
Joint meeting of experts on targets and indicators for health and well-being in Health 2020

Copenhagen, Denmark, 5–7 February 2013





**World Health
Organization**

REGIONAL OFFICE FOR **Europe**

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ABSTRACT

A joint meeting of experts on targets and indicators for health and well-being in Health 2020 was convened by the WHO Regional Office for Europe. Its aim was to advise on the measurement framework and indicators for the Health 2020 targets already set by the Regional Committee (including for well-being), and to determine the support needed by Member States to implement such a framework and for additional further development. The meeting reviewed the definition of well-being agreed in the context of Health 2020; examined research data and existing guidelines on tools and indicators for measuring well-being; and proposed overall satisfaction with life as the core indicator of subjective well-being. The meeting also reviewed the existing proposals from the expert group on development of indicators for Health 2020, agreeing overall general principles for indicators, and recommended quantified targets (where appropriate) and a shortlist of indicators for consultation with Member States and the Regional Committee.

Keywords

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Executive summary

A joint meeting of experts on targets and indicators for health and well-being in Health 2020 was convened by the WHO Regional Office for Europe. It brought together three groups: the expert group on measurement and target-setting for well-being; the expert group on development of indicators for Health 2020; and representatives of the working group on Health 2020 targets of the Standing Committee of the Regional Committee (SCRC). Its aim was to review all the recommended work from the previous meetings of the expert groups, to advise on the measurement framework and indicators for the Health 2020 targets already set by the Regional Committee (including for well-being), and to determine the support needed by Member States to implement such a framework and for additional further development. The resulting recommendations would be put to the SCRC for consultation in March 2013, followed by a web-based consultation with Member States during March and April. In May, the SCRC would decide on the indicators and targets to be submitted to the Regional Committee in September.

The experts first focused on measurement and target-setting for well-being. They reviewed the definition of well-being agreed in the context of Health 2020 (*Well-being exists in two dimensions, subjective and objective. It comprises an individual's experience of their life as well as a comparison of life circumstances with social norms and values*) and the two-way interaction between health and well-being. A systematic review of tools for the measurement of well-being was presented. Despite identifying numerous distinct measures, however, this review suggested that there was no single ideal well-being measure within the current health literature. It identified areas for further consideration, including gender differences and well-being in children.

The Organization for Economic Co-operation and Development (OECD) guidelines on the measurement of subjective well-being were discussed at length, and were welcomed as providing a very solid basis for work in this area. The well-being indicators used in existing international initiatives were summarized, showing a high degree of overlap in the domains of well-being chosen.

The group reviewed analysis from the Collaborative Research on Ageing in Europe (COURAGE) project, which underlined the links between health and well-being and suggested how policy-makers can improve well-being overall through improvements in health and functioning (for example, by addressing the built environment). Results from the WHO Study on global AGEing and adult health (SAGE) were presented. These likewise showed that overall happiness and experienced well-being have very similar determinants: a strong relationship with health status, chronic disease and disability; and consistent relationships with age, income, education and social networks. European Statistical System work undertaken by the European Union (EU) on measuring quality of life and well-being was also described; this followed a similar approach to other international initiatives and would be collecting data on subjective well-being during 2013.

After extensive discussion the experts agreed to propose overall satisfaction with life as the core indicator of subjective well-being. WHO will examine means of collecting this information from countries. Although there was interest in looking at the eudaimonic (having a sense of meaning and purpose in life) and especially the affective (relating to feelings or emotional states) aspects of well-being, more work is required before these could be recommended for Health 2020. The lack of data meant that no robust quantification for these indicators could be proposed; this

situation will improve as more data are collected in the coming years. There was also interest in measuring subjective well-being across multiple domains of life. Several resources were identified to enable Member States to report on this as an additional indicator.

It was agreed that more time and further information (including from experts not present at the joint meeting) were required to evaluate the appropriate objective indicators of well-being, and that this should also take account of the overall set of Health 2020 indicators. It was therefore decided that both the expert groups would be invited to review this table after the meeting, once the overall recommendations on measurement frameworks and possible indicators for Health 2020 were made.

Progress had already been made in several areas concerning development of indicators and quantification of targets for Health 2020 overall, including the conclusion of technical work on WHO's global monitoring framework for noncommunicable diseases (NCDs) and work by the SCRC working group on Health 2020 targets. Data availability for indicators was reasonably encouraging, although challenges remain throughout the European Region.

The existing proposals from the first meeting of the expert group on development of indicators for Health 2020 were reviewed; these included 22 core indicators (of which nine related to inequities) and 16 additional indicators. The experts agreed overall general principles for indicators, including the necessity of ensuring coherence with WHO's global monitoring frameworks; of ensuring face validity; of keeping to routinely reported data with acceptable availability in order to minimise the burden on Member States; and of respecting the Regional Committee's existing agreements on the nature of European targets for Health 2020. The experts felt that the current evidence did not permit the quantification of all six targets where qualitative and directional descriptions were more suitable. Quantified targets (where appropriate) and a shortlist of indicators were recommended on this basis; these will be put forward for consultation.

Introduction

A joint meeting of experts on targets and indicators for health and well-being in Health 2020 was convened by the WHO Regional Office for Europe. It brought together three groups: the expert group on measurement and target-setting for well-being; the expert group on development of indicators for Health 2020; and representatives of the working group on Health 2020 targets of the SCRC. Its aim was to review all the recommended work from the previous meetings of the expert groups, to advise on the measurement framework and indicators for the Health 2020 targets already set by the Regional Committee (including for well-being), and to determine the support needed by Member States to implement such a framework and for additional further development (see Annex 1).

Participants were welcomed to the meeting by Dr Claudia Stein, Director of the Division of Information, Evidence, Research and Innovation, on behalf of the WHO Regional Director for Europe, Mrs Zsuzsanna Jakab (Annexes 2 and 3). Dr Peter Achterberg chaired the meeting on 5–6 February, which focused on the work of the expert group on measurement and target-setting for well-being, and Dr Hugh Markowe chaired the meeting on 7 February, which focused on the work of the expert group on development of indicators for Health 2020 (agendas attached as Annex 2). On the proposal of the WHO Regional Office for Europe, Mr Nick Fahy and Dr Marieke Verschuuren were elected as rapporteurs for the meeting. Participants were invited to declare any conflicts of interest; none was noted.

Address by the Regional Director for Europe

The Regional Director for Europe, Mrs Zsuzsanna Jakab, joined the meeting for part of 6 February and welcomed the participants personally. She recalled that in 2012, alongside the adoption of Health 2020 with its six headline targets, it was agreed that quantified targets together with a shortlist of indicators would be provided to the 2013 session of the WHO Regional Committee for Europe. This additional consideration enabled the global monitoring framework for NCDs to be taken into account, as this had now been endorsed by WHO Member States. The quantified targets and shortlist of indicators prepared by this meeting would be put to the SCRC for consultation, followed by a web-based consultation with Member States before submission to the Regional Committee in September.

The Regional Director underlined the importance of having a monitoring system to underpin WHO's strategies and congratulated the groups on the excellent progress already made towards putting this in place for Health 2020. The 2012 European health report (to be published shortly) would provide a baseline for this monitoring system, and she thanked all those involved in preparing it.

WHO's success depends on working with a range of partners. Successful recent collaborations include the newly established initiative on health information between the National Institute for Public Health and the Environment (RIVM), the Netherlands and the WHO Regional Office for Europe, as well as partnerships with the EU, OECD and others.

In conclusion, the Regional Director expressed her thanks for the work of the groups and her hope that all participants would also be advocates for this important work in the future.

Aims and expected outcomes of the meeting

The main aims of the meeting were to:

- review all the recommended work from the previous meetings of the expert groups (1–3);
- advise on the measurement framework and indicators for the Health 2020 targets already set by the Regional Committee (including for well-being); and
- make recommendations on the further work required to take this framework forward.

The key objective was to offer guidance on how best to consult Member States on the proposed measurement framework. This necessitated identifying the support needed for collection, analysis and reporting of these indicators, as well as the work required to finalize indicators such as those for well-being, while taking into consideration practical constraints (such as the limits on proposals for further data collection).

The timeline for the Health 2020 indicators process was a tight one. The report (including the proposed table of indicators) needed to be drafted by 15 February in order to be agreed and submitted for translation by 22 February. The SCRC would be consulted in March, followed by a web-based consultation of Member States during March and April. In May, the SCRC would then decide on the indicators and targets to be submitted to the Regional Committee in September.

Update on progress with Health 2020 and other relevant initiatives

The Health 2020 framework includes a focus on well-being as well as health, based on the definition proposed by the expert group on measurement and target-setting for well-being at its second meeting (2). More generally, Health 2020 takes a holistic approach, addressing the determinants of health across the whole of society and government. The strategy includes six targets, one of which is to enhance well-being.

Progress was being made on the Regional Office's joint project with the European Commission and OECD to implement a single integrated health information system for Europe. Work was also being undertaken towards a health information strategy for Europe, with a working group of Member States chaired by the Netherlands and the Russian Federation. RIVM and the WHO Regional Office for Europe had signed a letter of intent to establish an initiative on health information, including joint work on health indicators, a single health information platform and health information networks. The discussion underlined the importance of strengthening cooperation between WHO and the EU and emphasized the good progress made by WHO and the European Commission in cooperation on the single health information.

Measurement and target-setting for well-being

Outcomes of and progress since the last meeting of the expert group

The outcomes of the last meeting of the expert group on measurement and target-setting for well-being, as described in the meeting report (2), were a definition of well-being (*Well-being exists in two dimensions, subjective and objective. It comprises an individual's experience of their life*

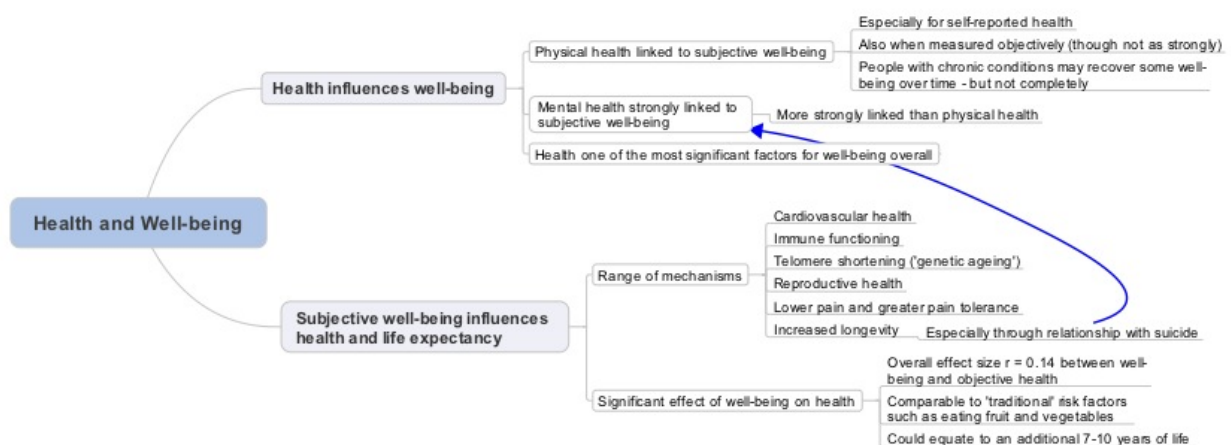
as well as a comparison of life circumstances with social norms and values) and a set of 13 principles for measurement and indicators.

The expert group had also set out a road map for action. Of the points listed, progress with the literature review and towards better understanding of the links between health and well-being were described during the joint meeting, and the steps necessary for consideration of these issues by the governing bodies of the WHO Regional Office were also discussed. There had not been progress, however, on the recommendation regarding identification of stakeholders and policy uses of indicators for well-being, including policy levers for ministries of health.

Understanding the links between health and well-being

One key issue identified by the expert group was the need for better understanding of the links between health and well-being. Some follow-up work had briefly reviewed literature in this area, drawing in particular on work by the New Economics Foundation (4) as well as other studies. The review showed that both physical and mental health influence subjective well-being; indeed, health is one of the strongest influences on well-being overall (Fig. 1).

Fig. 1. Overview of links between health and subjective well-being



The relationship between physical functioning and subjective well-being is not as strong, but this may be precisely because of the added value of measuring subjective well-being; it captures perceived impacts of ill health (such as pain), which traditional biological measurement does not (5). This is a two-way relationship, as well-being significantly influences future health through a range of mechanisms such as the functioning of the immune system and responses to stress (6). The review suggested that well-being has a substantial (though variable) effect on health that is comparable to that of other factors, such as a healthy diet, that have more often been the targets of public health interventions (7).

In discussion, the following points were made.

- The summary was welcomed, in particular because it explained the link between subjective well-being and health. It also showed that including what people feel and report (as opposed to objective elements only) clearly adds different information for policy discussions.

- There was interest in the review being published. It was agreed that this could be done in brief in this meeting report; a more substantial and systematic review would, however, require additional work. The meeting might therefore make both short-term and longer-term recommendations about future research and development needed in this area.
- There were doubts about the presentation of health as “physical health” and “mental health”, especially given the lack of a clear definition of “mental health”. One alternative would be to use a bio-psychosocial model, although this could be difficult to present briefly.

Measuring well-being

Tools to measure well-being: results of a systematic literature review

A systematic review had been made of the literature from PubMed, which aimed to identify all available tools to measure well-being, and to assess their psychometric and feasibility characteristics. In particular, the review considered several questions.

- Can a clear definition of well-being be provided to enable interpretation of the responses?
- What definitions and concepts underpin the different measurement tools?
- How are the constructs operationalized?
- Which characteristics are reported?
- How well do the different measures handle issues of population diversity (such as gender differences in concepts of well-being)?

The review looked at papers listed in the PubMed database between 2007 and 2012. It found and reviewed 12 201 articles according to pre-defined inclusion and exclusion criteria; 487 full text articles were retrieved and analysed. 56 distinct measures were identified, and data from these measures were extracted.

Here are the key findings.

- Most studies used cross-sectional designs, with a wide variety of specific procedures.
- Measures could be grouped into a limited number of domains: measures of affect, life satisfaction measures (covering single items, multiple items or across different domains), mental health scales, multidimensional scales and spiritual well-being scales.
- The differentiation between results from men and women seems unsatisfactory. There is a lack of integration of social expectations (how social norms and expectations may skew results).

The review would be continued to examine measurement tools in other databases, but it already seems that there is a need for standardization of assessment. For example, there are effects of the precise methodology of different approaches (such as the time of day the questions are asked or the effect of preceding questions), but these are under-researched. Moreover, there is a need for more conceptual clarity on whether well-being is measured as an outcome, exposure or intermediary factor.

On this basis, it would be useful to bring together information on existing measures, to undertake further research on the measurement of well-being, to set up a public database, and to work towards a new integrated instrument.

In discussion, the following points were made.

- While there was clearly a very wide variety of concepts and approaches, meeting participants were optimistic about the emergence of consensus – for example, as described by OECD in their draft guidelines on the measurement of subjective well-being. Given the need for the meeting to make a recommendation to WHO, this should be for further work to strengthen and improve the existing instruments to measure well-being and their use, including drawing on the results of this review.
- Since well-being is conceptualized in a wide variety of ways by these different measures, it was agreed that a database of tools would be useful. This should be able both to identify the component parts of the overall construct of well-being and to set out the different measures for those parts. It should also take into account other relevant work, such as that of the Roadmap for Mental Health Research in Europe (ROAMER) project discussed at the first expert meeting (1).
- The construct of well-being seems to be evolving, as are related measurement tools. There were some doubts about the relevance of some specific components identified, such as the construct of spiritual health.

Draft OECD guidelines on the measurement of subjective well-being

The draft OECD guidelines (8) represent the first attempt to provide international recommendations on collecting, reporting and analysing subjective well-being data. The guidelines are divided into four chapters:

1. concept and validity
2. methodological issues
3. a recommended measurement approach
4. reporting, analysing and interpreting the data.

They provide guidance for collecting data on three important elements of the subjective well-being construct: life evaluation, affect and eudaimonia or psychological well-being.

Chapter 2 of the guidelines gives a detailed outline of methodological issues in collecting subjective well-being data. These include the impact of question wording and response formats, as well as broader survey design considerations such as question order, mode effects, and the impact of day of week and time of year. Data comparability relies on a highly consistent approach to measurement.

Chapter 3 introduces recommendations on good measurement practice, including prototype question modules. In recognition of the different user needs and resources available to statistical producers, the guidelines provide six question modules (A–E) for different purposes. The main focus is the core module (A), which contains just five questions: one on life evaluation, three on affect, and one on eudaimonia. All national statistical agencies are encouraged to implement this core module in its entirety. When it is not possible to collect the full core module, the primary

life evaluation measure provided should be used at the minimum. Modules B to E are more detailed and more experimental measures, focused on specific aspects of subjective well-being. These are not necessarily intended to be used in their entirety or unaltered, but rather provide a resource for statistical agencies or researchers in developing their own questionnaires.

Chapter 4 includes potential uses of the data, such as complementing existing well-being measures to help monitor the progress of societies; providing a basis for research on the determinants of subjective well-being; and supporting policy design, development and evaluation. For example, the data may support evaluation and cost–benefit analysis, particularly where non-market outcomes are involved. Different measures may also offer different insights on individual well-being. Life evaluation, affect and eudaimonia show some differences in terms of their determinants, and may have differing policy applications. For example, affect measures have links to physiology and health (in both the short and longer term), and reflect the impact of activities and environments.

The guidelines also discuss two key issues relevant to WHO’s work on target-setting for well-being. First, although subjective well-being shows strong and meaningful relationships with life circumstances, there is evidence that individuals’ reported levels of subjective well-being can sometimes adapt over time to both positive and negative life changes. This has led to some concern that subjective well-being could underestimate objective deprivations. Nevertheless, adaptation to some life events appears to be absent, slow or incomplete. Furthermore, the rate and extent to which adaptation occurs show individual differences. Understanding who adapts and why – and the social and public resources that can support adaptation to adversity in particular – are therefore key potential policy uses of subjective well-being data.

The second issue concerns the potential for cultural bias to affect the international comparability of subjective well-being data, at least in terms of comparing simple mean averages. Changes in subjective well-being over time and differences in patterns of determinants can, however, be usefully compared. Further research is needed both to quantify the degree to which cultural bias is a problem and to more adequately separate cultural bias from cultural impact. Bias relates to cultural differences in how subjective well-being is reported: this could arise from linguistic differences, differential number use or different modes of emotional expression across cultures. Cultural impact, on the other hand, refers to cultural differences that affect how people actually feel about their lives, thus contributing to valid variation in subjective well-being measures.

Issues such as adaptation and cultural bias underscore the need to collect both objective and subjective data in order to build a full picture of a person’s (or a nation’s) well-being. Nonetheless, subjective well-being does capture meaningful information on how people think about and experience their lives, adding to what we can learn from objective indicators.

The draft guidelines are intended to be published on 20 March 2013, United Nations World Happiness Day. Further development and discussion will continue, with a document setting out next steps planned for the end of 2014.

In discussion, the following points were made.

- The draft guidelines were enthusiastically welcomed as providing a very solid basis for future work in this area and for the recommendations to be made to WHO by the meeting. Participants felt it might be valuable to have a single joint paper setting out a common

approach from OECD, WHO and the EU, providing a basis for shared and consistent approaches.

- National statistical offices of OECD member countries had been actively involved in reviewing these guidelines, although this did not imply any specific commitment to implement them as such.
- Although the questions proposed by the guidelines were tested as far as possible, given the nature of research in this field, some judgement had been exercised by OECD in making specific suggestions (this was particularly the case for the affect and eudaimonia areas).
- The measures of affect proposed in the guidelines (such as questions 2–4 of module A, which asked how much of the previous day the respondent felt happy, worried or depressed) received considerable discussion. Doubt was raised about how meaningful it was to ask people to recall durations of emotional states from the previous day; some considered “yesterday” too short a time period to produce meaningful information (although OECD explained that the goal was to measure experienced affect, rather than long-term dispositional affect), while others had doubts that even recall over one day (proposed in order to avoid the distorting effect of the survey process itself) might not produce meaningful information (though OECD considered that there was evidence to suggest that it would). Doubt was also raised about the specific terms “happy” (which might duplicate satisfaction with life as a whole), “worried” (which seemed to be more cognitive than affective) and “depressed” (which also seemed to bring in more than affect), and whether these could be combined meaningfully into a single measure of affect (such as the balance between positive and negative affect). The term “happy” might also provoke negative reactions from policy-makers. Although OECD clearly had a basis from their review for proposing this approach, it was not a straightforward set of proposals, given the existing literature (which itself is not straightforward). It was agreed that further, more technical discussion would be required to explore these issues further.

Current use of indicators for well-being

Use of well-being indicators in international initiatives: a summary

An overview of current uses of well-being indicators from different countries and international organizations looked in particular at:

- the Canadian Index of Well-being (CIW) (9)
- Measuring National Well-being (MNW) from the United Kingdom (10)
- OECD’s Better Life Index (BLI) (11)
- the European Commission’s Sponsorship Group on Measuring Progress, Well-being and Sustainable Development (SpG) (12).

This found a high degree of overlap in the well-being domains chosen by the different initiatives (Fig. 2).

Fig. 2. Similarities in domains between well-being initiatives



Note: the respective order in each text box is CIW, MNW, BLI and SpG.

There was greater variety in the indicators used to assess the different domains, although a number of common elements were still present. There were subtle differences in the precise formulation of apparently similar indicators.

In discussion, the following points were made.

- Overall, participants felt that this commonality of approaches was encouraging for the feasibility of WHO's intentions, although the variety of measures underpinning similar indicators could create difficulties.
- Different approaches to presentation and communication of the initiatives were also noted, in particular when combining indicators into composites. There was general reluctance to take the approach of proposing composite indicators: although these had been used at the national level in some cases (for example, in Bhutan's index of gross national happiness), use at the international level led to problematic uses for "ranking".

Use of well-being indicators in COURAGE

The COURAGE project (13) developed a protocol for evaluation of non-fatal health and health-related outcomes, reflecting a bio-psychosocial model and using the International Classification of Functioning, Disability and Health (ICF) (14). The project was set up as a result of research showing that existing studies of ageing populations tend to confuse health state, quality of life and well-being. It provides objective and evidence-based prevalence trends and relates these to both quality of life and well-being outcomes, as well as to the role of health determinants such as the built environment and social networks. Such measures are particularly important in the context of an ageing population, but are often lacking and not comparable across countries.

The COURAGE approach was applied to a sample of 10 800 people in Finland, Poland and Spain. The interesting variety and complexity of the results highlight the need for more general

measures of health and well-being at the European level, combined with more detailed analytical data.

The COURAGE analysis shows that functional status is an important predictor of well-being: improving functional status catalyses health and increases population well-being. The work shows that action taken to improve the built environment and make it more facilitative can improve functional status and thus well-being. This has important policy implications; the research can therefore help to support policy initiatives to improve health at the population level.

The ensuing discussion emphasized that Health 2020 reflects this approach, in that it takes a holistic view across government departments, connecting policies elsewhere (such as the built environment) and well-being.

Use of well-being indicators in SAGE

The SAGE survey (15), as outlined at the first meeting of the expert group (*see 1*), is a multicountry study of ageing and health, drawing on samples from six countries (China, Ghana, India, Mexico, the Russian Federation and South Africa) and demographic surveillance sites from the International Network for the continuous Demographic Evaluation of Populations and Their Health in developing countries (INDEPTH) in eight countries (Bangladesh, Ghana, India, Indonesia, Kenya, South Africa, Tanzania and Vietnam), with a total sample of around 90 000 people. The study looks at health status and the factors that influence it: health conditions, functioning in daily life (self-reported health status and performance tests in a range of domains) and people's subjective appraisal of their health status, quality of life and well-being (evaluative and experienced).

SAGE measures subjective well-being through a combination of life satisfaction (using WHO Quality of Life (WHOQoL) 8: eight questions about satisfaction with different domains of life and life overall (16)) and experienced well-being using an abbreviated version of the Day Reconstruction Method (DRM) (*see 1*). The data collected allow analysis of various factors affecting changes in well-being over the life-course and over time. The results suggest that overall happiness and experienced well-being have very similar determinants: a strong relationship with health status, chronic disease and disability; and consistent relationships with age, income, education and social networks.

The SAGE results emphasized the utility of measuring the affective (or experienced) element in addition to the evaluative component of subjective well-being, as there seems to be a clear relationship between affect and good or bad health. The challenge is to understand how this relationship is mediated: for example, whether limitations in functioning oblige people to undertake less enjoyable activities. More data are required to understand this interaction. Including indicators on subjective well-being with its separate evaluative and experienced components within a monitoring framework for Europe could provide valuable insights.

In discussion the following points were made.

- Both the national and regional levels are relevant: Gallup data (17) show that the context of a local geographical region has an important effect on well-being. SAGE would be able to provide data on inequalities within and between countries.

- Social factors were also agreed to be highly relevant, although actions that might improve social networks rely on cross-government recognition of the issue, as they lie outside the scope of health ministries.

Measuring quality of life and well-being in the EU

The European Commission worked to measure quality of life and well-being in the European Statistical System (the combination of EUROSTAT (the statistical office of the EU) and the statistical authorities of the EU and European Free Trade Association (EFTA) Member States). The Commission set out this work in its communication on measuring progress in a changing world (18), which identified five key actions:

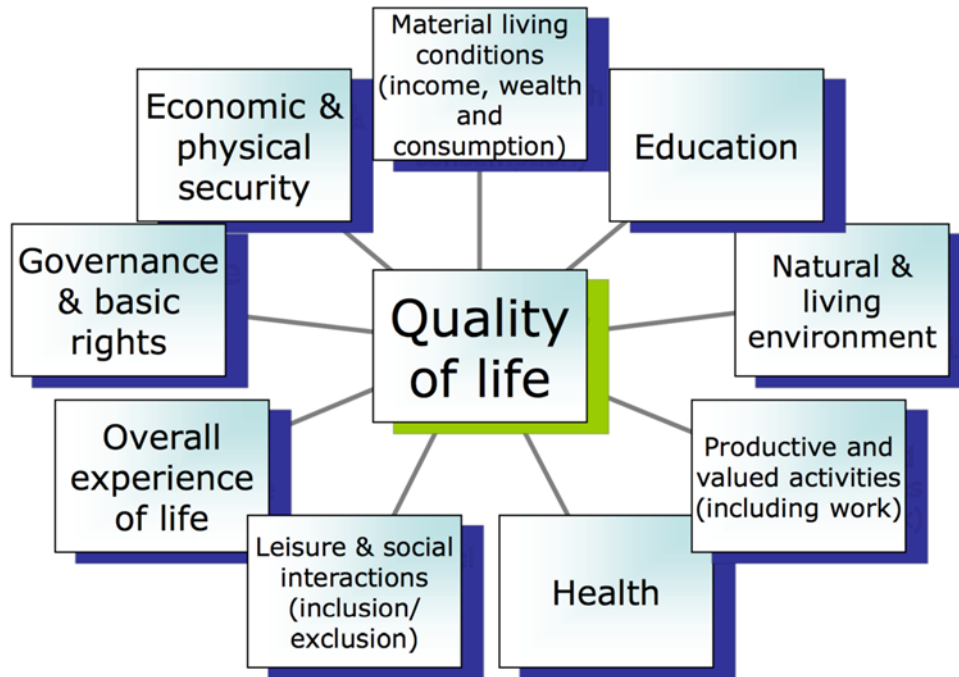
- complement GDP (gross domestic product) with environmental and social indicators (including on quality of life and well-being);
- provide near real-time information for decision-making;
- report more accurately on distribution and inequalities;
- develop a European sustainable development scoreboard; and
- extend national accounts to environmental and social issues.

The SpG prepared a report focusing on making better use of and improving existing statistics with a view to providing the most appropriate indicators, the recommendations of which are being integrated in the Commission's statistical work programme (12). The approach was based on a combination of consistency with theory (as set out in the Stiglitz report (19)), political relevance (in accordance with the Commission's Europe 2020 strategy (20)) and measurability (as set out in the communication on measuring progress in a changing world (18)).

The SpG included a taskforce on quality of life. This agreed eight plus one dimensions on quality of life, which include health and correspond well with those being discussed by the joint meeting (Fig. 3).

The core instrument for this multidimensional approach to quality of life is the EU Statistics on Income and Living Conditions (EU-SILC) survey (21), in which a micro-data set will be established for analysis. EU-SILC is the core social survey for EU and EFTA countries, with both cross-sectional and longitudinal (four-year) data, covering a total of more than 130 000 households and about 270 000 individuals. These data will be complemented with other data sources, including the European Health Interview Survey (EHIS) (22), the EU Labour Force Survey (EU LFS) (23), and the Harmonised European Time Use Survey (HETUS) (24), and will undergo further development over time. The intention is to use both objective and subjective data for each domain, and to include distributional measures (such as geographical region, vulnerable groups). Synthetic indicators will be developed to go alongside a scoreboard of primary indicators. The first set of quality of life indicators should be published by EUROSTAT early in 2013.

Fig. 3. Quality of life dimensions identified by the SpG taskforce



The health dimension in particular is addressed as follows:

- overall health status by an indicator on physical/mental health status (EU-SILC, EHIS);
- access to health care by an indicator on unmet need for medical examination or treatment (EU-SILC, EHIS);
- drivers of (un)healthy behaviours – no indicator yet defined.

The aim is for a routine mechanism to report on these indicators, which can be measured at the individual level. There will also be “context” indicators (such as life expectancy), which are meaningful at the population level. The exact type of indicators to be used for distributional measures has not yet been decided.

Three types of question will be posed to address overall experience of life:

- evaluative, cognitive questions (such as those on life satisfaction)
- affect questions (including positive and negative affect)
- questions on eudaimonic well-being (such as purpose, meaning and flourishing).

Variables will be used from existing surveys, including the European Social Survey (a research consortium, not covering all EU countries) (25), European Quality of Life Surveys (EQLS) (26) and Eurobarometer (2010) (27). An ad hoc EU-SILC module on subjective well-being will also be incorporated in 2013 (28). This will cover all the dimensions of the framework described above through a total of 22 variables, and will be supported by a manual and reference questionnaire in all EU languages. This has been developed in cooperation with other international initiatives, including OECD.

As well as developing reporting and further data collection, it will also be important to achieve political acceptance and use of these data, allowing society more broadly to “catch up” with these statistical developments. The range of national initiatives in this area (in Austria, Belgium, Finland, Germany, Italy, the Netherlands and the United Kingdom) suggests that there is widespread interest in these issues.

In discussion, the following points were raised.

- On the distinction between synthetic and composite indicators, EUROSTAT considers a synthetic indicator one that varies consistently with other indicators in the same area, and which is therefore taken as representing that area. This is quite different from composite indicators, which are made up of several different indicators with different measurement scales.
- There seemed to be much commonality in approach between the different international organizations in this area, and it was agreed that on this basis a joint paper on key indicators of well-being in Europe from the EU, OECD and WHO could be valuable in describing such a shared approach.

Well-being indicators for Health 2020

There was extensive discussion of the best approach to setting well-being indicators for Health 2020 when considering outcomes of and progress since the last meeting (see above). Participants looked at both the subjective and objective dimensions of well-being.

Subjective well-being

Discussion of indicators and measurement of subjective well-being included the following points.

- There was broad consensus on taking overall satisfaction with life as the core indicator of subjective well-being. Participants felt that this might be measured, for example, through question A1 in the core module of the draft OECD guidelines (8): “Overall, how satisfied are you with life as a whole these days?”.
- Little is yet known about the relevance of the eudaimonia aspect of subjective well-being to health. The draft OECD guidelines (8) do not explore this specific link; further work is necessary to better understand it and to establish what kind of information measurement of this construct provides, as well as its relevance for health, before proposing it as an indicator for Health 2020.
- The meeting was not able to reach a conclusion on the aspect of positive and negative affect. There is evidence to suggest that there are links between affect and health, and that these could provide relevant information for health policies in particular, reflecting the impact of activities and environments. There was no consensus in the discussion, however, on the best measurement approach to take or on precise identification of an indicator in this area, in particular with reference to the draft OECD guidelines (8). It is important both to develop a better understanding of the links between affect and health (at the individual and population levels) and to pursue technical discussions that could help build consensus on effective measurement.
- There was considerable interest in measuring life satisfaction across multiple domains; this could provide information of particular relevance to policy-makers and support

engagement across government. There are, however, several alternatives for indicators and measurement of this area, including the seven domains of the Personal Well-being Index (29), the slightly extended list of 10 domain evaluation questions provided in module E of the OECD guidelines (8), the WHOQoL 8 (16), and the instruments being developed by EUROSTAT. Although there was much discussion of the differences and merits of indicators and measurement approaches and the domains they covered, all would involve collecting data on a significant number of new domains, which raised consequent doubts about their practicality for Member States. While in theory a shortlist of particularly relevant domains could be identified, doing so would require further empirical analysis to evaluate which of the different domains added relevant information from a health perspective.

- The Regional Committee had agreed that there should be a single regional Health 2020 target for life satisfaction (rather than national targets, for example). There was concern in the joint meeting that this would be difficult to achieve, given the current state of available data and knowledge of trends and differences in well-being between Member States. Different ways of approaching this were discussed, such as aiming for stable or increasing levels of well-being, or quantifying reductions in inequalities through a reduction in standard deviations. Overall, however, it seemed clear that there were simply not enough data to assess what would be considered appropriate improvement, given the innovative nature of the indicator, the wide differences between countries across the Region, and technical issues such as the need for better understanding of the factors affecting cross-country comparability. Data on this indicator provided by countries in the coming years will help to address these issues, and could provide a basis for setting a quantified target in the future.
- Further development is needed to address gender differences in concepts of well-being and to take a life-course approach to measuring subjective well-being.

Following these discussions participants agreed to recommend a core indicator for subjective well-being of life satisfaction, which could be measured using a single overall question. Quantification will be set according to the indicator baseline, with the aim of narrowing intra-regional differences and stimulating a general levelling up. Countries could also consider measuring life satisfaction across multiple domains using tools such as those described above (PWI, OECD module E, WHOQoL 8, and so on).

Support for Member States

Discussion of the support available to Member States to facilitate reporting on the subjective well-being indicator identified several resources.

- The OECD guidelines on the measurement of subjective well-being (8) will be freely available and OECD can provide support with their implementation. A regional event for Europe is planned to discuss the guidelines, which may also provide an opportunity for support.
- Gallup carries out an annual survey that covers all the countries of the WHO European Region (17), and already works with OECD countries and OECD. It is also possible for non-OECD countries to work with Gallup. It was agreed that it would be helpful for WHO to obtain further information on who can provide such engagement and what support could be offered, as the basis for a more substantial discussion.

- Surveys can be carried out at greatly reduced costs using alternative methods such as internet-based survey tools. The tools carry their own challenges, including the possibility of biased samples and potential lack of internet access throughout a population, but these can be controlled for (to some extent, at least), for example by also collecting demographic variables.
- The EUROSTAT manual supporting the implementation of the EU-SILC 2013 ad hoc module described above will also provide a valuable multilingual resource.

Objective well-being

Objective indicators of well-being were also discussed at length. It was agreed that it was important to have objective indicators alongside the subjective dimension, reflecting the definition of well-being agreed by the expert group (2).

The meeting briefly reviewed possible indicators for different domains, taking as a basis the shared domains identified by the review of well-being indicators in international initiatives (see above and Table 1). After initial consideration it was agreed that more time and further information (including from experts not present at the joint meeting) were required to evaluate what indicators would be appropriate. The evaluation should also take account of the overall set of Health 2020 indicators, which might cover relevant domains. It was therefore agreed that both the expert groups would be invited to review this table after the meeting, once the overall recommendations on measurement frameworks and possible indicators for Health 2020 were made. Some indicators chosen for other targets might also be considered relevant for the objective dimension of well-being, for example. The expert groups might, however, consider that there were important gaps for which additional objective indicators were required; these could be proposed directly or might require further work.

Next steps

The meeting agreed on the following next steps for measurement of and target-setting for well-being.

- Recommend adoption of the indicator of subjective well-being (“life satisfaction”) for target 4 of Health 2020.
- Commission further work to propose how this indicator could be quantified, on the basis of the initial data collected by Member States, with the aim of narrowing intra-regional differences and levelling up.
- Commission further work to better understand the links with health of the eudaimonic and affect measures of subjective well-being and relevant indicators.
- Perform further empirical analysis to evaluate which of the different domains of subjective well-being add significant relevant information from a health perspective, in order to guide choices and priorities for Member States in considering whether to collect data on multiple domains of subjective well-being.
- Invite both the expert groups to review the proposed set of objective indicators of well-being (Table 1) and compare them with the overall recommendations (Annex 1) to identify both the existing Health 2020 indicators relevant for well-being and any important gaps for which additional indicators of well-being were required. These could be proposed directly or additional work to evaluate them could be identified.

Table 1. Possible objective well-being indicators discussed during the meeting of 6 February 2013

Domain	Priority yes/no?	Objective well-being indicators					
		Core indicators suggested	Priority yes/no?	Availability	Additional indicators suggested	Priority yes/no?	Availability
Education		Educational attainment level			Percentage of early school leavers ⁱ		
Living standards		Connection to sewage system			Mobile phone coverage, internet access		
Personal finance/ income		Disposable income GDP per capita GINI coefficient ⁱⁱ			Poverty ⁱⁱⁱ		
Environment		Air quality, PM ₁₀			Lead exposure, other European Environment Agency (EEA) indicators		
Leisure and culture		To be established WHO to check details with the United Nations Organization for Education, Science and Culture (UNESCO)					
Democratic engagement		Voter turnout					
Jobs		Unemployment rate (long term and in youth) ^{iv}					
Relations		People living with a partner					
Communities and safety		Crime rates					

ⁱ The expert groups adopted “Proportion of children of official primary school age not enrolled” (core indicator 3.1c). Although not the most relevant indicator in all parts of the Region, the group still felt this was the best option for an indicator on education, given the combination of data availability and potential to stimulate policy action.

ⁱⁱ The expert groups adopted “GINI coefficient” (core indicator 3.1f).

ⁱⁱⁱ The expert groups did not make a choice on this as no data source could be identified for an adequate number of Member States.

^{iv} The expert groups adopted “Unemployment rate, disaggregated by age” (core indicator 3.1d)

Development of indicators for Health 2020

Updates on progress and relevant issues

Expert group on development of indicators for Health 2020

The recommendations from the first meeting of the expert group on development of indicators for Health 2020, in June 2012, had included some general principles, including building on existing health information activities, sharing knowledge and expertise, enhancing the collection of non-fatal health outcome data (such as morbidity, self-reported health and disabilities) and improving coverage of indicators on issues such as mental health and healthy ageing. There had been preliminary discussion of well-being indicators (which had referred to indicators such as childhood obesity and mental health), but the approach should now reflect the approach of this joint meeting (see the section above on measurement and target-setting for well-being). Since the June meeting, the Regional Committee had agreed overall targets for Health 2020, and technical work on the global monitoring framework for NCDs had also been concluded.

The expert group had also agreed the following principles and criteria in developing indicators.

- Indicators should be routinely collected, simple and inexpensive to administer.
- They should be robust and valid for measuring target achievement.
- Data should be available in the majority of Member States (both EU and non-EU).
- Data should be able to be stratified (by age and sex, and ideally also by ethnicity, socioeconomic strata and vulnerable groups).
- Core and additional indicators should be distinguished.
- The final number of core indicators should be kept to a minimum (around 20 overall).

In discussion, the importance of nomenclature and clear definitions was discussed, particularly in relation to potentially unclear terms such as “mental health”.

SCRC working group on Health 2020 targets

The working group was content with the outcome of discussions by the expert groups and the progress being made. There were some particular points that the joint meeting should keep in mind.

- It would be important to take into account the outcome of the discussions on the global monitoring framework for NCDs and its voluntary targets. This process was awaiting formal confirmation by the World Health Assembly in May.
- This joint meeting would need to be clear about what is meant by “European targets” in the context of Health 2020; this might need to be linked to target 6 on national targets.
- The meeting should also consider how reporting would be effected, and perhaps have a model of what this might look like and what process could be expected, so that Member States were clear about what they were committing themselves to.
- It would be important to know how the updated measurement framework agreed on the basis of proposals from this meeting would be included in Health 2020.

In discussion, the following points were made.

- A draft framework for monitoring Health 2020 targets and indicators had been put to the SCRC. Platforms for reporting included the annual report of the Regional Director to the Regional Committee, a specific publication on core health indicators in the WHO European Region, the European health report and online resources such as the Health for All database (30) and the health information portal intended to be launched (with RIVM) at the end of 2013.
- The updated measurement framework agreed on the basis of proposals from this meeting could be included in a specific additional publication for Health 2020; the next edition of the European health report would also reflect this work.

Shortlisting indicators and quantifying targets

Data availability for potential targets and indicators

While the picture of data availability for potential indicators and quantification of targets was encouraging overall (Table 2), both the western and eastern parts of the WHO European Region were missing data on some indicators. For example, recent data on causes of premature mortality were missing from Belgium and Denmark in the western part of the Region, from very small countries such as Andorra, Monaco and San Marino, and from some countries from the eastern part of the Region (Albania, Azerbaijan, Tajikistan, Turkey, Turkmenistan and Uzbekistan).

Table 2. Examples of availability of potential Health 2020 indicators in the Health for All database, 2009–2010

Target	Indicator	Availability	Disaggregation
2, 3	Life expectancy at birth	42 (missing: Albania, Andorra, Azerbaijan, Belgium, Bosnia and Herzegovina, Denmark, Monaco, San Marino, Tajikistan, Turkmenistan, Uzbekistan)	By sex, age (at birth, 1, 5 and 65 years)
1, 3	Infant mortality	42 (missing: Albania, Andorra, Azerbaijan, Belgium, Bosnia and Herzegovina, Denmark, Monaco, San Marino, Tajikistan, Turkmenistan, Uzbekistan)	Alternative: crude mortality rate, less than 1 year, by sex and cause
1	Standardized death rate, diseases of the circulatory system	42 (missing: Albania, Andorra, Azerbaijan, Belgium, Denmark, Monaco, San Marino, Tajikistan, Turkey, Turkmenistan, Uzbekistan)	By sex, age (5-year age groups), subnational (only for 24 countries via the Health for All database and EUROSTAT)
1	Cancer incidence	39 (missing: Andorra, Cyprus, Estonia, France, Germany, Greece, Monaco, Montenegro, Portugal, the Russian Federation, San Marino, Slovakia, Spain, Turkey)	Alternative: estimates available from the International Agency for Research on Cancer (IARC)

Target	Indicator	Availability	Disaggregation
4	Incidence of mental disorders	24 (missing: Albania, Andorra, Austria, Belarus, Bosnia and Herzegovina, Croatia, Cyprus, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Monaco, Montenegro, the Netherlands, Norway, Portugal, San Marino, Slovenia, Sweden, Switzerland, the United Kingdom)	
1	Pure alcohol consumption, litres per capita, age 15+	44 (missing: Albania, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Portugal, Turkmenistan, Ukraine, Uzbekistan)	By type of alcohol
1	Percentage of regular smokers in the population, age 15+	33 (missing: Andorra, Austria, Bulgaria, Croatia, France, Georgia, Germany, Kazakhstan, Kyrgyzstan, Montenegro, Portugal, Republic of Moldova, the Russian Federation, San Marino, Serbia, Slovenia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkmenistan, Uzbekistan)	By sex
3	Percentage of live births to mothers aged less than 20 years	45 (missing: Albania, Belarus, France, Montenegro, the Russian Federation, San Marino, Turkey, Turkmenistan)	
1, 5	Percentage of children vaccinated against measles	50 (missing: the Czech Republic, Italy, Montenegro)	
1	People killed or injured in road traffic accidents	49 (missing: Andorra, Montenegro, San Marino, Turkmenistan)	Alternative to motor vehicle accidents, which is available by age and sex
5	Private households' out-of-pocket expenditure	53 (none missing)	
3	United Nations Development Programme Human Development Index	51 (missing: Montenegro, San Marino)	

In discussion, the following points were raised.

- This assessment of availability is based on data provided to WHO by Member States. Some countries appear to have data but are not providing it to WHO; this might mean that availability is better than it currently seems.
- In considering availability of data for indicators, the number of countries alone is not sufficient: the geographical spread should also be considered, as well as the inclusion of very large countries such as the Russian Federation.

- The presentation was based primarily on the Health for All database; there might be other sources that could be considered routine (and which were used for indicators in the global monitoring framework for NCDs, for example).
- Some indicators might be so important that the meeting would propose them anyway, highlighting limited availability as a call to action.

Overview of existing proposed indicators

Overall, the proposed indicator set had 22 core indicators, of which 9 related to inequities (and 3 were duplicates, meaning there were 19 separate core indicators). For 8 of these, additional indicators were also defined, with 16 additional indicators in total; some of these had “subindicators”, the meaning of which should be defined. Of the core indicators, 15 were quantitative, and four qualitative. The areas of morbidity and health status were relatively sparsely covered (with only one morbidity indicator and none on health status). There were also no demographic indicators; the first meeting had assumed that such data would be routinely produced by Member States already. About one third of the indicators related to processes, while two thirds related to outcomes.

The discussion noted the importance of also considering spread of indicators across the life-course.

Review of Health 2020 targets, indicators and quantification

The joint meeting reviewed proposals for indicators and quantification for the Health 2020 targets in detail. The revised proposals agreed are shown in Annex 1.

Some general principles were agreed.

- Contradiction with WHO’s global monitoring frameworks – in particular the global monitoring framework for NCDs – must be avoided.
- Face validity of the indicator set as a whole should be ensured; selected indicators should also be clearly explicable and comprehensible for policy-makers.
- Indicators can be linked to more than one target (for example, the area of inequalities is also particularly relevant across other targets).
- Exactly what is covered by each indicator should be clear; this could be achieved, for example, through cross-references to the International Classification of Diseases (ICD) codes, also used in the WHO list of causes of death for mortality indicators.

Discussion focused on the following areas in the review of the Health 2020 targets.

Health 2020 target 1 (Reduce premature mortality in Europe by 2020)

- Participants considered whether it was appropriate to use standardized death rates rather than the unconditional probability approach of the global monitoring framework for NCDs in the first core indicator.
- The meeting also debated whether to use a definition of premature mortality, and if so, whether to use the definition from the global monitoring framework for NCDs (deaths between 30 and 70 years of age).

- There was discussion of whether to include the wide range of risk factor indicators from the global monitoring framework for NCDs, or whether to identify a narrower set of such indicators for the Health 2020 measurement framework, taking into account their particular relevance for the European Region (for which the major risk factors are identified by WHO as alcohol, tobacco, high blood pressure and obesity) and their practicality (in particular, their availability and appropriateness for Europe, such as identifying tobacco use rather than smoking). Participants reiterated the decision of the expert group on development of indicators in June 2012 that in the absence of measured data in an adequate number of Member States, self-reported data will be an acceptable alternative (3).
- It was agreed that since the target from the global monitoring framework for NCDs was defined in terms of a percentage reduction, this should be reflected in the approach for Health 2020.
- Participants agreed that sources other than the Health for All database could be considered where appropriate, such as the Health Behaviour in School-Aged Children (HBSC) survey (31) for indicators of overweight and obesity among young people, or the European School Survey Project on Alcohol and Other Drugs (ESPAD) (32) for alcohol.

Health 2020 target 2 (Increase life expectancy in Europe)

- Participants debated how much information the indicator on life expectancy at birth would add in addition to the indicators included under other targets on mortality.
- There was discussion of how far healthy life expectancy would be appropriate as a core indicator rather than an additional one, given the link to well-being. This was problematic, however, since several of the non-EU countries of the WHO European Region were not able to report on it.
- Participants considered the best approach to take in determining quantification of targets, such as whether to set quantified targets by subregion, or to look at historical trends (for example, international comparison of gaps between countries with the highest and lowest trends for indicators such as the difference in life expectancy); and if trends were used, whether to pursue current trends, reverse them or follow some other basis.
- The meeting debated whether inequalities relating to a target such as life expectancy could be measured using standard deviations (for example, looking for a reduction in divergence of the standard deviation of average country life expectancy across the European Region). Another approach could be to aim to reduce the gaps in life expectancy between high- and low-income groups of countries, though it had the disadvantage of introducing another variable, such as GDP. This could be overcome by calculating reduction in inequalities using a variation coefficient; the method did not need to be specified in this indicator, however, as countries would simply report on life expectancy and the variation coefficient would be calculated by the Secretariat.

Health 2020 target 3 (Reduce inequities in Europe)

- Concern was raised that data availability might affect how far issues such as social exclusion could be addressed.
- Participants were concerned that references to “population groups” were unclear, and might be distracting.

- They felt that the WHO European review of social determinants of health and the health divide might also provide additional insight into these issues, but it is not yet available. Initial indications suggest, however, that its data focus on the EU rather than the whole WHO European Region. This was a contribution that would need to be specifically reviewed; the meeting invited the Secretariat to review the proposals of this meeting against the review once it is published, and to suggest any necessary modifications regarding the meeting's proposals to the SCRC.
- There seemed to be some questions about the availability of data for the GINI coefficient indicator. It was agreed, however, that it should be kept as a core indicator.
- Given the general reluctance of using composite indicators, participants felt that the Human Development Index (HDI) (33) would not be an appropriate indicator to include (and could in any event be calculated from other sources if needed).
- The meeting agreed that there is a key difference between descriptive indicators and analytical indicators, and that this exercise should focus on descriptive indicators on both practical and conceptual grounds.
- Participants felt it might be useful to review this list against that of the indicators' subgroup of the EU's Social Protection Committee.

Health 2020 target 4 (Enhance well-being of the European population)

- The meeting referred to its earlier discussion (see the section on measurement and target-setting for well-being above).

Health 2020 target 5 (Universal coverage and the "right to health")

- The term universal coverage is understood by WHO as meaning that all people have equitable access to effective and needed services without financial burden; the meeting agreed that it would be helpful for specific indicators to cover these three dimensions, even if only as additional indicators.

Health 2020 target 6 (National targets/goals set by Member States)

- Participants agreed on the importance of recognizing the different distribution of responsibilities within different Member States.
- Although this target has (more or less by definition) no routine data, the meeting noted that some countries may already have policies or processes in place that address these issues; these should be recognized in the quantification and indicators for this target.
- Participants felt it would be useful for Member States to share information with WHO and other countries regarding their actions related to Health 2020 to enhance WHO's ability to add value to the process.

Conclusions

The quantifications of targets (where appropriate) and indicators as outlined in Annex 1 have been recommended for consultation with Member States. They will be taken forward by the WHO Secretariat, first to the SCRC in March 2013 and then to a web-based consultation with all Member States of the European Region.

The Secretariat thanked all involved for their contributions and invited participants to facilitate active, timely and supportive engagement from Member States' administrations, especially given the very tight and inflexible timetable for this process.

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Annex 1

PROPOSED INDICATORS AND QUANTIFICATION OF TARGETS

Area/target	Quantification	Core indicators	Data source (No. of Member States for which the source holds data)	Additional indicators	Data source (No. of Member States for which the source holds data)
Health 2020 area 1. Burden of disease and risk factors Overarching or headline target 1. Reduce premature mortality in Europe by 2020	1.1. A 1.5% relative annual reduction in overall (four causes combined) premature mortality from cardiovascular disease, cancer, diabetes, and chronic respiratory disease until 2020	(1) 1.1a. Standardized overall premature mortality rate (from 30 to under 70 years) for four major noncommunicable diseases (cardiovascular diseases, cancer, diabetes mellitus and chronic respiratory disease), disaggregated by sex	HFA-MDB ^v (42)	(1) 1.1a. Standardized mortality rate from all causes, disaggregated by sex and cause of death	HFA-MDB (42)
		(2) 1.1b. Age-standardized prevalence of current tobacco smoking among persons aged 15+ years.	Source used by the Global Monitoring Framework for Noncommunicable Diseases (Global Health Observatory) (50)	(2) 1.1b. Prevalence of weekly tobacco smoking among school-aged children	HBSC ^{vi} Survey (38)
		(3) 1.1c. Total (recorded and unrecorded) per capita alcohol consumption among persons aged 15+ years within a calendar year (litres of pure alcohol)	Source used by the Global Monitoring Framework for Noncommunicable Diseases (Global Health Observatory) (50))	(3) 1.1c. Heavy episodic drinking among adolescents	ESPAD ^{vii} (34)

Area/target	Quantification	Core indicators	Data source (No. of Member States for which the source holds data)	Additional indicators	Data source (No. of Member States for which the source holds data)
		(4) 1.1d. Age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as a body mass index > 25 kg/m ² for overweight and > 30 kg/m ² for obesity)	Source used by the Global Monitoring Framework for Noncommunicable Diseases (Global Health Observatory) (46)	(4) 1.1d. Prevalence of overweight and obesity among school-aged children	HBSC Survey (38)
	1.2. Achieved and sustained elimination of selected vaccine-preventable diseases (polio, measles, rubella) and prevention of congenital rubella syndrome	(5) 1.2a. Percentage of children vaccinated against measles, polio and rubella	HFA ^{viii} (51)		
	1.3. Reduction of mortality from external causes	(6) 1.3a. Standardized mortality rates from all external causes and injuries, disaggregated by sex	HFA-MDB (42)	(5) 1.3a. Standardized mortality rates from motor vehicle traffic accidents	HFA-MDB (36)
				(6) 1.3b. Standardized mortality rates from accidental poisonings	HFA-MDB (42)
				(7) 1.3c. Standardized mortality rates from alcohol poisoning	HFA-MDB (35)
				(8) 1.3d. Standardized mortality rates from suicides	HFA-MDB (42)

Area/target	Quantification	Core indicators	Data source (<i>No. of Member States for which the source holds data</i>)	Additional indicators	Data source (<i>No. of Member States for which the source holds data</i>)
				(9) 1.3e. Standardized mortality rates from accidental falls	HFA-MDB (42)
				(10) 1.3f. Standardized mortality rates from homicides and assaults	HFA-MDB (41)
Health 2020 area 2. Healthy people, well-being and determinants	2.1. Continued increase in life expectancy at current rate (= annual rate during 2006–2010) coupled with reducing differences in life expectancy in the European Region	(7) 2.1. Life expectancy at birth	HFA (42)	(11) 2.1a. Life expectancy at birth and at ages 1, 15, 45 and 65	HFA (41)
Overarching or headline target 2. Increase life expectancy in Europe				(12) 2.1b. Healthy life years at age 65	Eurostat (31 (EU-27 plus Iceland, Norway, Switzerland and Croatia))
Health 2020 area 2. Healthy people, well-being and determinants	3.1. Reduction in the gaps in health status associated with social determinants within the European population	(8) 3.1a. Infant mortality per 1000 live births	HFA (42)		
		(7) 3.1b. Life expectancy at birth, disaggregated by sex	HFA (42)		
		(9) 3.1c. Proportion of children of official primary school age not enrolled	UNESCO ^{ix} (46)		
Overarching or headline target 3. Reduce inequities in		(10) 3.1d. Unemployment rate, disaggregated by age	ILOSTAT ^x and Eurostat (ILO 38, SILC ^{xi} 30, total 43)		

Area/target	Quantification	Core indicators	Data source (<i>No. of Member States for which the source holds data</i>)	Additional indicators	Data source (<i>No. of Member States for which the source holds data</i>)
Europe (social determinants target)		(11) 3.1e. National and/or subnational policy addressing health inequities established and documented	Direct reporting by Member States through the Annual Report of the WHO Regional Director for Europe		
		(12) 3.1f. GINI coefficient	World Bank & Eurostat (<i>22 World bank, 26 SILC, total 40</i>)		
Health 2020 area 2. Healthy people, well-being and determinants	Will be set as a result of the baseline of the core well-being indicators with the aim of narrowing intraregional differences and levelling up	(13) 4.1a. Life satisfaction	To be established – WHO in discussion with existing survey providers	4.1a. Indicators of subjective well-being, either in different domains or by eudaimonia or by affect; to be developed	To be established
		4.1b. Indicators of objective well-being in different domains; to be developed and potentially already covered by other areas of Health 2020 targets	Must be from readily available sources	4.1b. Indicators of objective well-being in different domains; to be developed	From readily available sources
Overarching or headline target 4. Enhance well-being of the European population		(14) 5.1a. Private household out-of-pocket expenditure as a proportion of total health expenditure	HFA (<i>53</i>)	(13) 5.1a. Maternal deaths per 100 000 live births	HFA (<i>49</i>)
		(5) 5.1b. Percentage of children vaccinated against measles, polio and rubella	HFA (<i>51</i>)	(14) 5.1b. Percentage of people treated for tuberculosis who completed treatment	WHO Global TB report (<i>46</i>)
Health 2020 area 3. Processes, governance and health systems	5.1. Moving towards universal coverage (according to WHO definition)* by 2020				
Overarching or headline target	* Equitable access to effective and needed services without	(15) 5.1c. Per capita expenditure on	HFA (<i>53</i>)	(15) 5.1c. Government	HFA (<i>53</i>)

Area/target	Quantification	Core indicators	Data source (No. of Member States for which the source holds data)	Additional indicators	Data source (No. of Member States for which the source holds data)
5. Universal coverage and the “right to health”	financial burden	health (as a percentage of GDP)		expenditure on health as a percentage of GDP	
Health 2020 area 3. Processes, governance and health systems	6.1. Establishment of processes for the purpose or setting national targets (if not already in place)	(16) 6.1a. Establishment of process for target-setting documented	Direct reporting by Member States through the Annual Report of the WHO Regional Director for Europe		
Overarching or headline target 6. National targets/ goals set by Member States		(17) 6.1b. Evidence documenting: (a) establishment of national Health 2020 policy, (b) implementation plan, (c) accountability mechanism	Direct reporting by Member States through the Annual Report of the WHO Regional Director for Europe		

^v The mortality indicator database of the Regional Office.

^{vi} The Health Behaviour in School-aged Children *survey*.

^{vii} The European School Survey Project on Alcohol and Other Drugs.

^{viii} The Health for All Database of the Regional Office.

^{ix} United Nations Educational, Scientific and Cultural Organization.

^x Database of labour statistics of the International Labour Organization (ILO).

^{xi} European Union Statistics on Income and Living Conditions.

Annex 2

AGENDA – JOINT MEETING OF EXPERTS ON TARGETS AND INDICATORS FOR HEALTH AND WELL-BEING IN HEALTH 2020

Tuesday, 5 February 2013 –Third meeting of the expert group on measurement and target-setting for well-being

Opening

Welcome by WHO Secretariat

Election of rapporteurs

Adoption of agenda and programme

Session 1: Update on progress with well-being work

Short update on progress with Health 2020 & other relevant initiatives (WHO Secretariat)

Outcomes of and progress since the last meeting (Nick Fahy)

Aims and expected outcomes of the meeting (WHO Secretariat)

Discussion

- *Agreeing the questions and outputs of this meeting*
- *Defining time lines for delivery*

Session 2: Understanding the links between health and well-being

Results of work arising from June meeting (Nick Fahy)

Discussion

- *Which concepts are most useful for the work of WHO, especially in view of indicator development?*

Session 3: Measuring well-being: tools, guidelines and indicators

Tools to measure well-being – results of a systematic literature review (Jutta Lindert)

Discussion

- *Which of these tools can generate population-level indicators on subjective well-being?*
- *Tools for research versus tools for monitoring*
- *Which tools would be most suitable for the measurement of well-being at WHO?*

Draft OECD guidelines on the measurement of subjective well-being (Carrie Exton)

Discussion

- *To what extent can subjective well-being be included in Health 2020?*
- *Relationship between subjective well-being and OECD's Better Life Index*

Update: expert group on development of indicators for Health 2020 (Hugh Markowe)

Discussion

- *To what extent can subjective well-being be included in Health 2020?*
- *How can the discussions with the expert group on indicators best be guided?*
- *Can an operational framework for the measurement of subjective well-being be proposed?*

Summary and key points for WHO from Day 1 (Rapporteurs)

Wednesday, 6 February 2013 – Joint expert group meeting

Opening

Welcome by WHO Secretariat

Aims and expected outcomes of the day (WHO Secretariat)

Update: expert group on well-being – outcome of discussions of Day 1 (Peter Achterberg and rapporteurs)

Update: expert group on indicators – impressions from Day 1 and relevance for indicators group; criteria for indicators (Hugh Markowe and rapporteurs)

Discussion

- *Questions for clarification*

Session 1: Current use of indicators for well-being

Use of well-being indicators in COURAGE and SAGE (Matilde Leonardi and Somnath Chatterji)

Use of well-being indicators in international initiatives: a summary (Coen van Gool)

Discussion

- *Given the tools and indicator work to date, what steps need to be taken to move to objective and subjective well-being indicators for Health 2020?*

Measuring quality of life and well-being in the EU (Marleen De Smedt)

Discussion (contd.)

- *Given the tools and indicator work to date, what steps need to be taken to move to objective and subjective well-being indicators for Health 2020?*
- *Criteria for indicator selection*

- *Given the tools and indicator work to date, what objective and subjective well-being indicators might be considered for consultation with Member States?*
- *How is this best presented to Member States?*

Session 2: Joining the experts – well-being and Health 2020 indicators

Address by the Regional Director, Mrs Zsuzsanna Jakab

Discussion (contd.)

- *Can a shortlist of objective and subjective indicators be identified?*
- *What support will Member States need for the collection, monitoring & reporting of these indicators?*

Session 3: Well-being indicators for Health 2020

Discussion (contd.)

- *Can a shortlist of objective and subjective indicators be identified?*
- *Which are the Health 2020 actions with the strongest evidence of improving well-being?*
- *What is meant by a “European target” for well-being?*
- *What support will Member States need for the reporting of these indicators?*
- *Recommendations for next steps and action plan*

Summary and key points for WHO from Day 2 (Rapporteurs)

Thursday, 7 February 2013 – Second meeting of the expert group on development of indicators for Health 2020

Session 1: Bringing it together

Goals, expectations and outcome of the day and recommendations from June meeting (Hugh Markowe)

Summary of previous day (Rapporteurs)

Update from the Secretariat – process of next steps with Member States (WHO Secretariat)

Update: recommendations from the SCRC working group on Health 2020 targets (Chair, Sweden)

Discussion

- *Questions for clarification*

Session 2: Shortlisting indicators

Update: overview of existing proposed indicators (Chair and Marieke Verschuuren)

Discussion

- *Agreement on the process to quantify and shortlist indicators in 6 areas of Health 2020*
- *Agreement on need for core and other indicators*
- *What is meant by a “European target”?*

Session 3: Quantification of targets and indicators

Targets 1 and 2

Discussion

- *Agreement on target quantification and final proposal of indicators*

Targets 3 and 4

Discussion

- *Agreement on target quantification and final proposal of indicators*

Targets 5 and 6

Discussion

- *Agreement on target quantification and final proposal of indicators*

Session 4: Next steps

Summary of meeting recommendations (Rapporteurs)

Process for consultation with Member States (WHO Secretariat)

Discussion:

- *Agreement on next steps for consultation with Member States*

Closure of meeting

Annex 3

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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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