Thalassaemias were traditionally believed to occur only in regions of the world where malaria is or was endemic, including the Mediterranean, the Middle East, South and East Asia, the Pacific and South China, with carrier rates varying from 2 to 25%. It is now known that haemoglobin disorders occur widely across the world, including in northern and western Europe, not in the indigenous population but as a result of global population movements. Thalassaemias and sickle cell disease are increasingly common in these countries and – with the exception of Spain and Portugal, where the incidence rate is approximately 1–2% – incidence rates are as high as those historically found in southern Europe (4–18%), the region where haemoglobinopathies were first recognised and where successful control programmes were first developed. In southern Europe and especially in the Mediterranean countries, annual affected birth rates have been reduced dramatically (by 80–100%), with Cyprus, for example, reaching between zero and three affected births each year since 1987, with open-ended survival and very satisfactory quality of life for patients. Today, in these countries the only factors contributing to development of complications, low survival and poor quality of life are related to poor adherence to clinical management. These are the standards the rest of the Europe should aim to reach. In northern and western Europe, in recent years health professionals and policy-makers throughout the region have been confronted with the challenge of setting up, providing and making accessible adequate services to ‘at-risk’ populations for prevention and treatment of haemoglobin disorders. Accurate epidemiological data, a prerequisite for developing health policies, are to date very limited. A recent study1 attempted to identify the proportion at risk of haemoglobin disorders in European countries. Data concerning country of birth and ethnic origin of at-risk populations were adjusted to provide estimated prevalence rates. Clearly, accurate information and significant micro-mapping are required to guide the activities and efforts of national health authorities in these countries. This is particularly difficult as ethnic groups are widely scattered throughout Europe.

In northern and western European countries, in contrast to countries with limited resources, national health systems and infrastructures are available for developing national strategies for effective prevention and optimal treatment of haemoglobin disorders. However, groups at increased risk are unevenly distributed and often concentrated in major cities, so establishing equal access to such services is an important issue. The support of national public health authorities and political powers is required to ensure awareness of the management of thalassaemia and the establishment of reference centres; epidemiological studies (micro-mapping for the identification of populations at risk is a prerequisite to the development of appropriate services); establishment of educational programmes for health professionals, patients and the community; and promotion of patient/parental support groups. Other issues that need to be addressed in order to offer holistic services for haemoglobin disorders in these countries include the increasing prevalence of α-thalassaemia, cultural, linguistic and religious differences and the social and genetic implications of consanguineous marriage.