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The future of the WHO Regional Office for Europe

As requested by the Regional Committee at its fifty-fourth session (RC54), and following the discussions by the twelfth and thirteenth Standing Committees of the Regional Committee, the Regional Director submits to the Regional Committee the present document on the future of the WHO Regional Office for Europe. This document proposes a long-term vision for the role and position of the Regional Office including partnerships with other organizations, with particular reference to the partnership with the European Union, as explicitly requested by RC54. The document also suggests the main strategic directions that the Regional Office should develop from now until 2020 in order to be in the best position to fully play its role as the reference organization in the field of health in the Region.

The document, accompanied by a draft resolution, is submitted for the consideration of Member States.

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Contents

Page

Introduction

1. The Constitution of the World Health Organization (WHO) *(1)* clearly defines the Organization's functions and objectives. However, since its adoption in 1946, the world has changed dramatically. Science and technology have advanced at a rapid pace. Life expectancy has increased by 20 years globally and by about 10 years in the European Region.

2. Unfortunately, progress does not reach everyone. Globally, gaps in income and social justice are widening dramatically. This is why poverty and health inequities are major challenges for the health sector today. Many diverse stakeholders are active in the health field, resources are limited and other sectors such as trade, environment, agriculture and education also have an influence on health.

3. If they are to remain at the forefront of the complex public health arena in the future, WHO in general and the Regional Office for Europe (EURO) in particular need to have a clear understanding of their position and function in this new and rapidly evolving context in order to be able to work efficiently and strategically towards their objectives.

4. At global level, WHO's Eleventh General Programme of Work (GPW11) *(2)* describes how the Organization will fulfil its constitutional functions. The World Health Assembly will decide on a GPW11 which will redefine WHO's core functions and cover a period of 10 years (2006–2015).

5. At the regional level, the Regional Committee at its fifty-fourth session asked the Regional Director to develop a long-term vision of the role and position of the Regional Office for Europe up to 2020, taking into account GPW11 and the various stakeholders in the international public health environment. A working group was set up in September 2005 to contribute to this work. It consisted of members of the Standing Committee of the Regional Committee (SCRC) and experts in sociology, futurology, health economics, epidemiology, politics and journalism. The group met four times between September 2005 and May 2006. The meeting outcomes were presented at the subsequent sessions of the Standing Committee.

6. The working group analysed present health challenges and the work of partners active in the health field, and considered EURO's added value, its current roles and policy directions, and its proposed strategic directions towards 2020. Each strategic direction includes specific examples of activities to be undertaken.

7. In view of current moves to reform the United Nations and the likelihood of future changes in the mandates of partner organizations, the strategic directions will be revisited at regular intervals.

8. The present document is a synthesis of the major conclusions and proposals of the working group and the subsequent discussions in the Standing Committee.

9. The paper consists of three sections:

1) Projected trends in health status and the health sector in the European Region in 2020
2) Positioning the Regional Office for Europe in 2020
3) Paving the way for the Regional Office for Europe from now until 2020

Projected trends in health status and the health sector in the European Region in 2020

10. A period of 15 years can be seen as both short and long. It is short if we remember the main health challenges of the 1990s: tobacco, HIV/AIDS, alcohol, cancer, cardiovascular diseases and health financing. Although progress has been made in some of these areas, we are still facing the same health challenges today.

11. Fifteen years is a long period of time if we reflect on the changes that have taken place in the political, social and health fields. In the WHO European Region, major reforms have been implemented in health systems over the past 15 years, particularly in transition countries, and major health threats have occurred. There has been a massive rise in obesity rates, and an increase in the prevalence of HIV/AIDS and poverty-related diseases such as tuberculosis. On a global scale, natural hazards (e.g., heat waves, earthquakes, tsunamis), conflict-related injuries, severe acute respiratory syndrome, avian flu and bovine spongiform encephalopathy have posed additional health threats.

12. In 1990, poverty and health inequalities were not perceived as major challenges to the health sector in the European Region. This has since changed, with equity, social inclusion, and poverty reduction becoming increasingly important for Member States and hence for EURO and other parts of the United Nations system. This reality is reflected in the Millennium Development Goals (MDGs) and the Regional Office's 2005 update of the Health for All policy framework.

13. One major success of the past 15 years has been the declaration of the Region as poliomyelitis-free in 2002. This complemented the global eradication of smallpox over 20 years previously and, it is planned, will be followed by the eradication of measles in Europe in 2010.

14. However, with the exception of very evident successes such as the achievement of a poliomyelitis-free Europe, it is difficult to assess either the improvements or the failures in the health sector. This is due to the lack of systematic and serious evaluations, which, in general, are not fully integrated into health programmes and interventions. In the forthcoming period, such evaluations, accompanied by a more professional, transparent and accountable approach to public health, will become increasingly necessary. It is foreseen that they will become common practice and will allow for improved integration of lessons learnt into the design of public health policies and actions.

15. Rather than trying to design hypothetical scenarios around the health status of the population and the situation of the health sector in 2020, it seems more useful to concentrate on those trends that are already visible. This approach makes it possible to determine how the health sector could act proactively to prevent or cope with negative trends that represent a danger to health. Equally, it helps to identify ways in which the health sector can benefit from positive trends already visible today.

Some major negative trends that represent a danger to health if not efficiently counteracted

16. **Growing inequities** in the health status of different populations within and between countries are evident. In the coming years, the gap between the health status of disadvantaged groups and that of the rest of the population is likely to increase, with obesity, mental illness and addictions, in particular, affecting them more.

17. **Increasing threats to health** will probably be another trend in the coming 15 years. The growing number of natural and man-made threats or possible threats to health, from influenza to nuclear accidents and bioterrorism, will put pressure on health systems because of their unpredictable, sudden and possibly massive nature.

18. **Increasing economic and political pressure on public spending** continue to affect health budgets, making it difficult to maintain long-term investment. This development comes simultaneously with an increase in life expectancy and a growing demand from the public for health services of high quality. At the same time, it is difficult to properly control health investment and expenditure, which, in turn, creates additional risk for public financing, while linkages between the population's health and good economic performances are underestimated.

19. **There are difficulties in developing a broad vision of health systems** not limited to personal health care but integrating other public health services such as disease prevention and health promotion.

20. **The lack of systematic mechanisms for evaluating** health interventions **and assessing the performance** of health systems reduces the possibilities of learning from experience, of increasing cost–effectiveness and of creating a dynamic for progress.

21. **Increasing labour migration** is taking place from poor to rich regions and countries because of globalization, making it harder for countries to retain qualified staff.

Some predictable positive trends

22. On average, the **health status of the population of the WHO European Region will improve** (which does not contradict the increased inequities mentioned in the previous section). Better medical practices, technologies and preventive measures, in addition to more commitment on the part of the population to healthy lifestyles (except in the case of vulnerable groups), will contribute to the overall improvement of health. This is the positive part of increased longevity.

23. **With health increasingly becoming a core societal and political issue,** it will be a matter of concern to populations and consequently to governments. The media (broadcast, print and electronic) will allocate more space to health issues. This amplified information flow will have both positive and negative impacts, depending on the quality of the information and the intention of the information provider. Similarly, health products of various types will occupy a larger market share, with both positive and negative outcomes; however, they may lose in competition with health-damaging products.

24. **Health systems will benefit from the investment and knowledge of other sectors.** One of the consequences of the increased importance of health in society will be a mobilizing effect towards health improvement in other sectors. The health sector will also benefit from the experiences of the other sectors in fields such as general and staff management, quality and safety, disaster preparedness, etc. This could partially compensate for the lack of increase in direct health budgets.

Positioning the Regional Office for Europe in 2020

Consistency with WHO's global position

25. The present document is consistent with the GPW11, which is currently being prepared and outlines the main directions for the Organization's work until 2015. GPW11 will be taken forward through the development of a six-year Medium-term strategic plan (MTSP) for 2008–2013, with biennial programme budgets approved by the governing bodies.

26. GPW11's identification of WHO's core functions for 2006–2015 is based on:

- **WHO's unchallenged comparative advantages**, which lie in its impartiality, neutrality and strong convening power. Its commitment to the values of its Constitution as well as its legitimacy stemming from its close relations with governments are other strengths. WHO also plays an

unparalleled role in tackling diseases and putting its normative work into action. WHO promotes evidence-based debate, and has numerous formal and informal networks around the world.[1]

- **An assessment of the global health agenda** that identifies six issues as the most relevant and urgent for the whole health community to tackle: 1) investing in health to reduce poverty; 2) building individual and global health security; 3) promoting universal coverage, gender equality and health-related human rights; 4) tackling the determinants of health; 5) strengthening health systems and equitable access; and 6) harnessing knowledge, science and technology.[2]

27. Building on the analysis of the above, WHO's core functions are defined as follows[3]:

- providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- setting norms and standards, and promoting and monitoring their implementation;
- articulating ethical and evidence-based policy options;
- providing technical support, catalysing change, and building sustainable institutional capacity; and
- monitoring the health situation and assessing health trends.

The Regional Office in 2020

28. WHO's global objectives are shared by all levels of the Organization – headquarters, the regional offices and the country offices. However, it is one of the strengths of the Organization that each region has its own characteristics and thus has to emphasize certain functions and tailor its services to the specific needs of its Member States.

29. To show the way from now to 2020, the Regional Office for Europe has, through this document submitted to the Regional Committee, reassessed its added value and position, both in the Region and within the global context of GPW11 and the MTSP, and has identified regional strategic directions for its work in the future.

The Regional Office's added value and special character

30. As underlined in GPW11, WHO's essential asset is its impartiality and authority as a reliable source of technical advice. Its leadership derives from the moral authority of the United Nations. One of the notable strengths of EURO is its ability to serve as a bridge between countries, especially between the eastern and western parts of the European Region, and between diverse societal sectors. EURO also has long experience in advocating and striving towards values-based governance and promoting its broad vision of public health. Both of these aspects are expressed in the Health for All policy framework and its 2005 update.

[1] See *(2)*, p. 20.
[2] See *(2)*, p. 14.
[3] See *(2)*, p. 5.

Paving the Path for the Regional Office for Europe from now until 2020: Strategic directions towards 2020

31. Six strategic directions towards 2020 are suggested as the result of the work done by the working group, the SCRC and the EURO secretariat.

1) All against health inequities, values for health policy
2) Evidence and information for health policy and public health
3) Strengthening health systems
4) From partnership to task-sharing
5) International response on health security
6) EURO's leadership and WHO new regional input

Strategic direction 1: All against health inequities, values for health policy

32. The WHO Constitution states that, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being". Through its Health for All policy, EURO is committed to the values of equity, solidarity and participation. Despite their diversity, WHO Member States in the European Region agree on these common principles. In fact, many governments have referred to them explicitly in formulating their national health policies.

33. According to the 2005 update of the Health for All policy framework *(3)*, equity implies that everyone has a fair opportunity to attain his or her full health potential, and that no one is prevented from achieving this potential, if at all possible. Based on this definition, a health policy emphasizing equity would seek to eliminate or minimize avoidable differences in health outcomes: it would promote equity of opportunity in achieving one's full health potential. A challenge in this context is to reach a common understanding on what this actually means; values are subject to interpretation.

34. GPW11 has identified this area as one of the key health issues for the next 12 years[4] and emphasized that, to achieve the target set, health systems will have to become more equitable.

35. It is generally recognized that one of the basic functions of the state is to promote equity *(4)*. Greater equity in turn requires that there be greater equality in at least some areas, be they life chances, opportunities, capabilities or outcomes. Today much more is known about health inequalities and their causes than was the case some 25 years ago. Particular attention has been paid in the European Region to socioeconomic inequalities in health, which have been growing despite overall improvement in mortality and morbidity. Inequalities in health will continue to exist as long as genetic make-up, age, sex, socioeconomic status, lifestyle, and living and working conditions vary among individuals. Health also has multiple modifiable determinants: material wellbeing and employment, education, social status and inclusion, living and working conditions, physical environment (quality of air, water, food, road safety, etc.), and lifestyle (diet, physical activity, smoking, substance abuse, etc.). The pathways through which these factors affect health are complex, intertwined and not always straightforward. Furthermore, the relations between health and many of these factors are reciprocal.

36. EURO's interest in the coming years will therefore focus on assessing the extent to which health inequalities are caused by modifiable factors and how can they be influenced and altered by societies, governments and individuals themselves. The WHO Commission on Social Determinants of Health will further advance our understanding of health inequalities and outline the ways in which they can be tackled.

[4] See *(2)*, p. 12.

37. During the 1990s, a consensus emerged within the international community that the overriding goal of development policy was the reduction and eventual elimination of poverty. The MDGs provided clear benchmarks for measuring progress towards the achievement of this objective. Although the paramount objective is poverty reduction, it is also argued that development policy should be concerned with inequality as well. The *World development report 2000/2001 (5)* emphasized that high levels of inequality are bad for poverty reduction. EURO's work in this domain will also address the insufficient attention paid in the MDGs to addressing inequality and will hence help to achieve the Goals in a way that reaffirms the universality of the human rights they rest upon.

38. Health systems play a significant role in health inequalities, and many of the socioeconomic determinants discussed above in fact exert their impact on health inequalities through gaps and weaknesses in health system functions. The *World development report 2006 (6)* recommended measures to promote access, affordability and accountability as an approach for reducing health inequalities. As the United Nations specialized agency for health, WHO is well placed to tackle the problem through a health systems approach. In the coming years, EURO will study health inequalities comprehensively and give due recognition to all determinants of ill health and health inequalities, whether they are economic, social, lifestyle-related or caused by dysfunctional health systems. Within WHO's broad vision of health systems, EURO will propose practical and realistic solutions for reducing the inequalities, and support countries in their actions:

- to make health-promoting, preventive and curative interventions more **accessible** to populations. This will be done through actions aimed at achieving universal coverage and fairer distribution of health system resources, and at reducing geographic disparities;
- to make health promotion, prevention and care more **acceptable** to populations by improving the responsiveness of the system to people's expectations, regardless of their socioeconomic status, reducing discrimination and cultural barriers against minority ethnic and religious groups, migrants and refugees, and improving the quality of care, including patient safety, for everyone.

39. EURO will continue to advocate the adoption of healthy public policy in other sectors, and protection of the interests of socioeconomically disadvantaged groups through better stewardship and ethical governance. This includes: interaction with other sectors to maximize the health-enhancing potential of economic, social, education and environmental policies; health impact assessment, including of the impact on health inequalities; environmental protections; healthy living and working conditions; the development of regulations to reduce market failures in health care; and the explicit targeting of benefits to socioeconomically disadvantaged groups.

40. EURO will also contribute to breaking vicious circles and reducing the impact of more upstream determinants of health inequality such as social exclusion and marginalization, poverty, and inadequate education. This will be done by addressing health conditions that cause stigma and social exclusion, and reducing the direct and indirect economic burden of ill health on people, thus increasing the economic and educational productivity of the poor, and thereby improving their chances of employment and a higher income.

41. Tackling inequity will entail giving expression to solidarity through the redistribution of resources, which might sometimes necessitate "positive discrimination". It will be essential to communicate with and inform people about the rationale for such measures. This is an area where EURO is well placed to play a leading role, building on the work it had done in updating the Health for All policy framework and giving prominence to the values of equity, solidarity and citizens' participation, under the overarching concept of "health as a human right".

42. Ethical, value-based governance of health systems is therefore the way to achieve a reduction in health inequalities. Ethical governance involves continually grappling with necessary trade-offs – for example, between equity and cost–effectiveness. It also requires governments and the international community to adopt new or modified ways of working.

43. EURO will support countries by generating evidence, producing guidelines, case studies and indicators for monitoring progress, and providing technical advice and political support. It will also take advantage of opportunities to engage in negotiations with all actors and to build coalitions and partnerships to promote a change towards greater equity. This could be done through projects that would pave the way towards a European Ministerial Conference on the subject, in order to spread knowledge and experience, provide policy direction and stimulate action towards reducing health inequalities by 2020.

Strategic direction 2: Evidence and information for health policy and public health

44. GPW11 identifies "gaps in knowledge" as one of the major health challenges of the future.[5] An important part of the credibility and recognition of WHO as a leading international health organization lies in its capacity to provide expertise and advice based on the best available evidence.

45. In the European Region, the process of building an evidence-based organization has started in recent years with the support of a scientific committee: the European Advisory Committee for Health Research. Established in 2001, the Committee has guided the work of the Office in this field. Its definition of evidence is "findings from research and other knowledge that may serve as a useful basis for decision-making in public health and health care"*(7)*. This implies that the concept of evidence is more than just the findings of scientific research, and is open to knowledge gathered of the effectiveness of actual health actions.

46. The findings of the Committee pave the way for progress in this field in the coming years, both for the health sector in the different Member States and for the work of the programmes in the Regional Office. The main recommendations from the Committee are: to put together a process that ensures the rapid diffusion of the best available evidence within the health community; and to grade the strength of that evidence as a basis for EURO's recommendations and advice.

47. One of the best tools available to WHO and the Regional Office in serving Member States is the gathering and dissemination of evidence-based information, as defined above. EURO already gives high priority to such services and will need to pay them increasing attention in the coming 15 years. The European Observatory for Health Systems and Policies and the Health Evidence Network are already well-known sources of evidence-based information. In addition to these, EURO will develop a value-added health intelligence service for its Member States; this will provide both quantitative and qualitative actionable information, knowledge and skills, supported by evidence-based valid and reliable statistics. It will be created by analysing the available evidence-based information on experience gained in developing health policies in Europe and the world, making sense of that information and its analyses, and assessing their relevance and adequacy so that the resultant product can be used for making informed policy decisions at sectoral and national levels.

48. In some public health fields, there is a clearly increasing need, and demand from decision-makers, for evidence-based protocols. This particularly concerns proving effectiveness in disease prevention and health promotion. Decision-makers are willing to invest in those programmes that are proven to be cost-effective. This is probably a good avenue to follow with the aim of reducing the increasing burden on health care systems.

49. The independent role of WHO globally and of the Regional Office in the European Region will also allow research to be stimulated independent of vested economic interest groups. There is a need for debate on the ethical use of research findings. This is of particular importance in the pharmaceutical sector where evidence-based information, obtained through studies that include end-user involvement, is needed and requested.

[5] See *(2),* p. 12.

50. Between now and 2020, EURO will continue and build up:

- its efforts to promote the gathering and dissemination of synthesized, evidence-based public health knowledge from validated sources both for decision-makers and for the general public through the mass media;
- its support for research to produce new and operational evidence for health decision-makers;
- its support for policy-making by providing a well-established health intelligence service and standardized approaches, in order to foster cooperation in the area; and
- its practice of regularly assessing the progress of evidence-based decision-making within the European Region.

Strategic direction 3: Strengthening health systems

51. Health systems are included in the GPW11 as an important item on the global health agenda.[6] Strengthening health systems is essential to secure real and sustainable improvements in the health status of populations and, specifically, to guarantee equal access for the whole of society, including disadvantaged groups. However, health systems all over the European Region are confronted with high expectations, multiple health crises and limited resources. Countries have struggled with their health systems for the past 50 years; improving their performance will remain a major strategic objective for EURO.

52. At its fifty-fifth session, the Regional Committee adopted resolution EUR/RC55/R8 on strengthening health systems in the European Region *(8)*. Implementation of the resolution will make it necessary, amongst others, to develop conceptual work to ascertain the role of health systems in improving health, and to sensitize governments to the challenge of ensuring sustainability and supporting efficient management practice at system and institutional levels, as well as introducing regulations and norms to address market failures in the health system.

53. EURO's broad vision of health systems includes all entities involved in health promotion, disease prevention and public health, as well as those engaged in treatment and care, and gives greater prominence to public health services. It also strongly advocates intersectoral cooperation by reaching out to ministries other than those responsible for health.

54. Currently EURO is gathering the necessary evidence for, and developing, guidelines across four core functions of health systems: service delivery, financing, the generation of necessary resources and stewardship. This work is guided by practical experience and the adaptation of the WHO health systems framework in different countries. This is particularly important in light of the current stagnation or even decline in public expenditure, compared with the growing need and demand for high quality personal and public health services. For these reasons, the values linked to health actions that are included in the 2005 update of the Health for All policy framework under the umbrella of ethical governance are particularly important for the current and future management of health systems and for promoting accountability. The European Observatory on Health Systems and Policies will continue to play a strong role in gathering evidence, while EURO's Futures Fora programme could be one way of making such evidence accessible to policy-makers.

55. The implementation of the concept of "health democracy", linked to the informed participation and the empowerment of citizens is of particular interest in the field of the health systems stewardship and governance. EURO should be a strong promoter of citizens' participation in the European context, while simultaneously promoting evidence-based professional practice. There is some experience of this type of involvement of the population in the health system, which could serve as a positive model.

[6] See *(2)*, p. 17.

56. The timeframe for the development of this strategic direction will be articulated around the preparation of and the follow-up to the European Ministerial Conference on the subject planned for 2008. During the fifty-fifth session of the Regional Committee, Member States endorsed the organization of the Conference as a way of signalling the importance of the topic and mobilizing decision-makers and researchers. The Conference will consider a number of relevant issues, such as:

- the role of health systems in tackling the challenges of a globalized world;
- the health system performance framework and its specific definitions of boundaries, goals, functions and performance appraisal methodology;
- available evidence regarding the use of vertical, single topic programmes as entry points compared to more general approaches; and
- evidence of the comparative effectiveness of different approaches in helping countries to help themselves.

57. The Regional Office's work on strengthening health systems between now and 2020 will, to a large degree, be determined by the outcomes of the Ministerial Conference. On its way to 2020, EURO will regularly evaluate the degree to which the outcomes of the Conference are stimulating the work of Member States to better suit their health systems to the needs and demands of Europe's citizens.

Strategic direction 4: From partnership to task-sharing

58. The Regional Office's Country Strategy "Matching services to new needs" (EUR/RC50/10), adopted by the Regional Committee at its fiftieth session, provides the basis for the Office's present approach to partnership development. Strengthening international partnerships for health is one of the four principles of the strategy.

59. The Country Strategy defines EURO's overall partnership aim for the coming years as to "rapidly take initiatives to mobilize the international community, help countries themselves to coordinate the interventions by different organizations, and ensure that these interventions result in progress for the health systems of the countries concerned and, ultimately, in better health for their people."

60. Since the adoption of the Country Strategy, partnership development has been more systematic. Collaboration with the Council of Europe, the European Union, the World Bank, and other United Nations agencies, particularly the Joint United Nations Programme on HIV/AIDS, the United Nations Children's Fund, the United Nations Population Fund, the United Nations Development Programme and the Office of the United Nations High Commissioner for Refugees, has been reinforced at regional level. In a second phase, partnerships with development agencies such as the United Kingdom Department for International Development, the German development agency, GTZ, and the German development bank, KfW, and those of the Nordic countries have been strengthened. Collaboration with these organizations has been strengthened, both at institutional level through basic agreements and regular assessment meetings, and through concrete and successful cooperation at country level.

Collaboration with the European Union

61. The specificity of the partnership with the European Union (EU) is expressed in various ways. It has developed, in particular, through the European Commission's Directorate-General for Health and Consumer Protection, for example on mental health, environmental health, obesity and physical activity. There is also growing involvement in successive EU Council Presidency programmes.

62. The EU has particular expertise in areas where it has its specialized agencies. The Regional Office was also very closely involved in the setting up of the European Centre for Disease Prevention and Control (ECDC) in Stockholm in 2005 and good collaboration has already been established. This collaboration is particularly important. ECDC has a very precise mandate, but the missions and modus operandi of the two organizations are complementary and should never overlap or be conflictual in

nature. Such partnership requires a thorough functional analysis, followed by consideration of the potential for sharing functions between EURO and ECDC with, for instance, EURO acting as a bridge to the countries of the former Soviet Union.

63. EURO will develop a strategy for its relations with the EU, in particular the European Commission and ECDC, defining their complementary roles and the implications for collaboration. A review of mandates, expertise, networks and past collaboration could help to clarify roles and comparative advantages, as well as best ways of working together.

64. In the collaboration with the European Commission, a distinction must be made between technical and political cooperation. The former is a relatively straightforward matter, best pursued by drawing on EURO's technical expertise and sharing tasks within specific projects. The latter, however, involves striking a delicate balance between the constraints of WHO's own governance structures and its status as an intergovernmental body, as defined by its Constitution, on the one hand, and the Commission's status as an observer at the World Health Assembly, contrasted with the extent to which EU member countries are prepared to delegate responsibility to it, on the other. The status of the European Commission in WHO governing bodies, including those for the European Region, is currently undergoing a review process and will need to be more clearly defined in the future.

65. Relations between the European Community and EURO (and WHO more generally) over the next 15 years will be linked to geopolitical changes, constitutional issues, structural changes, financial pressures and operational issues covering the way in which mandates are delivered, including the scope for more collaborative action. However, without any doubt, attaining the highest possible level of health (WHO Constitution *(1)*) or achieving the highest degree of health protection (Treaty establishing the European Community) will remain a common goal during that period.

Geopolitical changes

66. Fifteen years ago, EURO faced rapid expansion in the number of its Member States. At the same time, the number of member states in the European Union was around half of its current level of 25. Future possible accession states have already been identified. The date on which they will join the EU is not yet known, but further expansion is almost certain. Within the current boundaries of the WHO European Region, the number of Member States may also increase over the coming years. New states may emerge in the Balkans and in other parts of central and eastern Europe. These boundary changes within the WHO European Region and the further increase in the number of European Union member states can affect the way in which national governance is delivered. This will impact on the way in which Member States engage with multinational organizations. New challenges will need to be addressed and new ways of operating found, in addition to coping with the impact of these changes on agenda setting, policy development and the demand for technical support.

Constitutional issues

67. The WHO Constitution as it currently stands provides a sound basis for the operation of WHO. However, the way in which WHO delivers the objectives set down in the Ninth and subsequent General Programmes of Work will need to take account of the current debate on reform of the United Nations and will be subject to the sustainability of financing when this is heavily reliant on voluntary funding. Changing the Constitution according to the demands of the new situation will be a difficult and time-consuming process, that cannot be implemented overnight, as history has shown.

68. The European Community's work on health issues remains linked to a not very explicit legal base. Health systems in Member States have to comply with a range of EU safety, labour health and other regulations. EU policies cover markets and most aspects of health systems, including patients, health professionals and other staff, devices, drugs, buildings and finance. This broad range of interests has underscored the EU's coordinated input to the global negotiations on the Framework Convention on Tobacco Control and the International Health Regulations and future collaboration will need to take account of this wider role of the Community on health issues.

69. Nevertheless, public health is the EU's central health mandate. Through the Directorate-General for Health and Consumer Protection (DG Sanco), it provides the opportunity for the health agenda to be represented in deliberations within the Commission and provides the means for ensuring consideration of the health aspects of all Community policies. The public health article (Article 152) provides for specific legislation in the areas of the quality and safety of organs and substances of human origin, blood and blood derivatives. DG Sanco is also the sponsoring Directorate General of the new ECDC in Stockholm, which has responsibility for risk assessment, while the Commission retains responsibility for risk management. ECDC has a valuable role as part of WHO's Global Outbreak Alert and Response Network (GOARN) and may expand its activities to involve public health networks that deal with areas other than communicable diseases. In addition to this work, DG Sanco's efforts are focused on building an EU policy community through, for example, its Platform on Diet, Physical Activity and Health. This has no legislative basis but seeks to encourage a coordinated approach across the EU.

70. There are a number of other policy areas that impact on the health agenda, e.g. research, procurement, environmental issues (such as waste) and EU aid. The EU contributes considerable resources through its grants, notably in the case of work linked to the EU's European Neighbourhood Policy.

Structural change

71. The development of ECDC is an innovation which signposts the way in which the EU will operate in the future. The establishment of the European Food Safety Authority, which has working links with the Codex Alimentarius (of which the European Community is a member), is another example of this. Further agencies might emerge as part of the EU's enhanced monitoring and regulatory functions.

72. WHO operates as a technical agency. It operates through its regional offices and country presence. In addition to the office in Copenhagen, the Regional Office for Europe works through a number of geographically dispersed offices, which act as focuses and centres of excellence for specific aspects of the health agenda. A number of collaborating centres support these offices and the country presence. The interaction between these structures and the EU agencies will be an issue for dialogue and collaboration over the coming years, with avoidance of overlap and duplication being of paramount importance.

Financial pressures

73. The EU has a specific approved budget for its public health programme. The revised public health proposals have been streamlined into three strands: 1) improving citizen's health security; 2) promoting health for prosperity and solidarity; and 3) generating and disseminating health knowledge. Key issues are:

- health threats and communicable diseases;
- health determinants/disease prevention, focusing on lifestyle-related and socioeconomic determinants of health, healthy ageing and the links between health and productivity;
- exchange of best practice, including on children's health, gender and health, mental health and rare diseases;
- health inequalities within and between member states;
- data and monitoring of health at EU level;
- informing and consulting citizens and stakeholders; and
- programme evaluation.

74. Budgets have also been set for work in support of the EU's neighbourhood policy, which has a health component, and for other relevant areas such as the research and technological development framework programmes.

75. For WHO, the United Nations reform agenda, with its emphasis on a more coherent cross-United Nations country-level approach and the uncertainties with regard to sustainable funding, will be the subject of much attention in the future. These issues were also raised in the context of GPW11 and will underpin the development of the MTSP 2008–2013 and the regular programme budgets over the same period. Although financial pressures will affect the work of both WHO and the European Commission, there is a considerable level of complementarity between WHO's work and the public health programme of the EU. Within this context, WHO will have to define how to deliver in the most effective and efficient way on its core mandate and functions.

Operational issues and future work

76. The future delivery of public health activities in the period up to 2020 will be enhanced through closer collaboration and joint activities between EURO and the European Commission. This has the potential to be of benefit to all WHO Member States in the European Region. Particular attention will be given to:

- mapping skills and capabilities based on current constitutions and planned approaches for public health issues;
- cementing collaboration though a more visible joint working approach suited to the potential contribution and governance of both WHO and the EU. Practical examples are the EU's participation in meetings of WHO governing bodies, and WHO's involvement in more high profile work in the meetings of the EU;
- having clear points of contact – for the Commission, this means having better links to WHO engagements at regional and global levels, whilst for WHO there needs to be some mechanism for engagement across the Commission's directorates general and particularly with the Directorate-General for External Relations (DG RELEX);
- learning the lessons from existing collaborative ventures to signpost the way forward for enhanced collaboration: for example the work on the Framework Convention on Tobacco Control and the International Health Regulations, the European Observatory on Health Systems, and environment and health issues;
- identifying areas of work susceptible to more coherent working arrangement. An example would be the establishment of a joint approach to support the sustainable development of the hospital and primary care systems in the non-EU member states in order to enhance protection from cross-border health issues, including communicable diseases and multidrug resistance.

77. It will continue to be essential that EURO should serve as a bridge to the 28 Member States in the European Region that are not members of the EU.

Other partnerships

78. The development of partnerships with nongovernmental organizations (NGOs) has been addressed in a less proactive manner owing to a lack of clear policy resulting, in particular, from the complexity of the work taking place on the subject globally. Nevertheless, the Regional Office for Europe has maintained its collaboration with NGOs such as associations of health professionals, the International Committee of the Red Cross, Rotary International and the Soros Foundation.

79. The crucial role of partnerships in improving the health status of the population in the future underlines the need for EURO to build up this function and further develop its policy, strategy and actions with regard to partnership development. Herein – and as a reaction to two major directions for the future: ethical values for health governance and increased efficiency of health systems – EURO will focus increasingly on concrete collaboration and clear deliverables with partners in the countries, closer to the citizens. Collaboration will be based on functional rather than geographical partnerships.

80. The lack of effective partnerships can compromise population health. It increases inequity and inefficiency and sends confusing or even contradictory messages to the general public. Unnecessary

overlap or the duplication of effort can deny limited health resources to the people who need them most. By preventing such shortcomings, partnerships promote equity and solidarity.

81. Between now and 2020, EURO will reinforce existing measures into a more systematized approach to partnership development. It will continue to work together at regional level with its "natural" partners, e.g. the United Nations agencies, the Council of Europe and the European Union agencies. However, since GPW11 defines one of WHO's core functions as "providing leadership in matters critical to health and *engaging in partnerships where joint action is needed"*[7], EURO will carefully establish its priorities and put even greater emphasis on collaboration with clear deliverables at country level.

82. With the aim of focusing on action, specific and strategic collaboration with main partners should be designed in the form of "task-sharing" contracts with clear objectives, mechanisms, and scope. The management of task-sharing will be reviewed through an innovative process for the governance and management of shared projects.

83. One key aspect in this process is the current development of a EURO strategy for partnership development. The strategy will define clear partnership objectives and deliverables, which must be at the heart of the selection, implementation and evaluation cycle of all of EURO's cooperation activities. Once the strategy is agreed on, an action plan for all the Office's task-sharing activities will be developed. EURO will regularly report to the Regional Committee on the implementation of the strategy.

84. For its key "natural" partners, EURO will develop individual strategies, identifying task-sharing and institutional opportunities for the future. It will also develop clear strategies for its relations with NGOs and collaborative centres.

Strategic direction 5: Leading the international response on health security

85. Health security features prominently on the global health agenda.[8] Conflicts, natural disasters, disease outbreaks and zoonoses are increasing in number. The role and impact of health on security - or stability – is reflected in a new international consensus that there is a shared responsibility for collective security and the challenge of prevention.

86. Recent dramatic political and socioeconomic changes in many countries in the European Region have left health systems and people with insecure environments and insufficient resources and capacities to cope with the new challenges. The European Region is even more vulnerable today than in the past – some communicable diseases are re-emerging, and extreme weather events, other natural and man-made disasters, armed conflicts and unprecedented social violence are increasing. Through its support to the Member States, EURO continues to learn lessons on ways of coping with various man-made and natural crises.

87. New global threat scenarios, such as a potential influenza pandemic or the deliberate use of biological, chemical or radionuclear agents, conflicts, global environmental changes and the trade in hazardous substances pose new challenges to national health systems and governments. The realistic scenario of a global influenza pandemic has helped to raise awareness in Member States.

88. The experience gained in the Region from the response to the health challenges arising from the complex emergencies in the Balkans underlines the importance of national health systems being fully prepared to respond effectively to the health security aspects of such crises.

89. The implementation of the revised International Health Regulations and World Health Assembly resolution WHA58.1 on health action in relation to crises and disasters will be a priority for the entire organization in the coming years.

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[7] See *(2)*, p. 21.
[8] See *(2)*, p. 15.

90. In emergencies and post-conflict situations both within and outside the Region (the tsunamis and earthquake in Pakistan, for example), EURO will work together with other parts of the organization, other United Nations agencies and other partners to meet immediate health needs. Within the European Region, collaboration with EU institutions, especially ECDC, during preparedness and response periods will be of particular importance; work is currently being done to clarify the roles of the different partners.

91. Between now and 2020, EURO will support ministries of health in setting up preparedness plans that include defined coordination mechanisms and communication channels. One important lesson learned from the past is that risk communication is an essential strategic element in any crisis response. Simple and easily understandable messages communicated by the media can increase public awareness of protective measures that can reduce risks to health. It will also be vital to gradually integrate vertical programmatic approaches into a coherent and systematic horizontally coordinated response. This will turn vertical technical success stories into sustainable long-term improvements in health security.

92. Between now and 2020, EURO, together with other players, will:

- identify future challenges, collect evidence and analyse lessons learned;
- assess risks;
- engage in communication and advocacy;
- support Member States in developing comprehensive health systems preparedness and response plans;
- ensure rapid response, determining the most appropriate course of action for the United Nations agencies and other players, and promoting intersectoral coordination (including the private sector and civil society).

93. In consultation with Member States, EURO will, in 2006–2007, propose an approach for enhancing health and security in the European Region. This will lead towards a strategy and provide a framework for action in this domain.

Strategic direction 6: EURO's leadership and new regional input

EURO's leadership in the European Region

94. GPW11 identifies leadership as WHO's first core function for the period 2006–2015.[9] The Organization's leadership role derives from its added value and the mandate it has been given by its Member States in the World Health Assembly and the regional committees.

95. However, a clear distinction has to be made between political leadership or governance, exercised at regional level by the Regional Committee and the SCRC, and the "executive management" or stewardship functions carried out by the Regional Office. In this respect, the Regional Office will continue to perform its leadership role in synergy with its Member States, acting as a technical secretariat for the decisions taken by its governing bodies.

96. EURO's firm evidence-based expertise, its closeness to Member States and its strength to mobilize its partners in task-sharing will form the core of its leadership role.

97. EURO will develop strategies for the consideration of the Regional Committee and will evaluate their repercussions on the health policies of Member States, primarily in the following domains:

- leading international response to crises
- strengthening health systems
- advocating action against major risk factors

[9] See *(2)*, p. 21.

- supporting vulnerable groups
- promoting intersectoral action for health.

98. EURO will perform its leadership role by promoting broad health policy covering different aspects of public health, translating research into policy and actions, issuing guidelines for good practice, and acting as a bridge between countries in different parts of the Region, as well as between the health sector and other sectors. In some cases, it may also have a normative role clearly related to action, particularly regarding the strengthening of health systems.

99. This leadership role should be recognized by the WHO's natural counterparts – health decision-makers at government level and, through them, the general public. EURO's advocacy role should focus on defending the health of vulnerable groups and protecting the population from risk factors.

100. EURO will promote the concept of "health democracy" ("government by the people") which is based on citizens' involvement and participation and governments' accountability to the electorate. If they are to participate, citizens and communities need information and education. EURO will support Member States in providing health information to and increasing the awareness of their citizens, thus enabling them to participate constructively at community level in improving health systems. National parliaments (or health commissions) could be associated in this process. Considering the large public demand for information at the grassroots level, the fragmentation of the media and the speed with which new technologies disseminate information, the broadest possible media involvement is required in promoting public health issues; EURO will contribute to this through its leadership role. To meet the need for reliable information, the Regional Office will source and validate information, possibly by establishing WHO collaborating centres in knowledge management and other areas and by supporting best practice in providing information to patients' organizations. By 2020, it will be common practice for EURO to regularly evaluate its impact and its leadership role in this particular domain.

101. In order to give this leadership role a better grounding, better use of the networks of national counterparts and collaborative institutions also needs to be developed and strengthened.

EURO's regional input

102. The different levels of WHO are complementary: the role of WHO headquarters is predominantly one of global governance and normative guidance, providing "global health goods" and developing and leading global networks; the role of the regions is predominantly to strategize country support and to respond to regional priorities; country offices represent the level for the operational implementation of policy and actions.

103. In recent years, a major shift towards country-based operations has taken place, and human and financial resources are increasingly being channelled to the country offices. This change will require more modern and supportive administrative processes and more decentralization and accountability at both regional and country levels. New evaluation and planning mechanisms at country and regional levels will also be developed in the coming years.

104. Considering its significant expertise and its proximity to Member States, WHO would benefit from following a concept of "Distributed leadership", feeding country-level evaluation outcomes and inter-regional priorities into the global agenda in a bottom-up approach. *The world health report* could be an example of this. Another example would be the strengthening of health systems, where the proximity of the Regional Office to the countries would facilitate the analysis of country situations and the answers and support provided by WHO globally.

105. A balance will have to be struck between EURO's implementing function, i.e. ensuring that global policies are carried out, and the "bottom-up" process of developing policy that would then feed into the global level. One possible approach would be to ensure a "feedback loop", whereby the experience from

implementation at regional and country levels could be drawn on to help reformulate and improve global policies.

106. **It needs to be emphasized that the global and the regional roles are complementary.** The current managerial trend for decentralized organization is for them to work together to provide the best services to their Member States, combining the top-down and bottom-up approaches, the goal being to reinforce the unity of the organization.

Conclusion

107. This document presented to the Regional Committee, at its fifty-sixth session will be regularly reviewed and updated between now and 2020. Many unpredictable events may happen during that period. Some that can already be foreseen will have an influence on the health of the populations of the European Region and consequently on the work of the Regional Office for Europe. Amongst those are the future development of the European Union and the United Nations reform. Thus, as indicated in the draft resolution attached to this paper, progress reports will be presented to the Regional Committee on a regular basis.

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