REGIONAL GUIDE
EURO REGION

2025 AMWHO INTERNATIONAL CONFERENCE

Bridging Health and Healthcare Disparities between Low, Middle, and High-Income Countries to Achieve Universal Health Coverage

Introduction

The World Health Organization's (WHO) European (EURO) region consists of 53 countries spanning from mainland Europe to the south of the Mediterranean Sea. [1] This region is home to around 900 million people, encompassing diverse political, economic, and cultural backgrounds. These backgrounds shape different countries' approaches to healthcare from varying taxpayer systems to using traditional homeopathic techniques for medicine. [2] The WHO EURO's first and current regional office is in Copenhagen, Denmark. [3] The WHO EURO region was a bridge between the Eastern and Western blocs during wars to maintain healthcare accessibility, especially in the post-World War II era. [3] This allowed healthcare programs to transcend past the Soviet Union and into Eastern Europe from Western countries, which was only successful through different policies and the European Union (EU) relationship. [4]

Although Western European countries like France and Luxembourg pride themselves on their high GDP and effective healthcare systems, Central and Eastern European countries have struggled for decades compared to their wealthy neighbors. [5] For example, the Czech Republic, Poland, and Slovakia spend 3 to 4 times less than Western Countries like Switzerland or Great Britain.[5] This causes the price of over-the-counter medications, food, and energy to spike. Hospital equipment is old and poorly maintained, as these countries invest less in their infrastructure due to a low GDP. [6]

A history of wars and political turmoil is common among European countries. Recent data suggests that these may lead to increased rates of depression and diabetes as seen in Germany and Austria.[7] Beyond WWII, European conflicts continue to affect healthcare outcomes in the EURO region. The war between Ukraine and Russia has left citizens with broken hospital systems, a lack of vaccines, and a decline in essential preventative services.[7,8] This situation underscores the importance of sustained international support to rebuild the healthcare system in Ukraine.

Collaboration with the EU continues to expand, resulting in benefits for countries both within and outside of their borders. These include but are not limited to increased access to the COVID-19 vaccine in the middle to low-income countries, advancing effective universal healthcare systems, and enhancing disease prevention devices across the EURO region.[9] Vaccine collaboration between the EU and the EURO region of the WHO expands beyond the COVID-19 pandemic as well as the EURO region. In 2022, these organizations joined forces to provide access to critical vaccinations in Sub-Saharan Africa.[9] These efforts combined enable the countries within the EURO region to be more adequately equipped when it comes to health challenges such as health and disease emergencies, access to free quality healthcare, and cultural and economic differences within each country of the WHO EURO region.[9]

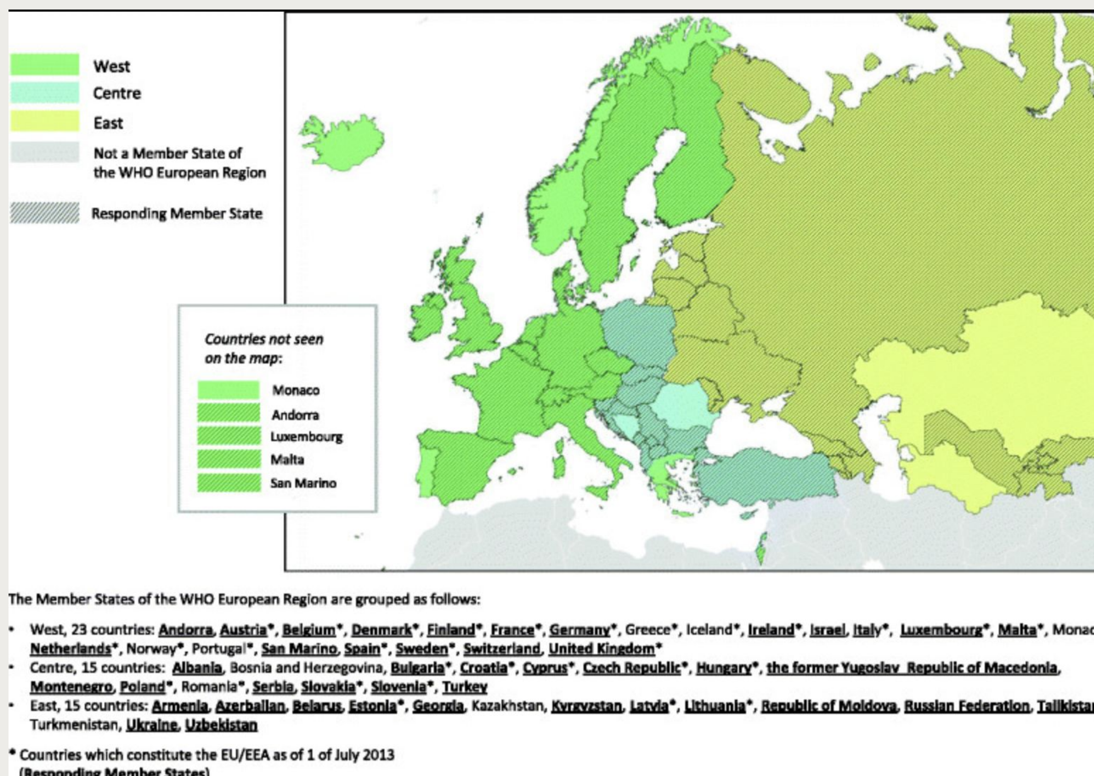

Figure 1.[10] Member States of the WHO European Region

Subtheme 1: Inequalities in Infectious Disease Management

Economic disparities and political challenges have left many parts of the EURO regions with outdated healthcare systems and ineffective solutions when presented with disease emergencies.[11] For example, in 2022, HIV/AIDS rose in Central and Eastern European countries, with 71.6% of new diagnoses made in the Eastern region of Europe, with the West following behind them at 20.3% and just 8.1% in Central Europe.[12] In the Eastern region, however, HIV testing improved which led to an increase in diagnosis and improved care.[13] Additionally, in 2022, 38 out of the 53 WHO European Member States reported increased TB notifications.[14] However, only 60-70% of first-line medications are successful in curing the infection in EURO countries. The WHO attributes this to an increase in drug-resistant TB and issues with treatment compliance.[15] TB treatment should be successful in 9 out of 10 patients infected.[15] Between 2017-19, Ukraine faced a measles outbreak with over 115,000 infections, 43 of them resulting in death.[15] Low vaccination rates and the destruction of healthcare facilities are a direct outcome of the beginning of the war with Russia and other war-related challenges.[15]

Factors contributing to these disparities include the devastating impact of ongoing conflicts, such as the war in Ukraine, which disrupts healthcare access and vaccine distribution.[15] Cultural attitudes towards vaccination further complicate these challenges, as acceptance varies significantly across different communities.[15] Additionally, inadequate healthcare infrastructure hampers the ability to store and distribute vaccines effectively, leading to outbreaks of diseases that could otherwise be controlled.[15] The measles outbreak in Ukraine, exacerbated by low vaccination rates and the ongoing war with Russia, underscores the challenges of maintaining immunization programs in conflict-affected areas.[15] The rise in tuberculosis in Romania represents the pitfalls of dated healthcare structures that existed under past political powers.[16] This calls for a change in both how healthcare is viewed and provided to citizens.[17] Case studies on the resurgence of tuberculosis in Romania and the measles outbreak in Ukraine illustrate how these factors intersect to create significant public health challenges, highlighting the urgent need for targeted interventions to bridge these gaps.

CASE STUDY 1: TUBERCULOSIS IN ROMANIA

Tuberculosis (TB) is a bacterial infection that impacts the respiratory system and is spread when people cough, sneeze, or spit.[18] 1.3 million people died from TB in 2022, ranking it second amongst infectious diseases with the highest mortality rates.[19] Romania has the highest infection rate of the disease in the EURO region, reporting almost 25% of all TB cases in the European Union (EU) with an infection rate six times higher than the EURO average.[20, 21] Drugs for TB include isoniazid and preventative tuberculosis treatment (PTP) that kills the bacteria before it becomes an active disease.[22] However, TB management in Romania has proven challenging, particularly given its high rate of multidrug-resistant tuberculosis (MDR-TB), with around 800 new cases annually but only about 60% receiving proper diagnosis.[23]

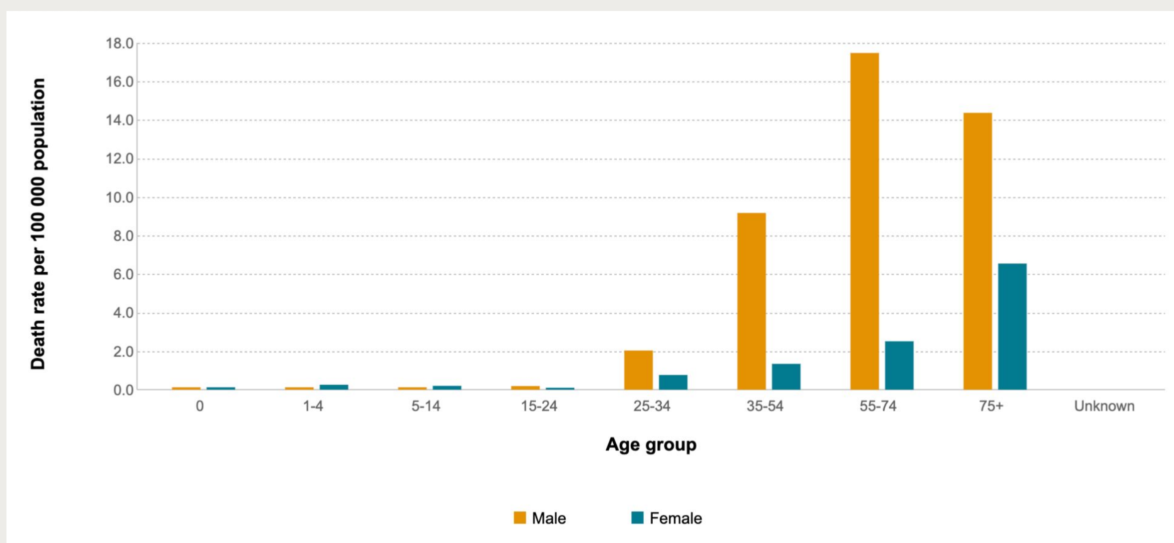

Figure 2[21]. Tuberculosis Deaths Based on Age Group and Sex.

This issue is exacerbated by Romania's broken healthcare infrastructure, which stems from its communist past and the centralized healthcare model it established.[24] The 1949 Health Act was the first centralized health legislation under communist influence, establishing the Semashko healthcare model.[24] Under the Semashko model, healthcare was publicly funded and centralized with almost universal entitlement to free healthcare.[24] From the 1950s to the 1980s, the government held complete control over the management of the healthcare system.[25] However, chronic underfunding from state revenues led to resource shortages, outdated facilities, and limited access to modern treatments.[25] By the end of the Romanian communist regime in 1989, the public health system was tarnished.[26] The 1990 Health Reform Law marked a transition into the market economy for the Romanian healthcare system.[26] Local authorities were given greater control over healthcare management.[26] Inadequate funding and infrastructure hindered this decentralization, leading to substantial disparities in healthcare access across various regions.[26]

The healthcare reforms of the 1990s ultimately failed due to persistent economic instability, high levels of poverty, and the ongoing "brain drain" of medical professionals, as skilled nurses and doctors left their poorer home countries for higher-paying work in Western Europe, the United States, and Australia, hindering efforts to rebuild and improve health systems.[27] The 1997 Health Insurance Law attempted to create a health insurance model influenced by employers and employees.[21] Similar bills were enacted throughout the past twenty years. Yet due to a broken start to the healthcare system, Romania faces severe underfunding with only 3.6% of its GDP contributing to healthcare, ranking last amongst the EU.[25, 26]

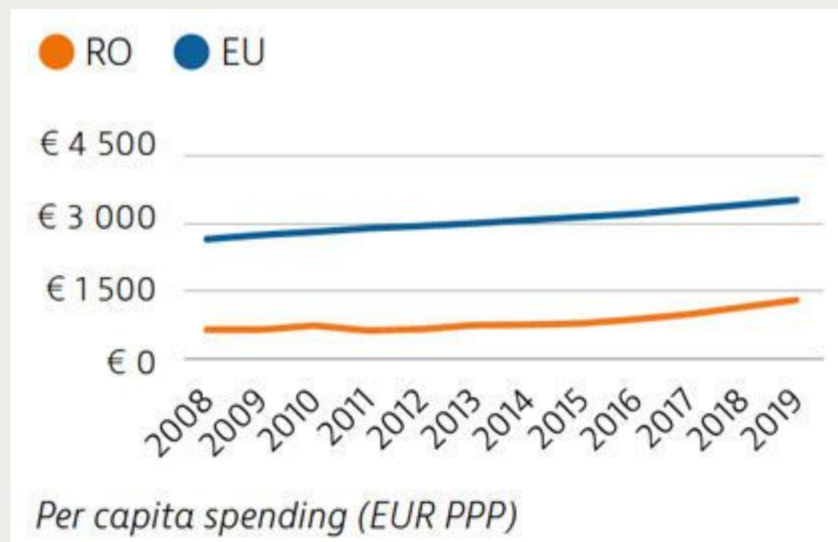

Figure 3[28]. Comparison of Per Capita Spending (EUR PPP) Between Romania and the European Union (2008–2019).

The underfunded healthcare system in Romania is the main barrier to effective TB management. Outdated facilities, a lack of basic hospital supplies, and high premiums for patients compound the challenges for those seeking treatment. Beyond this, rural areas face heavy burdens regarding TB management. Many patients in rural areas can not afford the treatment or take the time off for treatment. Andrei, 44, was diagnosed with TB after police found him coughing up blood lying on the street.[24] As an unemployed, agricultural worker, working 'off the books', he does not receive sick leave from the Romanian government. If Andrei decides to continue with treatment, he'll potentially lose 3-4 months of work, resulting in a loss of 20-30% of a household's annual income.[25] Legal restrictions surrounding TB exacerbate the difficulties associated with treatment for thousands of other Romanian TB patients like Andrei. Tom Maguire of the Guardian notes that the "National Drug Agency in Romania is currently unable to approve the use of TB medications not produced in western Europe or the US, no matter how safe, effective or affordable they are".[24, 26] Patients living in rural areas also face treatment delays as they live further from hospitals, have a shortage of specialists nearby, and have prolonged diagnostic times.[27]

Efforts to mitigate TB in Romania have been spearheaded by both regional groups and global organizations such as the EU and WHO.[28] The Marius Nasta Institute was the first TB hospital in Romania and conducts the country's most critical research to develop cures.[28] The Association for Support MDR-TB Patients was recently created in 2011 and attempts to tackle resistant TB through research and breaking societal stigma.[28] On a large scale, the National Strategy for Tuberculosis Control is a collaboration between the Romanian government and the WHO.[29] This joint effort is working to adapt the financial model, increase the use of innovative diagnostic tests, vaccines, and treatments, and update the legislative framework.[29] Through these combined efforts, Romania seeks to mitigate the socioeconomic and historical factors contributing to its current TB crisis.[29] Introducing mobile health clinics in rural areas could improve access to treatment for underserved populations, while subsidies for TB medications could alleviate financial barriers for low-income patients. Along with these efforts, increasing public awareness through social media campaigns can help combat stigma and encourage earlier diagnosis and treatment adherence.[30]

CASE STUDY 2: MEASLES OUTBREAK IN UKRAINE

Measles is a highly contagious viral disease transmitted via physical human-to-human contact.[31] Though it is often seen as a mild disease, mortality remains high in developing and impoverished countries (>5% mortality).[31] Measles mainly affects younger children, aged 5 to 6 months of age, with most children dying from the disease within the first 3 years of their life.[31] Adults older than 20 are also at increased risk of infection.[31] Symptoms often include, but are not limited to, a runny nose, cough, high fever, and most noticeably what's known as the "Measles Rash", flat red spots that appear first on the face and across the hairline, which can then spread across the entire body.[32] Complications go beyond just the rash, however, as persistent diarrhea, pneumonia, encephalitis, and hospitalization can be involved.[32]

Measles was first discovered in the 9th century, but it was not until the early 20th century that the disease was given the attention it needed.[31] Development for the vaccine began around the late 1950s when John Enders developed the vaccine and began testing it on children in New York City and Nigeria.[31] In 1961, it was deemed 100% effective and the first measles vaccine was available for public use by 1963.[31] The WHO partnered with over 20 newly independent and decolonizing countries in central Africa to administer vaccines aimed at controlling measles.[31] When the W.H.O. established the Expanded Program on Immunization (EPI, now known as the Essential Programme on Immunization), measles became one of the first diseases targeted by the W.H.O. as they began mass producing the measles vaccines to send to underdeveloped countries across the world.[31] Widespread childhood vaccination against measles has been reduced dramatically worldwide, and is a vaccine most children are suggested to receive in their early adolescence.[31]

While measles infection rates have dropped significantly over the past few decades, the disease remains common in impoverished and war-torn countries.[14] Between 2017-2019, 115,000 Ukrainians were infected with measles with 43 of those resulting in death. Dr. Jano Habicht, Head of the WHO Country Office in Kyiv, Ukraine, told the Lancet Microbe that the "challenges of war" with Russia had a great impact on their health infrastructure and the ability for children and young adults to receive a measles vaccination.[14] Ukrainians in some occupied areas said that healthcare is extremely limited and sometimes non-existent, as a "health needs assessment conducted in September 2022 by WHO found that many children and adults in areas of active combat or beyond Ukrainian control were not accessing immunization services".[14] It is not only the war that has limited nationwide immunization, as during the outbreak in 2017 to 2019, the national measles vaccine coverage rate was only 42%, while in comparison, the measles vaccine coverage for children in the United States was nearly 91% according to recent surveys. [14,33]

In March of 2023, UNICEF delivered 35,200 doses of combined measles, mumps, and rubella vaccines to local Ukrainian healthcare systems with the support of the National Immunization Program.[34] The WHO, amongst other organizations, has called for immediate steps to address these issues and prevent another measles outbreak, as Ukraine continues to have limited access to healthcare due to the barriers of war.[34] One way that Ukraine could increase the rates of vaccination would be to start collaborating with trusted community leaders in this rural area to increase vaccine literacy and accessibility.[35] With the help of the WHO and the local government system, they could reach individuals who don't know the kinds of vaccines they need, as well as increase the availability of the vaccines in community centers.[35]

Subtheme 3: Sustainable Community-Based Initiatives

While large hospital systems and government-funded healthcare dominate treatment options for patients in Europe, community-based healthcare (CBHC) has provided unique opportunities for citizens.[36] Community-based healthcare centers (CBHCs) empower community members by giving them ownership of healthcare, enabling the provision of cost-effective and more accessible healthcare resources compared to public healthcare systems.[36] These initiatives function by fostering local participation and tailoring healthcare to meet the needs of specific communities.[36] Many of these programs practice long-standing traditions that have survived mass urbanization and assimilation throughout the last century.[36] In rural and low-income areas, where healthcare resources are limited and geographic barriers restrict access, community-driven models are vital for promoting health, preventing disease, and improving patient outcomes.[36]

Village Health programs in Kyrgyzstan and the Buurtzorg model in the Netherlands represent the impact of CBHC in transforming patient care and improving public health.[37,46] Community health workers in Kyrgyzstan provide health education, home visits, and vaccines.[37] The Buurtzorg (Dutch for 'neighborhood care') model in the Netherlands is a nurse-led model that focuses on patient-centered, holistic care. They are driven by a motto of 'humanity over bureaucracy', a message that many other CBHCs follow.[46] Together, these case studies demonstrate the potential of community-based healthcare to deliver equitable, sustainable solutions that address both local needs and broader healthcare disparities across the EURO region.

CASE STUDY 1: COMMUNITY HEALTH WORKERS IN KYRGYZSTAN

In Kyrgyzstan, with widespread poverty, lack of infrastructure, and geographical isolation contributing factors to make access to health services highly the Community Health Workers' (CHW) role as a bridge between the formal healthcare system and the disadvantaged communities has become imperative.[37] Indeed, the Kyrgyzstan health system faced grave problems after the fall of the Soviet Union. Lack of infrastructure, shortage of health professionals, and basic health services severely disrupted rural areas.[37] As a result of geographic isolation and recovering economies, access to healthcare was not accessible to most rural populations; for those at a lower-income status, the costs were nearly impossible to meet.[38] As a precursor, CHWs make a tremendous contribution toward health equity in both the meeting of medical needs and encouraging community participation and trust.[39]

The Village Health Committee was formed in 2002 through the institutionalization of community-based health initiatives with the collaboration of the Swiss Agency for Development and Cooperation and the Swiss Red Cross.[40] The Village Health Committees (VHCs) organize community-based volunteers who are responsible for planning local health programs, identifying the prevailing health problems, and ensuring access to health services within the community.[41] By 2018, nearly 1,700 VHCs were operating in Kyrgyzstan, covering approximately 90% of all villages, and laid an important framework for improving rural health.[42] Rather than the traditional method of the federal government directing healthcare initiatives, VHCs leverage community engagement to prioritize their health needs.[42] VHCs have thus created more awareness and investments through regular meetings and community workshops regarding the pathologies that are more common, such as hypertension.[42]

They provide culturally appropriate health education on disease prevention, nutrition, and maternal and child health in communities where formal health education is limited or nonexistent.[43] The CHWs make home visits to the clients for early problem identification and follow-up care, counseling, and health screenings, including blood pressure.[43, 44] This assumes greater significance in a country like this, where distances between people's houses and either clinics or hospitals are great, requiring extensive travel.[44] Community Health Workers can address medical and social causes of health directly with individuals in their homes, building trust and compliance. WHO has helped accomplish structured training to improve the effectiveness of CHWs.[44]

For example, the 2023 program in Issyk-Kul and Naryn Oblasts trained 350 community health workers in vaccine communication.[45] The training aimed at imparting the required communication competencies to the CHWs to build trust in vaccination programs to increase vaccination in districts with high levels of vaccine hesitation.[45] This program is also a very good example of the extensive role that CHWs play in influencing public opinion and perceptions regarding health-related interventions beyond the provision of healthcare services.[45] With their work, access to healthcare has improved, diseases are being diagnosed at earlier stages, and there is increased community involvement in Kyrgyzstan.[45]

In such cases, community health workers help alleviate some financial and geographic barriers that have long prevented rural residents from receiving timely medical interventions by bringing healthcare to the villages.[45] Such involvement in patient monitoring and health checks supports early identification of chronic conditions, thus preventing complications and minimizing the need for more sophisticated—and expensive—interventions.[45] In addition, local peoples' ownership through participation in VHCs instills a sense of shared responsibility for community health, which has been important to the sustainability of these programs.[45]

Community-based health workforce in Kyrgyzstan is best described by the role and place of the CHWs.[45] Further, they contribute to the work related to reduced health disparities, resilience, and the capability of persons and their communities to take responsibility for their health, and there will be increased access and more inclusiveness in the healthcare system throughout Kyrgyzstan Expanding structured training programs for CHWs and increasing funding for community health initiatives can further enhance their impact.[45] Moreover, integrating digital tools for patient monitoring and data collection could improve efficiency and healthcare outcomes in remote areas.

CASE STUDY 2: BUURTZORG FOUNDATION IN THE NETHERLANDS

In the 1990s, the Dutch government became increasingly concerned about the high costs and lack of efficiency within their healthcare system.[46] This led to the introduction of community-based healthcare systems and a greater emphasis on the role of family members in caring for older relatives.[46] These reforms followed the trend of the New Public management in the public sector of their healthcare system, a movement that had spread across the country in the early 1990s. By the mid-2000s, however, healthcare reform began to decline.[46]

Buurtzorg is a Dutch Neighborhood Care Model established in 2006 that focuses on revolutionizing community care in the Netherlands.[46] Before it was founded, community care programs had declined in quality, become cost-inefficient, and disillusioned the nursing workforce.[46] Leading a holistic care model led by community nurses, Buurtzorg looks after patients in their own homes in a way that opens the door for independence and collaboration, as the founder states: “The community-based nurse should have a central role – after all, they know best how they can support specific circumstances for the client”.[46] Within a decade, over 10,000 nurses in 850 teams across many towns and villages all over Holland, as well as expanding outside of the Netherlands and into 24 other countries.[47]

But what makes Buurtzorg so special? They follow what they describe as the “onion model,” which works outwards to assemble solutions that bring independence and improved quality of life.[48] This model assembles the building blocks for independence based on these human values: “People want control over their own lives for as long as possible; people strive to maintain or improve their own quality of life.”.[48] With this value in mind, the healthcare provider seeks to build a solution involving the client and their networks around them (schools, places of work, relatives at home, etc.).[46] A team of 12 nurses will work in a specific neighborhood, taking care of people who need support, while taking the time to get to know community members and healthcare providers who work in the area.[46]

The main care that Buurtzorg provides is typical medical treatment and nursing services that are typical in nursing homes, such as dressing wounds and giving injections, as well as personal care such as taking a shower or helping with daily activities (cooking, responding to emails, etc.).[46] Buurtzorg's innovative approach emphasizes minimal management layers, allowing nurses to work autonomously and make decisions at the ground level, enhancing job satisfaction and reducing bureaucracy.[49] This structure fosters a more responsive and personalized care environment.[49] Nurses are empowered to manage their teams and schedules, enabling them to spend more time with patients and less on administrative tasks.[49] The success of Buurtzorg is evident in its patient satisfaction rates, which are significantly higher compared to traditional care models.[50] For instance, buurtzorg's approach has yielded patient satisfaction ratings that are 30% higher than those of comparable organizations.[50]

It also achieves better health outcomes and cost savings for the healthcare system, reducing the need for hospitalizations and long-term care facilities.[51] A KPMG study indicates that Buurtzorg delivers high-quality care with 35.7% fewer care hours compared to the market average.[51] Buurtzorg has been recognized globally as a model of efficient and compassionate community-based healthcare, inspiring similar initiatives in various countries and reshaping how care is delivered in the community setting.[52] Its model has been adopted in countries like Japan, Norway, Sweden, the United Kingdom, and the United States.[52] Countries in the Euro region might consider adopting the Buurtzorg model to address the growing concern that physicians lack meaningful relationships with their patients, despite the model's reliance on specific cultural and social values.[46] This could involve creating independent teams, separate from national or state health institutions, composed of hired professionals or volunteers dedicated to providing personalized care and ensuring patients feel well-attended. [53]

Subtheme 6: Primary Health Care to Reduce Non-Communicable Diseases (NCDs) Through Prevention

CASE STUDY 1: TACKLING OBESITY IN THE NETHERLANDS

Obesity in the Netherlands has been increasing steadily over the past few decades. According to the World Health Organization (WHO), the prevalence of overweight and obesity among Dutch adults has risen, with an estimated 50% of the population classified as overweight and nearly 15% considered obese.[54] This growing public health issue is contributing to a higher incidence of chronic diseases like diabetes, cardiovascular conditions, and certain cancers, posing a significant strain on the healthcare system.[55]

Several factors contribute to the rising rates of obesity in the Netherlands: the typical Dutch diet, rich in dairy, processed meats, and high-calorie foods, combined with an increase in fast food consumption, has contributed to unhealthy eating habits.[56] Additionally, portion sizes have gradually increased over the years, further promoting weight gain. While the Netherlands is known for its cycling culture, a significant portion of the population still leads sedentary lifestyles due to long working hours, commuting, and increased screen time.[56] Physical inactivity, especially in children and adolescents, has been linked to higher obesity rates.[56] People in lower socioeconomic groups are more likely to experience obesity.[56, 57] Some contributing factors to obesity include limited access to healthy foods, financial constraints, and higher levels of work-related stress.[58] Low-income neighborhoods often have fewer options for affordable, nutritious food, leading residents to rely on cheaper, calorie-dense options.[58] Although lifestyle factors play a significant role, genetics also contribute to obesity.[58] Some individuals may have a predisposition to gain weight due to their genetic makeup, making it harder for them to maintain a healthy weight.[58]

In response to the growing obesity crisis, the Dutch government and public health organizations have implemented several strategies.[59] The Netherlands has introduced public health initiatives aimed at reducing obesity, such as the "Healthy Weight" program, which encourages healthier eating and physical activity.[59] There are also campaigns to reduce the intake of sugary drinks and processed foods. Programs targeting children, such as promoting physical activity in schools and offering healthier food options in cafeterias, have been rolled out to prevent obesity from a young age.[60] The Dutch government debated implementing taxes on sugary foods and drinks to discourage consumption.[60] Research suggests that taxes could be an effective tool in reducing obesity rates.[60] Media campaigns and educational programs aim to raise awareness about the risks associated with obesity and encourage lifestyle changes.[60] These initiatives emphasize the importance of balanced diets and regular exercise.[60]

Despite these efforts, tackling obesity in the Netherlands faces several challenges. Many Dutch people resist dietary changes or government-imposed regulations, viewing them as an infringement on personal freedom. Overcoming this resistance requires more than just policy changes—it requires a shift in cultural attitudes toward food and physical activity. While healthier food options are available, they are often more expensive.[61] For lower-income groups, the cost of fresh produce and healthier alternatives can be prohibitive. Addressing this disparity is crucial in tackling the obesity epidemic.[61] Changing long-standing behaviors related to eating and exercise is a slow process.[61] Many individuals struggle to adopt healthier habits, even when the risks of obesity are presented.[61]
Obesity in the Netherlands is a complex issue driven by dietary, lifestyle, and socioeconomic factors. While the Dutch government has made efforts to address the epidemic through policy changes and public health campaigns, significant work remains to be done. Effective strategies will require a combination of education, accessible healthy food options, and cultural shifts in how the population views food and physical activity. Given the serious health consequences associated with obesity, continued attention and intervention are critical for reducing its impact on Dutch society.[62]

CASE STUDY 2: CARDIOVASCULAR DISEASE PREVENTION IN FINLAND

Cardiovascular diseases (CVDs) are a leading cause of death globally, resulting from complex interactions between genetic factors, lifestyle choices, and socioeconomic conditions.[62] In 2021, CVDs accounted for approximately one-third of global deaths, claiming 20.5 million lives.[62] Finland's innovative efforts in CVD prevention, particularly through the North Karelia Project, offer a valuable model for addressing these challenges.[62] Despite significant reductions in CVD mortality, disparities persist, especially among lower socio-economic communities. Tackling these inequities requires targeted interventions that build on Finland's successes while introducing new strategies to promote equitable outcomes.[62] Launched in 1972 in response to alarmingly high rates of heart disease, the North Karelia Project marked a turning point in Finland's battle against CVDs.[62] The project used a community-based approach, focusing on lifestyle changes such as smoking cessation, healthier eating, and increased physical activity.[62] By engaging local organizations and healthcare providers, the initiative empowered individuals to take control of their health, leading to a 65% reduction in coronary heart disease mortality in North Karelia by the late 1990s.[62]

However, despite the project's overall success, disparities persist among lower socio-economic groups in Finland.[63] These populations are affected by risk factors such as smoking, unhealthy diets, and limited access to preventive healthcare services.[63] Research shows that individuals with lower income or education levels are likely to engage in high-risk behaviors due to financial constraints, limited health literacy, and reduced access to affordable healthy options.[63] To address these challenges, Finland must adopt a similar strategy that prioritizes equity while leveraging the successes of the North Karelia Project.[63]

The use of technology also offers promising opportunities to promote healthy behaviors and reduce disparities.[64] Mobile health applications (otherwise known as mHealth) can provide personalized dietary advice, track physical activity, and offer smoking cessation support.[64] Studies have shown that mHealth interventions can effectively improve health outcomes, particularly when tailored to the needs of specific populations.[64] Addressing structural inequities through policy interventions is vital.[64] Subsidies for healthy foods and taxes on unhealthy products, such as sugary beverages and processed snacks, can make healthier choices more accessible to low-income households.[64]

Finland's experience with the North Karelia Project demonstrates that community-based interventions can significantly reduce CVD mortality.[64] Achieving equitable health outcomes requires sustained efforts to address disparities through targeted and innovative strategies.[64] By integrating technological advancements, policy reforms, and community engagement, Finland can further enhance its public health initiatives, ensuring that all citizens have the opportunity to lead healthier lives.[64]

Conclusion

The EURO region of the World Health Organization demonstrates the long-standing battle of closing healthcare gaps across different nations. From tackling infectious diseases like tuberculosis and measles to advancing community-based healthcare initiatives and preventing non-communicable diseases, the EURO region highlights the complexity of healthcare management. Case studies from a variety of countries reveal the need for targeted interventions, cross-border collaboration, and innovative responses tailored to precise local contexts. As these initiatives evolve, the EURO region's experience underscores the imperative for equitable and sustainable health systems focusing on resilience and access. Continued global and regional cooperation will be pivotal in addressing these pressing health challenges and fostering improved outcomes for all.

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