined by differences in “will,” including political will (“willingness by decision-makers to act . . . with the full and genuinely intended support of effective policy solutions collectively developed”). For health policies to be developed, politicians, policy makers, and professionals must become aware that a problem needs to be solved and that there is a potential solution. This can come about in many ways and often requires the actions of a range of individuals and organisations.

Although governments have responded quickly to many outbreaks of infectious disease, in other policy areas it has taken many years for an issue to be seen as a problem that requires concerted action, especially for behaviours that involve a degree of personal choice, such as smoking and drinking. Often, civil society organisations, professional bodies, and even individuals have had an important role in setting the agenda, as in the case of the British Consensus on Action on Salt & Health (CASH) and the paediatricians in the Netherlands who identified the prone sleeping position as a risk factor for cot death. In some cases, however, delayed action was due partly to the counter efforts of powerful vested interests. The most notorious example is secondhand smoking, where the tobacco industry conducted a major campaign to create confusion about whether exposure was harmful. Some countries have been more sensitive to lobbying by the tobacco industry than others.

The role of differences in will is apparent not only from simple observation but also from the fact that differences in overall performance between countries are closely associated with the values of a country’s population and, specifically, where they lie on a survival/self expression scale. This explanatory factor showed the strongest association with overall policy performance ($r^2=0.87$) (box 1, web appendix).

The more a population is oriented towards modern self expression values emphasising quality of life, the more successful that country’s health policies are. This is consistent with a large body of theory which suggests that once people have sufficient resources not to have to worry about how they will survive from day to day, they can begin to think about how they will invest in their health in the future. This creates the opportunity for health promotion efforts aiming to improve behaviours such as smoking and diet. However, will also seems to depend on a sense of national
solidarity. The ability to explain policy performance was enhanced ($r^2=0.90$) by the inclusion of a measure of ethnic fractionalisation, whereby ethnically, linguistically, and religiously more homogeneous populations performed better. This is consistent with research showing that divided societies are less willing to invest in collective goods.29

**Neighbours going in different directions**

Some of these differences come out clearly when we compare neighbouring countries that are similar in many respects but have pursued different health policies. Denmark and Sweden provide a first example. Denmark performs less well than its immediate neighbour Sweden,26 and while Sweden performs much better than expected on the basis of its national income, Denmark does not (fig 2)). Denmark’s mediocre performance applies to many areas of health policy including tobacco control, alcohol control, iodine deficiency, neonatal and maternal mortality, measles immunisation, and road traffic safety.4 Yet in comparative studies of processes and conditions of health policy, Denmark is consistently described as a country with well developed and well resourced policies that are supported by strong legal frameworks and a well functioning public health infrastructure,7 and a country with an excellent data infrastructure and a well trained workforce.28 It is unlikely, therefore, that Danish governments lack the means to achieve better performance; rather it seems that they lack the will to intervene strongly to counter health risks related to modern lifestyles. An in-depth comparison of health policy documents from the four Nordic countries shows that while the health problems are the same, Finnish, Swedish, and Norwegian documents have a strong emphasis on social relations, living conditions, and participation, while Danish health policy documents focus on individual behaviour, responsibility, and autonomy.29 30

In continental Europe, Belgium stands out as an underperformer, in comparison with both its immediate neighbour the Netherlands and with all other countries at a similar level of income (fig 2)). Belgium has a relatively low score on survival/self expression values and also has a relatively high degree of ethnic-linguistic fractionalisation (between the Flemish and Walloon communities), which suggest that part of the explanation for its low performance may be a lack of collective will to tackle health problems. However, it performs worse than expected even after values and ethnic fractionalisation are taken into account, and another possible explanation is that it lacks the means to implement policies: it has a shortage of skilled public health professionals31 and effectiveness of the Belgian public health infrastructure is hampered by the split between the Flemish and Walloon communities and the federal government.

In central and eastern Europe, Slovenia is performing relatively well, not only in comparison with other former parts of Yugoslavia (which have gone through a much more disruptive secession process32 and have lower national incomes) but also in comparison with Hungary. Slovenia is more active than Hungary in tobacco control, has lower death rates from lung cancer and liver cirrhosis (although still high compared with western Europe), does better on iodine deficiency, healthy eating, teenage pregnancy, maternal and infant mortality, and child and road safety. Slovenia has gone through a rapid process of political and economic modernisation since it became independent in 1991 and is the richest of the countries in central and eastern Europe.33 34 The population has a relatively modern value orientation, as measured on the survival/self expression scale, which is likely to be reflected in its health policy choices.

**What is to be done?**

The European experience suggests that, in general, health policies tend to follow national incomes, and to align with the values of their populations, but in some cases, governments seem to be in the lead, doing more than might be expected, while in others they lag behind, doing less. A key question is whether international organisations like the World Health Organization and the European Union can help to bring the poorest performers to the levels of the best? They have shown that they have the will to do so, as set out in, for example, the inspirational Health 2020 strategy recently adopted by the European Region of the WHO.35 Clearly international organisations can support mutual learning and exchange of experience but this is unlikely to be enough. Can they provide both the will and the means? In theory, the European Union has the resources to close the health gap between countries—for example, by using the European Structural Funds and the Cohesion Fund, which aim to reduce disparities in terms of income, wealth, and opportunities.36 In practice, however, it has other priorities and covers only the wealthier part of the European region. Our data show that developing effective mechanisms to close the health gap between all European countries could lead to enormous health gains.
Henshcel, Babak Khoshnood, José Martin-Moreno, Andrew McCulloch, Sylvia Medina, Francesco Mitis, Ionela Petea, Ralf Reintjes, Liselotte Schäfer-Ellmer, Dinesh Sethi, Ingrid Wolfe, and Jennifer Zeitlin for their invaluable contributions to the book Successes and Failures of Health Policy in Europe: Four Decades of Diverging Trends and Converging Challenges. We also thank the Rockefeller Foundation for hosting JPM and MM during a residency in their Bellagio Centre and the European Observatory on Health Systems and Policies for financial support.

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### Table 1 | Deaths saved by health policy interventions in 2009, Europe as a whole

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Observed deaths</th>
<th></th>
<th>No (%) of averted deaths*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>Infectious diseases (0-85 years)</td>
<td>57 925</td>
<td>21 537</td>
<td>28 207 (49)</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>273 904</td>
<td>91 510</td>
<td>17 223 (6)</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>—</td>
<td>129 396</td>
<td>—</td>
</tr>
<tr>
<td>Cervical cancer</td>
<td>—</td>
<td>20 703</td>
<td>—</td>
</tr>
<tr>
<td>Ischaemic heart disease</td>
<td>837 733</td>
<td>870 405</td>
<td>351 406 (42)</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>412 152</td>
<td>608 558</td>
<td>354 806 (86)</td>
</tr>
<tr>
<td>Liver cirrhosis</td>
<td>110 286</td>
<td>55 594</td>
<td>29 702 (27)</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>26 706</td>
<td>20 471</td>
<td>85 172 (319)</td>
</tr>
<tr>
<td>Maternal mortality</td>
<td>—</td>
<td>950</td>
<td>—</td>
</tr>
<tr>
<td>Road traffic injuries</td>
<td>60 733</td>
<td>19 620</td>
<td>73 144 (120)</td>
</tr>
<tr>
<td>Other external causes (1-19 years)</td>
<td>6 422</td>
<td>2 569</td>
<td>7 361 (115)</td>
</tr>
<tr>
<td>All selected causes of death</td>
<td>1 785 861</td>
<td>1 841 313</td>
<td>947 021 (53)</td>
</tr>
</tbody>
</table>

*Averted deaths estimated by taking each country’s age and sex specific death rates in 1970 (or least recent available year), multiplying this with each country’s age and sex specific population numbers in 2009, and taking the difference between the number of expected deaths thus calculated, and the observed number of deaths in 2009. Data from WHO Mortality Database.*
**Figures**

**Fig 1** Trends in life expectancy at birth (both sexes combined) in exemplar countries from western Europe (Sweden), central and eastern Europe (Hungary), and the former Soviet Union (Russian Federation).

**Fig 2** Relation between national income and health policy performance. GDP measured in 2000; health policy performance measured around 2008 (see box 1 for details of calculation). Luxembourg excluded because of outlier status.