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McKee, M; Fister, K; (2004) Post-communist transition and health in Europe. BMJ. pp. 1355-6.
ISSN 1468-5833 DOI: <https://doi.org/10.1136/bmj.329.7479.1355>

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Post-communist transition and health in Europe

Has yielded important insights, which need to be better documented

In July 2005 the *BMJ* will devote a theme issue to the medical problems of hundreds of millions of people in post-communist countries geographically located in central, eastern, and southeastern Europe. Communism came to the Soviet Union after the first world war and to the rest of now transitional Europe after the second world war. The fall of the Berlin Wall in 1989 marked the beginning of the end of communism, and the former communist countries entered a phase of transition to democracies and market economies.

The arguably common path that these countries started out on branched in many different directions, partly because they all started from different bases. Today the countries in transition are politically and economically as heterogeneous as is the health status of their populations.¹ Although for some the first stage of transition ended with their accession to the European Union in May this year, others are still battling the scars left over from recent or possibly newly emerging wars. Healthwise, however, they have certain common features.

Life expectancy at birth is now lower in the transition countries than that in western Europe (see bmj.com). Although in the 1960s it was slightly higher in former East Germany than in former West Germany, by the 1970s the numbers reversed and the gap has been widening ever since.² In 2000, life expectancy at birth was almost 12 years less in the countries of the former Soviet Union than in western Europe, and it is continuing to decline, making the former Soviet Union one of only two regions in the world where life expectancy is declining, the other being sub-Saharan Africa.³ But in other post-communist countries life expectancy is generally improving.⁴

Health gains are being driven largely by reductions in deaths from cardiovascular disease in some countries, mostly attributable to a combination of improved diet and improved medical care—in particular the treatment of hypertension.⁵ ^{w1} The high consumption of alcohol, particularly in the former Soviet Union, is a major risk factor affecting cardiovascular diseases and partly also the high number of deaths from injuries and violence. This perhaps reflects the feeling of hopelessness that now confronts many young people who see few prospects of a better future.^{w2} Additional risk factors include a diet that contains few micronutrients and a healthcare system that has proved unable to tackle chronic diseases.⁶ ^{w3}

Transition has had an impact on health in other ways. Societal changes have in some countries contrib-

uted to increases in several communicable diseases, most notably HIV, other sexually transmitted diseases, and tuberculosis.⁷ Some of the health effects of transition are already apparent, but others—for example, the predictable rise in lung cancer among the young women currently being targeted by Western tobacco companies—will become apparent in the future.⁸ A few countries, such as Poland, have resisted the tobacco companies and put in place policies that are ahead of many Western countries and have demonstrable benefits.^{w4}

Transition not only involves rediscovering but also redefining the societal classes, which were arbitrarily denied during communism. In some countries, middle classes with lifestyles similar to their Western neighbours almost disappeared during transition, whereas in others they emerged. But almost everywhere a few oligarchs have been able to acquire enormous wealth while many tens of thousands of people are falling through what remains of the social safety net.⁹ In many of the poorer former Soviet countries, the social safeguards of the past have almost disappeared, so that a serious illness in the family entails the risk of impoverishing the family entirely.^{w5}

Health systems are also in transition. Most countries have adopted some form of health insurance, although almost everywhere a high level of dependence on government subsidies still exists.¹⁰ A common goal is the implementation of modern primary care. A few countries have succeeded, but many—Bulgaria, Latvia, and Moldova, for example—have not.¹¹

Overall, the process of transition in this region has provided important insights, shedding light on key determinants of health (such as alcohol and nutrition), on reforms in the health sector, and on the challenges in implementing the concept of evidence based medicine.

Remarkably little information from these countries reaches the international community, for several reasons. As with development assistance for health in general,^{w6} funding for health research in this region is extremely low. Many academic departments have correctly concentrated on training a new generation of researchers and are only now in a position to engage in high quality research into the health of the population. In some places, especially in the former Soviet Union, language remains a barrier to effective international collaboration. Moreover, many colleagues from countries

P+ Additional references w1-w6 and a figure showing life expectancy are on bmj.com

in transition have important knowledge to share but seek training to present that knowledge.¹²

Our theme issue will seek partially to redress these issues. In particular, we are seeking papers that shed light on the impact of transition on population health, the experience of healthcare reform, the implementation of evidence based health care, and the reconfiguration of medical training programmes. We welcome original papers from any countries that are undergoing transition in central, eastern, and southeastern Europe, and also personal views and experiences of practitioners, especially those in primary care and public health.

We hope that this issue will encourage those who have much to say but who so far have felt unable to say it, and that it will serve as a forum for the exchange of information among the countries in the region and our readers. Please submit your papers via <http://submit.bmj.com> by 31 January 2005.

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Competing interests: None declared.

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Tourette's syndrome in children

Tic disorders are common and misunderstood

Tic disorders affect 4-18% of children at some stage of their development.¹ At one end of the spectrum are children with brief episodes of single tics, whereas at the other are children with chronic multiple tics, including Tourette's syndrome. Tics are abrupt and recurrent motor or vocal actions. Although involuntary, they may be preceded by a sensory urge, are sometimes suppressed for prolonged periods, or can even be triggered by external perceptions. They are sudden and purposeless. They can be divided into simple tics such as blinking, shrugging of the shoulders, grunting, and clearing one's throat, and complex tics such as licking, jumping, or touching objects. Tourette's syndrome is the most severe form, with multiple motor and vocal tics lasting for a year or more.²

The best known symptom of Tourette's syndrome, coprolalia (a complex vocal tic with involuntary swearing), occurs in less than 15%.³ This unusual symptom has contributed to the view that Tourette's requires extraordinary treatment. Most tic disorders including Tourette's need little medical input other than help with diagnosis and information, but an unusual or severe movement disorder requires specialist advice, and impairing emotional and behavioural problems need referral to mental health services.

The onset of Tourette's syndrome occurs around the age of 6-7 years, and, as with other neurodevelopmental disorders, it occurs more commonly in boys. Tourette's syndrome was thought to be rare, but recent school based studies have indicated a prevalence of 1-3%, if a broad definition of chronic motor and vocal tics is used.⁴ However, the syndrome itself might helpfully be thought

of as a spectrum,¹ particularly in terms of the impairment experienced by patients. Those with purely chronic tics usually have good adaptation. The presence of the more unusual Tourette's phenomena such as coprophenomena (obscene sounds or gestures) or echophenomena (repeating sounds or gestures) are rarer and may lead to distress and misunderstanding. A third group, those with psychopathology, are likely to need active and multimodal interventions.⁵

Parents and children need to understand that, although all these symptoms relate to the underlying brain disorder, interventions may be extremely simple—for example, allowing the child to have a short "tic break" in a long school lesson. The neurochemistry, neuroanatomy, and genetics of Tourette's syndrome have been the subject of speculation and research; dopaminergic pathways in the frontal and subcortical regions of the brain are involved, and a strong genetic basis exists.⁶ Recent studies have identified a group of children who suddenly develop tics and obsessive compulsive disorder associated with B-haemolytic streptococcal sore throat infection.⁷ However, despite streptococcal autoantibodies being a potential risk factor for developing Tourette's syndrome⁸ there is no evidence currently that these children should be investigated or treated differently from other children with Tourette's syndrome, other than by looking for and treating active streptococcal infection.⁹

Explanation and reassurance may be all that is needed for children who have mild tics.⁶ Educating the teachers and all professionals who come into contact with the child is important for reducing psychological distress. Children may be teased and bullied in the

BMJ 2004;329:1356-7