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EDITORIAL

Lung cancer in Europe

The levelling of an epidemic

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Lung cancer mortality essentially reflects – with a delay of several decades – the pattern of smoking in various populations, in the two sexes and in various age groups.[1–3] Thus, the peak rates in lung cancer mortality for men in northern Europe were reached in the late 1970s or early 1980s, in southern Europe in the late 1980s, whereas lung cancer mortality was still rising – to the highest rates ever registered – in most eastern European countries up to the mid 1990s. In women, most trends were upwards, thus leaving the impression of an expanding epidemic of lung cancer in Europe.[1–3]

It is however important to look at recent changes in lung cancer trends so as to understand future developments in the tobacco-related lung cancer epidemic. Considering the EU as a whole, male lung cancer mortality has been declining since the late 1980s, and the 15% fall registered between 1988 and 1998 (from 52 to 44/100,000 based on the world standard population), is the equivalent of saving 20,000 deaths in 1998. A similar fall in male lung cancer mortality since the 1990s was observed in Russia, although Russian rates remain over 40% higher than in the EU (63/100,000 in 1998). In eastern Europe, a modest fall (6%) has been observed only since 1995, and again the rates of eastern European countries in the late 1990s (59/100,000) are substantially higher than in the EU.

Among women the pattern is more complex, reflecting differing trends in smoking among women in various European countries.[4–7] In the EU, female lung cancer rates have risen to over 10/100,000 in the late 1990s. Over the last few years, however, the slope of the rise has been levelling off, suggesting that the female lung cancer epidemic in the EU as a whole may not reach the high levels observed in North America,[8–11] and in a few northern (e.g., Denmark, the UK) or eastern European countries (e.g., Hungary).[1,2] Similar trends have also been observed in middle-aged women, indicating a tendency for the rise of female lung cancer mortality in the EU to level off in the near future. In other eastern European countries the upward trends in female lung cancer mortality have been larger, approaching 11/100,000 in the late 1990s, but again the changes in slopes have been relatively favourable over recent years, mostly in middle age. In Russia, female lung cancer mortality rates have remained between 6 and 7/100,000 over the last two decades, and have tended to decline over the last few years. Russian trends in both sexes, however, are strongly influenced by cohort effects due to historically low rates in generations who were teenagers in 1945–1953, essentially because production of consumer goods, such as cigarettes, had a lower priority in the USSR than the post-war drive for industrialisation.[12] Thus, recent trends in lung cancer in Europe indicate that the epidemic has reached its peak and has started to level off in men. Rates in females have been declining in the Russian Federation, too, but are still rising in other areas, though to a smaller extent than in the past. If recent trends are maintained, and assuming some additional impact of tobacco control in European women, overall lung cancer rates in EU females may peak below 15/100,000 over the next decade.[10,13] Rates for males may fall below 40/100,000 within the next few years and, assuming a further reduction in smoking, approach 30/100,000 by 2015, i.e. a rate similar to that registered in the early 1950s.

The levelling of the lung cancer epidemic across Europe essentially reflects the declining prevalence of tobacco smoking in males over the last few decades, although occupational, environmental and dietary aspects[14] of lung cancer may exert minor influences on these favourable trends. However even greater efforts are needed finally to bring to an end the tobacco-related lung cancer epidemic in Europe.

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European Union enlargement

Will mental health be forgotten again?

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When the European Commission met in Copenhagen in 1993 to outline a methodology for EU accession, many eastern countries seemed far from meeting the necessary political, economic, and legislative criteria. Much has changed since the creation of the 'Copenhagen criteria' as the Council has now announced that eight nations in eastern Europe – Estonia, Hungary, Poland, the Czech Republic, Slovenia, Slovakia, Latvia and Lithuania – will be ready for membership by 2004, with Romania and Bulgaria ready by 2007. One topic yet to emerge however, is the provision of mental health care and the status of people with mental health problems in these countries.

Central and Eastern Europe face considerable challenges. The overall burden of disease due to neuropsychiatric disorders is estimated at 17.2% (DALYs), notably higher than the world average (12.3%).[1,2] Whilst these rankings suggest that the prevalence of disorders is comparable to that in western Europe, there is a consensus that both treatments and the organisation of mental health services have not kept up with reforms adopted in the west.[3]

Services have been influenced heavily by a historical legacy of large psychiatric hospitals and social care homes, a custodial rather than therapeutic attitude to patient care, and a reliance on pharmacological interventions. Psychiatry also has been subject to political abuse, with incarceration in psychiatric institutions used as a means of repression both in the former Soviet Union and elsewhere in Eastern Europe. Since 1980 the Geneva Initiative on Psychiatry, originally the International Association on the Political Use of Psychiatry (IAPUP), has led efforts within national and international psychiatric organisations to eliminate such systematic abuse. Community based care has been sparse and often equated with outpatient or dispensary care. Moreover, community social structures, including the role of the family, were weakened first under the former soviet-style system and later by the strain of economic transition. This has led to a lack of support for people with severe mental disorders outside the framework of institutionalised care, further aggravated by widespread stigma, discrimination and social exclusion.

Hierarchical systems of central planning limited the responsiveness of mental health institutions,[4] and for several decades, psychiatry in the east was isolated from western developments, access to journals, conferences, and other modes of information exchange. Unfortunately, as described by the WHO in the 2001 World Health Report, many of these features still characterise these countries' mental health care systems.[2]

Furthermore, poor conditions in psychiatric hospitals and care homes have given rise to human rights concerns. For example, the violation of rights documented in Hungarian care homes included the restriction of patients' movements (despite no legal authority to detain), invasion of privacy, inadequate communication facilities, ineffective complaint and monitoring mechanisms, poor access to medical treatment, and the use of outdated treatments. Some care homes continued to use severely restricting 'caged beds', despite international condemnation of the practice by disability rights groups and the Council of Europe. In Bulgaria the continued use of unmodified electro convulsive therapy has also been recently criticised.[5] Inadequate legal services and protection extended to people with mental health problems has drawn states into litigation before the European Court of Human rights.[6]

Moreover, as is the case in many countries throughout the world, mental health services are poorly resourced. EU

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