



EUROPE

Renforcer le Comité régional de l’OMS pour l’Europe : la voie à suivre

Le document ci-joint a été préparé dans le cadre de la contribution suisse à la phase de transition de la nouvelle directrice régionale de l’OMS pour l’Europe. Le Comité permanent du Comité régional (CPCR) a examiné ce document et y a apporté des commentaires. Ces derniers ont été intégrés à la version actuelle.

Ce document, disponible en anglais uniquement, met en lumière les évolutions et défis récents dans la Région européenne, tout en mentionnant les solutions éventuelles. Il doit être considéré comme un document de référence lors des préparatifs du Comité régional.

Challenges for health governance in Europe: the role of the WHO Regional office for Europe

An analysis for the Standing Committee of the WHO EURO
Regional Committee and its subgroup on Health Governance
in Europe

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ABOUT THIS PAPER

This paper has been written for Working Group on Health Governance of the Standing Committee of the Regional Committee of the WHO Regional Office for Europe. The Working Group on Health Governance was set up by the Seventeenth Committee of the WHO Regional Committee for Europe during its second session. The responsibility for its contents lays with the authors only.

The paper is to be considered as a “think piece” and is meant to stimulate further discussions and debate on governance questions of the WHO Regional Office for Europe.

SUMMARY

A number of changes in the environment of the WHO's Regional Office for Europe (WHO EURO), and the entering into office of a new Regional Director on 1 February 2010, provide a good opportunity to rethink strategic governance questions of the organisation. This paper aims to increase understanding of how these changes impact on WHO EURO, what questions they pose, and what options exist to address them. It addresses its formal-legal and moral authority, as well as its legitimacy base, and considers how the organisation could position itself and work together with the many other actors that today are working on health issues in the European region, with a view of moving the health agenda forward.

Changes discussed are the new multi-polar world order, heterogeneity in the region, increased interdependence and competition, health as a critical policy domain, an increase of health actors, the growth of health industry, and effective multilateralism and UN reform. In the past, such changes have caused organisational change. WHO EURO has shifted from a classical technical health organisation established in the aftermath of the second world war, first to a more innovative organisation covering the health issues of a prosperous region, and second to a decentralised organisation focused on helping countries to adjust health systems after the fall of the Berlin wall. At this period in time, the EU obtained a (modest) health mandate and expanded its membership. We identify six strategic responses that need to be addressed today: i) strengthening governance ii) intensifying the global - regional interface; iii) (re)positioning in the region iv) stakeholder management; v) new health priorities; and vi) financing.

In recent years, the EU role in health has expanded drastically and EU Member States nowadays form a majority within the Regional Committee of WHO EURO. Other countries align their policies to those of the EU, because they want to obtain membership, EU finances or other benefits. In combination with a reform of the system of EU external relations following from the entry into force of the Lisbon Treaty, this asks for a reconsideration of the EU-WHO (EURO) relationship. A strategic partnership could be established. Within WHO EURO, the majority threshold could be adjusted and more consultation with non-EU members should be warranted, for instance by means of a strengthened SCRC.

We argue that WHO EURO should be reorganised into a networked organisation. Internally, the Copenhagen Office needs to be strengthened. The work of GDOs and country offices could be decreased and become more aligned to that of the Copenhagen Office. A critical aspect is to bind external actors through flexible expertise-networks to WHO EURO. The field of actors is rather crowded and fragmented today and in the paper, and in Annex 3, we have made a first attempt to consider which actors set health standards, which analyse data and provide health advice and which are financing health.

WHO EURO finally also has a role towards global governance issues. Its relationship with WHO Headquarters in Geneva, as well as to other organisations of the UN family, implies certain roles and responsibilities, but also creates opportunities to advocate EURO preferences. The relationship between health and other policy areas, such as security, trade, social-economic and environmental policies is two-dimensional as well. Good health provides benefits, but changes in the other sectors, such as stability and economic growth and equity, are necessary in order to achieve a good level of health for all people. Coherence is thus essential. The relationship between health and foreign policy is most relevant in this respect for the work of WHO EURO, which could also contribute positively to inter-regional relations and make the wealth of expertise available within the region available to others.

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1 INTRODUCTION

In 2009 the 53 Member States of the World Health Organisation's Office for the European Region (WHO EURO) elected a new Regional Director who entered office on 1 February 2010. The new Director of the WHO EURO is likely to readjust the governance and focus of the organisation to the changes that have occurred in the European and global policy environment in recent years and to make it fit for what lies ahead. She will have to make sure that past achievements are secured and that the WHO EURO remains the key health organisation in the European Region.

This paper aims to increase understanding of how these changes impact on WHO EURO, what questions they pose, and what options exist to address them. It aims to capture the role of the WHO Regional Office within the complexity of contemporary health governance. In doing so we follow an understanding of governance as the “*conscious creating, shaping, steering, strengthening and using of international and transnational institutions and regimes of principles, norms, rules and decision making procedures*”.¹

Health governance at the European level has become a complex governance system of overlapping institutions, domains and levels. It is dynamic and pluralistic, fulfils many functions, but lacks coherence and is at times highly competitive. European health governance is also intertwined with transnational and global challenges: be it climate change or pandemic preparedness, be it tobacco or food policy – action needs to be taken at all levels of governance. The divide between foreign and domestic policies, regional and global policies is becoming more fluid and countries, as well as regional and international organisations, must seek to establish more coherence between various levels of action. Therefore the interface between the regional and the global level of the WHO is of high relevance for the organisation and its member states.

The challenge is how the WHO EURO will (re)position itself within this complexity. How can it contribute most effectively and efficiently to the peoples of Europe achieving the best possible level of health? We argue that in Europe, WHO at the regional level will gain its relevance:

- First, through being committed to a unique blend of three types of legitimacy: *formal – legal authority* as an organisation of sovereign states that can set norms and standards, *output legitimacy* based on technical excellence and public health innovation and foresight, and *moral authority* as a voice for vulnerable groups in health
- Second, through engaging as a hub for health in the region, by means of networking, dialogue and participation, with the many actors for health in the European Region, in order to move the health agenda forward.

¹ Krasner, S.D. (1983), *International Regimes*, Ithaca: Cornell University Press.

It is the interface between the three types of legitimacy, and new forms of participation of the various actors, that will ensure the relevance of the WHO as a key health organisation in the European Region.

This paper proceeds as follows. After this introduction, the second chapter discusses developments in the European and international context. The third chapter outlines key governance challenges for WHO EURO, such as emergence of the multipolar world order and the growth of the health economy. The fourth chapter looks at the relationship with the EU and considers how to respond to its growing health mandate and membership, which currently forms the majority of WHO EURO members. The fifth chapter argues WHO EURO should be reorganised into a networked organisation and describes which benefit could accrue from doing so and what would be required. The sixth chapter makes a first attempt to map all the actors working on health in the WHO EURO region. The seventh chapter analyses Europe's voice in global health governance.

2 THE CHANGING EUROPEAN AND INTERNATIONAL CONTEXT – IMPLICATIONS FOR HEALTH

The new importance of health as an issue of national, regional and international politics has been characterised as being a political revolution.² It cannot be seen as separate from major political, socio-economic and geopolitical changes under way. On the one hand, *issues of managing interdependence* such as climate change, food security, pandemic preparedness and the stability of the international financial system, are high on the agenda of global policy makers. On the other hand, *a shift in the global power balance* is occurring not only between countries and regions of the world, but also between state and non-state actors. These policy dynamics have significant impact on Europe and the role it plays in the world: they affect agendas, support for common solutions and commitment to global responsibilities.

New multi-polar world order

Europe must respond to a shift in the power constellation in the world from Western dominance towards a multi-polar world with the emerging economies as new important players internationally. The US, China and the EU are considered key anchors in the new system with pivotal roles for European countries such as Russia and Turkey whose support is needed for building strategic alliances.³ In addition, non-state actors, such as public-private partnerships, foundations, the private sector, and new clubs (e.g. G20), have emerged as important stakeholders at global and regional level. This changes coalition patterns, stimulates clubs and regional cooperation and influences the dynamics of decision-making and voting patterns within the UN institutions. New power centres and alliances are able to set the international health agenda.

² Fidler (2009), *After the Revolution: Global Health Politics in a Time of Economic Crisis and Threatening Future Trends*, in: *Global Health Governance*, Volume II, No. 2 (Fall 2008/ Spring 2009), <http://www.ghgj.org>

³ Khanna, P. (2008), *The Second World: Empires and Influence in the New Global Order*, Random House, 2008.

At the same time, the new setting increases complexities of geopolitics and diplomacy, in that more interests come to the fore and more stakeholders are needed to resolve them – also within Europe. To decrease complexity, regional and club approaches are becoming more important⁴, a notion with possible relevance for the WHO regions. The fact that the WHO is the only UN agency with a decentralised regional structure may become one of its new strengths. The size and membership of WHO EURO may make it particularly suited to address issues of regional and inter-regional concern which relate to health and to involve new stakeholders.

Heterogeneity of the European region

Health is an issue of high relevance for all countries in the European region. “A *healthy population is fundamental to prosperity, security and stability – a cornerstone of economic growth and social development. In contrast, poor health does more than damage the economic and political viability of any one country – it is a threat to the economic and political interests of all countries.*”⁵ Promoting health equity within and between countries throughout a region which encompasses some of the richest countries in the world and countries which have human development indicators similar to poor developing countries is a formidable challenge. Yet health can prove to be a critical bridge for joint action, with a positive impact on other policy arenas. Increased cooperation in the health sector could provide an avenue to bring European countries, as well as European organisations, together around a common purpose. The WHO offers an infrastructure where such cooperation can be facilitated. Joint action between WHO regional offices could address health issues with countries (and trouble spots) that border the European continent, in particular with regard to the borders of Russia, Turkey and the Asian republics. Health can have a role in mediation and relieving political tensions.

Increased interdependence and competition

Since the 1990s a globalisation of production, consumption, culture, and common trends has occurred. According to David Held et al. globalisation, in its simplest sense, refers to the widening, deepening and speeding up of global interconnectedness.⁶ While globalisation has created many opportunities to globalize solutions, intensify exchange through travel, communications and the internet, it has also intensified competition between players at the global level and created new peripheries and inequalities. In Europe, it has for instance become more difficult to expand or even maintain social benefits out of fear of companies relocating their activities to countries with less expensive systems. Globalisation has also

⁴ This has been referred to as “minilateralism” by Naím, M. (2009), “Minilateralism- The magic number to get real international action”, in: Foreign Policy May/June. .

⁵ Health is Global- A UK Government Strategy 2008-2013, p. 7

⁶ Held, D., McGrew, A.G., Goldblatt, D. and J. Perraton (1999), *Global Transformations: Politics, Economics and Culture*, Polity press.

facilitated the rapid spread of infectious diseases, as well as of products and lifestyles related to consumption that engender health risks.⁷

To address the phenomenon of regulatory competition between states, international and regional standard-setting is in increased demand – most explicitly in relation to trade and more recently to the financial system. In many cases, Europe is considered particularly supportive to multilateral solutions based on international law. In the field of health the successful examples include the International Health Regulations, the Framework Convention on Tobacco Control, and the TRIPs waiver to IPR rules to improve access to affordable medicines in developing countries. Other issues driven by globalisation, such as mobility of health workers, are on the agenda for global agreements. International health agreements are of high relevance to all European countries and require response at the regional and country level as well as by European institutions – here WHO EURO plays a critical role.

Health a critical policy domain

The positioning of health as a critical policy domain in Europe and globally has increased in importance and scope – the territory of health and health policy has expanded. Development, trade and security aspects of health have drawn attention to the relationship between health and foreign policy. The challenge of integrating health objectives in other policy areas, including social and environmental policy, has become critical as a result of the economic and climate crisis. The social dimension of health is pertinent as inequalities are increasing within and between European countries. Some governments have begun to foster innovations in bio-medical science and medical technology, since they consider it of great added value to their competitive position. Indeed, health as an economic sector in its own right is gaining attention, as increasing amounts of the GDP are related to health.⁸ In some European countries more than 10% of the workforce is in the health sector.⁹ New treatment possibilities also bring new pressures to bear on already strained health systems and in many European countries the debate on the sustainable financing of health systems has moved to the forefront of the political debate at a time in which government budgets are under immense pressure. Infrastructures, professions and mindsets developed in the 19th and 20th century still dominate the organisation of health and medicine at the beginning of the 21st century – considerable changes and reorientations will be required and the WHO office, in a region with vast intellectual assets, must help muster these for innovation and change.

An increase of health actors

⁷ Kickbusch, I. and G. Lister (2006), *European Perspectives on Global Health: A policy Glossary*. Brussels: European Foundation Centre, p.16; Guigner (2009), ‘The EU and the health dimension of globalization: Playing the World Health Organization Card’ in Orbie, J. and Tortell, L. (eds.), *The European Union and the Social Dimension of Globalization: How the EU influences the World*. Routledge.

⁸ Henke, K-D and K. Martin (2009), ‘Health as a Driving Economic Force’, in: Kickbusch (ed), *Policy Innovation for Health*, New York: Springer.

⁹ idem

The increasing importance of health is reflected in the multiplication of actors active on health issues within and outside of government and at different levels of governance – from local to global. These include international organisations, private sector, non-governmental organisations, foundations and hybrids between these types of organisations – and many of them are now active in the European Region of the WHO. Many came to Europe in the wake of the changes after 1989 and have significantly shaped the picture of European health, particularly in the Eastern part of the Region. The European Union (EU) is probably the actor that has made the largest change to the European health landscape. With the entry into force of the Lisbon Treaty in 2009, its structures for external relations are undergoing a major reform, which could even further strengthen its influence in global politics, including on health issues. This may have a considerable impact on health governance in Europe and requires a clear understanding of roles and responsibilities of the various EU actors, in particular the European Commission, the EU Council, the European Parliament and EU agencies (see Annex 1). But also other organisations, such as the OECD, have increased their work in health due to the growing economic significance of the sector. Countries of the European Region are members of many of these organisations simultaneously and work with many of the other actors – a range of networks have evolved that provide opportunities for joint action around common goals.

The growth of the global health economy

The private sector in health care is growing significantly on a global scale – it expands far beyond the pharmaceutical industry, into information technology for health, medical devices, private hospitals and services, management and monitoring systems, health promotion and wellness, as well as related areas of food, sports and tourism. The more recent debate speaks of a first and secondary health market. The healthcare sector has developed into a healthcare economy. Health-related spending is rising rapidly and the sector is relevant from an economic and political point of view for its added value to overall economic development and its impact on employment. In contrast to other sectors of the economy, the significance of the health economy for the national and the global economy has yet to be fully understood. There is no generally acknowledged breakdown of the healthcare economy within the national accounts statistics – even though some countries are piloting such an approach. No good overviews exist on healthcare expenditure and employment figures. This situation leads to very different forecasts regarding the development of the healthcare economy.¹⁰

For countries and regions, the relevance of innovation in health and bio medicine is increasingly exponentially and new conflicts emerge. Consider for instance the 2007 conflict on sharing virus samples.¹¹ Also within the European region there are tensions about access to medicines. With the recent H1N1 flu outbreak, the richer countries purchased vaccines from pharmaceutical companies limiting availability for the poorer countries in the region. New

¹⁰ Henke, K-D and K. Martin (2009), 'Health as a Driving Economic Force', in: Kickbusch (ed), Policy Innovation for Health, New York: Springer.

¹¹ Global Health Watch 2 – An alternative World Health Report (2008)

roles may emerge for an organisation like the WHO to act as a broker between countries and a global industry, in order to negotiate a lower price and to ensure a fairer distribution of available vaccines, as it is already done by the PAHO Revolving Fund for Vaccines Procurement.¹²

Effective Multilateralism – Reform of the UN

As Henry Kissinger has argued, international organisations can only be relevant and effective if they reflect the power constellations of the world they operate in.¹³ The emergence of new power centres and the increased role of non-state actors challenges the current system of international organisations. Organisations, such as the UN, IMF and World Bank, have moreover been accused of being unwieldy bureaucracies, being ineffective and at worst corrupt. Many do not reflect the present power constellations - despite the urgency of reform, which thus far has proved extremely cumbersome to pursue. This also reflects on the positions taken by European states.

One of the most pertinent reform issues is the call for improved coordination and coherence of the UN's agencies, funds, programmes, departments, research institutes and other bodies. It follows the 2006 report 'delivering as one' by a high-level UN advisory body which called for a bundling of UN activities at country level.¹⁴ In addition to internal resistance from the various UN agencies, who fear a reduction of their remit and activities, developing countries have been critical of such a reform as they fear that streamlining of UN activities will reduce the overall amount of resources available. Having 'one UN' office at country level furthermore invoked a debate on the need for donors to give more funds for the core budget and less for specific programmes.¹⁵

Nevertheless, it seems clear that it is necessary to reduce overlap of activities – also in health - of the various UN bodies particularly at the country level. This also applies to a number of countries in the European Region of the WHO. To make UN bodies work together it was agreed to start a pilot by establishing a "One UN House" in eight countries in 2007. In one of them, Albania, WHO was not among the 11 UN bodies that participated in the one UN Coherence Fund.¹⁶ For WHO – being a technical, not a development agency – special issues arise through such an involvement. These need to be analysed in relation to the existing country offices and their role.¹⁷

¹² PAHO Final Recommendations on pandemic influenza, August 2009, http://www.paho.org/english/ad/fch/im/PandemicFlu_TAGReco_Aug2009_e.pdf

¹³ Kissinger, H. (1994), *Diplomacy*. New York: Simon & Schuster.

¹⁴ United Nations (2006), *Delivering as One*, Report of the Secretary-General's Panel.

¹⁵ Von Freiesleben, J. (2008), *System-wide Coherence*, in: *Managing Change at the United Nations*, New York: Center for UN Reform Education.

¹⁶ One Coherence Fund for Albania. Memorandum of Understanding between the participating UN Organizations and the UNDP regarding the Operational Aspects of the One UN Coherence for Albania.

¹⁷ Lessons Learned Delivering as One UN – pilot countries, April 2009.

3 THE KEY GOVERNANCE CHALLENGES FACING THE WHO REGIONAL OFFICE FOR EUROPE

The fundamental values which unite Europe, such as universality, equity, solidarity, access to health care, and human rights, were agreed upon in the previous decades¹⁸ and maintain their relevance. They provide a common base for action. They provide the basis of the moral authority of the WHO – recently expressed succinctly by the WHO Director-General. In reflecting on the 2008 financial, food and fuel crises, she argued that *‘there is no sector better placed than health to insist on equity and social justice’*.¹⁹ The report of the Commission on Social Determinants of Health and renewed emphasis given to the Alma-Ata Declaration²⁰ and the primary health care approach, underlines WHO’s focus on promoting health for all people. At the level of the WHO EURO, these developments require a new impetus to be translated into action and initiatives. It must embark on a new phase of organisational focus and development.

A short historical review

Since its establishment, the European office of the WHO has gone through significant changes in roles and perspectives. These have come about because of changes in the environment, in health priorities and in the focus and capacity of WHO overall. For this short overview we identify three major phases of organisational focus and development:

Phase 1: a classical technical organisation (1950-1980)

Originally WHO EURO was established to tackle the “big five” health care needs in post-second world war Europe: tuberculosis, malaria, venereal diseases, maternal and child health and environmental sanitation.²¹ Later on, it developed into the centre of expertise concerned with a broad range of health issues pertinent to the European region. It emerged as the region of the WHO that was particularly concerned with the health challenges facing developed countries – but did so in balancing the constant systems competition between different world views and organisational models of health during the Cold War. In consequence it also established close ties with experts beyond the region in countries such as the USA, Canada, Japan and Australia. In the 1980ties it was also requested by the Director General of the WHO to take the responsibility for some global programmes such as health promotion and health of the elderly. The revolutionary Alma Ata Conference took place in the European Region in 1978 – but it was difficult to get European member states to accept its principles and turn them into action.

Phase 2: an organisation that innovates European health policy (1980-1989)

¹⁸ For a good overview see: WHO EURO (1998), *Health 21 – health for all in the 21st century: an introduction*, European Health for All Series No. 5.

¹⁹ Chan, M. (2008), “Globalization and Health”, Remarks at the UN General Assembly Panel Discussion on Globalization and Health, New York, 24 October.

²⁰ Chan, M. (2008), “Return to Alma Ata”, Geneva: World Health Organization.

²¹ WHO (2010), *Sixty Years of WHO in Europe*.

A radical shift took place in the work of the Regional Office when in the early 1980s member states – in following the vision of the then DPM and RD – embarked on exploring how to best translate the challenge of Health For All in the European Region. This led to the formulation of the first European Health Policy which set 36 targets to achieve better health in Europe.²² This document, together with many initiatives that followed in its wake, positioned the WHO Regional Office as a centre for health policy innovation – also made possible by a strong budgetary situation, based on a strong dollar. Many countries embarked on developing health policies of a new type which focused on health outcomes and aimed to strengthen health promotion and disease prevention. During this time the European office developed a number of policy documents with the aim to achieve policy coherence amongst member states on a wide range of health priorities. No other organisation challenged the WHO's central position in health leadership in Europe at this point in time.

Phase 3: An organisation that prioritizes country work (1989 -2009)

The next big upheaval came with the symbolic date of the 1989 fall of the Berlin Wall and the ensuing political changes. Not only did the Regional Office grow significantly in terms of membership as the countries emerging out of the former Soviet Union and former Yugoslavia constituted themselves. It was also faced with a new challenge of supporting the new – and often very poor – countries of the region to develop health policies and systems and tackle priority health issues, including HIV/AIDS. From that time on WHO EURO shifted into another mode of functioning: it was transformed into a rather decentralised structure resulting from the idea that it now needed to be organised more like the other regional offices of the WHO and be present at country level.²³ Country offices were established – despite significant resource constraints – and the Regional office was reorganised to support them in their work. Global actors, such as the World Bank and the IMF, began to play a major role in influencing health developments in the region – in particular in Russia and the countries of the former Soviet Union, as well as in South-East Europe - sometimes to the detriment of the values and policies of the WHO. The organisation increasingly found itself in competition with the resource base and the ensuing power and influence of other actors. It lacked the funds, and partly the expertise, to engage in health projects, but contributed through its moral authority, expertise and standards.

A new major player emerges

This shift led to a neglect of the needs of the major advanced economies in the region. Many of these were members of the European Union which was expanding its health mandate in small steps. In 1993, the Maastricht Treaty entered into force which gave the EU a (limited) mandate to work on public health. This was followed by the establishment of a specific European Commission DG for Health and Consumer protection (DG SANCO), a move which was also linked to the EU's response to several food and animal-related disease outbreaks. In

²² WHO Regional Office for Europe (1985), *Targets for health for all*, Copenhagen.

²³ Godlee, F. (1995), WHO in Europe: does it have a role?, *British Medical Journal* 310: 389-93.

subsequent EU treaty revisions the health mandate was strengthened consecutively and new bodies with health responsibilities were established. The one most closely linked to the work of the WHO is the European Centre for Disease Prevention and Control (ECDC), established in 2005. The 2004 and 2007 enlargements of the EU meant that also many of the former central and eastern European countries have become members of the European Union, and others are still willing to join. Even though the EU always underlines that it is not a technical health organisation and lacks expertise in the field, it still plays a significant role in defining health policy issues by setting regulations and establishing networks of experts based in the EU member states and beyond. In 2002 it adopted its first health programme and in 2009 the first European health strategy.²⁴ In March 2010 the European Commission presented a Communication on the EU's role in Global Health.²⁵ On the basis of this Communication the EU Council adopted Conclusions in which calls on EU Member States and the Commission to support an increased leadership on the WHO at global, regional and country level.²⁶

The strategic response

Being relevant means responding adequately to the challenges at hand. Today, WHO EURO must define its role in the Region and as part of a global organisation, in view of the historic developments and the overall challenges outlined in the first section of this paper. WHO EURO must now set the frame for the next phase of its work and it must do so not in competition with other organisations, but in building alliances and partnerships. In the following we identify six strategic responses that need to be addressed: i) strengthening governance ii) intensifying the global - regional interface; iii) (re)positioning its unique role in the region iv) stakeholder management; v) new health priorities; and vi) financing.

Strengthening strategic governance

The governing structure of the WHO regional office consists of one key advisory and one key decision making body. A group of 9 Member States form the Standing Committee of the Regional Committee (SCRC). They help to guide policy and programme development, and advise the RD on strategic choices. The Regional Committee (RC) is WHO EURO's decision-making body in which representatives of all Member State meet each September for three-and-a-half days. It has become a challenge to engage top level policy makers in both these bodies. For the SCRC this is related to it lacking oversight tasks similar to those of the WHO Executive Board. For the RC it is partly due to the fact that there are now so many competing ministerial meetings at the regional and global level, but also (and perhaps even

²⁴ EU health policy is guided by public health programmes and strategies. The most important policy documents are the first health programme covering the period 2003–2008 (which was adopted in 2002) and the second health programme covering 2008–2013 (adopted in 2007). The second health programme addresses the need to take health objectives into account in other EU policies and discusses challenges, such as ageing, bioterrorism and illnesses related to unhealthy lifestyles. See for a good overview Guigner (2009), *Health: A vital issue for Europe*. Studies & Research No. 68, Notre Europe.

²⁵ Commission Communication, The EU Role in Global Health, Brussels 31 March 2010, COM(2010) 128 final.

²⁶ Cf. Draft Council Conclusions on the EU role in Global Health, 9505/10, Brussels 7 May 2010. These were adopted in the Foreign Affairs Council of 10 May 2010.

more so) because of its loss of role as a strategic core of EURO governance. WHO EURO must strengthen its *strategic governance*, meaning those processes which set the long term strategic direction, advise the Regional Director and monitor progress towards the achievement of the organisation's goals and priorities. The latter in particular implies high levels of accountability and transparency. In order to be relevant again the RC needs to become the venue for strategic governance of the organisation and for providing opportunities to engage with the many stakeholders in European and global health. The RC must therefore strategically aim to ensure the interface between the three types of legitimacy and to make possible new forms of participation of the various actors. Formal decision-making structures must be improved, the numeric majority position of the EU countries must be balanced, avenues for informal consultation and consolidation must be developed and strengthened, and other players must be included in the deliberations.

Intensifying the global – regional interface

Strategic governance within the Regional Office always implies a strong link to the overall strategic directions set by the World Health Assembly. The regional structure with six regional offices is a unique feature of the WHO. The regional offices operate rather autonomously, an approach which is reinforced by the Regional Directors being elected directly by the member states of the region and then confirmed by the executive board of the WHO. There have been frequent complaints that there is not one, but seven WHOs. This is an issue of overall WHO governance that still needs to be resolved - even more so in view of global disease outbreaks and the global dynamics of the determinants of health. The adoption of new legal instruments such as the IHR and the FCTC reinforce the interface between global decision making at the WHA and the regional level – both in the lead up and the follow through. The present DG Dr. Margaret Chan, for instance, states clearly that '*the International Health Regulations recognise one WHO only*', and that '*their implementation requires that all levels of the organisation act in a consistent and coherent manner*'.²⁷ The Regional offices must play a key role in strengthening the capacity of the member states to fulfil their obligations at the national level and in creating the consensus to engage in collective action at regional and global level to ensure health security and promote health equity. The Regional Committee meetings must play a key role in this regard – linking the two levels of strategic governance of the organisation, the global and the regional. The agenda item “matters arising from the World Health Assembly” needs to gain a new relevance at the regional level, and the Executive Board members from the European region have a key bridging role to play in this regard. The link becomes even more critical as initiatives for reform of the organisation are taken forward at the global level.

(Re)positioning its unique role in the region

²⁷ Chan, M., Opening remarks at the Fifth Global Meeting of Heads of WHO Country Offices, 2 November 2009.

Central to governance are the concepts of leadership and authority. WHO's role is to act as the directing and coordinating authority on international health work. Its six core functions are²⁸: i) providing leadership on matters critical to health and engaging in partnership where joint action is needed, ii) shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge, iii) setting norms and standards, and promoting and monitoring their implementation, iv) articulating ethical and evidence-based policy options, v) providing technical support, catalysing change, and building sustainable institutional capacity, and vi) monitoring the health situation and accessing health trends. The regional office needs to provide leadership and excellence in relation to these functions within its sphere of responsibility. There is no other organisation in Europe that can combine the three dimensions of legitimacy in health: *formal- legal authority* as an organisation of sovereign states that can set norms and standards, *output legitimacy* based on technical excellence and public health innovation and foresight, and *moral authority*. This clearly requires a very high standard of agency governance and a conscious effort to establish and ensure excellence in WHO EURO's technical health expertise function and reliability in its monitoring and surveillance functions. The scientific quality, the ability to be on top of new developments and the practical use of expertise provided to Member States and other health actors in the region all need to be strengthened and harnessed in new ways. A new skills mix that is in sync with the new challenges is essential: health expertise needs to be combined with legal, economic, diplomatic, business and social policy expertise. And finally, ethics and integrity are crucial.

Stakeholder management: improving collaboration with other international organisations

The 53 EURO countries are members of various political structures and alliances which in turn influences their role and behaviour within WHO EURO. Member countries are also part of many other organisations and structures; of the 53 WHO EURO Member States: 48 are member of the Council of Europe, 23 of the OECD, 27 are members of the EU, 11 members of the CIS, 6 of them join the meetings of the G20, about 6 hold decisive positions in the governance bodies of the IMF and the World Bank, 5 are members of the Shanghai Cooperation Organisation and 3 are permanent members of the UN Security Council. Particularly the EU is an increasingly important entity; it now has legislative competences in a number of areas and is also pursuing a single voice of its member states on an increasing range of issues, including its external relations in health. The work of the WHO EURO needs to take these factors into account as it reflects its consultative and decision making procedures. It must consider and analyse the impact the decisions of these other bodies have on health and the work of the WHO and it must analyze how this multiplicity can serve health and make countries strong advocates for health and WHO positions in other organisations. In governance discussions such a process is called *stakeholder management*²⁹: through

²⁸ WHO 11th General Programme of Work, 2006-2015, adopted in May 2006.

²⁹ Freeman, R.E. (1984), *Strategic Management – A Stakeholder Approach*, Pitman; Mitchell, R.K., Agle, B.R. and D.J. Wood (1997), Towards a theory of stakeholder identification and salience. Defining the principles of who and what really counts, in: *Academy of Management Review*, vol 4, issue 22, pp. 853-886; Gärtner, R.

stakeholder analysis an organisation identifies the key actors and through *stakeholder planning* it builds the process to gain support for certain positions. It is critical to communicate with stakeholders early and often. The management structure of the Regional Office has to reflect this need.

Reassessing health priorities and strengthening expertise

Given the wide range of health challenges it has always been difficult for the WHO to balance the many expectations. In recent years, WHO EURO invested mainly in the area of communicable diseases and health care systems development and financing. Expertise on non-communicable diseases, responsible for 80% of the diseases burden in the European region, requires more attention, as do health inequalities and the social determinants of health. A new consensus between member states on priorities needs to be developed – preferably through a new European health policy document. The organisation of the health expertise of the organisation needs to be reconsidered – it should build on synergies that emerge through joint work in the European Office in Copenhagen rather than spreading staff in many centres around the region. A renewed effort will be needed to network centres of excellence in member states and to combine the analytical effort with other organisations – for example on health systems analysis with the OECD. In view of the mix of the three legitimacies, WHO will need to ensure that in particular its moral voice in relation to equity and social justice is not compromised and that its independence is ensured.

Addressing financial constraints

To carry out its tasks WHO EURO receives less than 7% of the WHO's annual budget (4200 million dollar for the period 2008-2009). In 2006-2007 about 180 million dollars were spent by WHO EURO. The budget for the period 2008-2009 is 274 million dollar. For 2010-2011 it is 262 million dollar.³⁰ Most of the funds are derived from voluntary contributions by the Member States, making it uncertain if all of them will be delivered, certainly in these times of economic crisis.³¹ A large proportion of them are also earmarked towards specific activities of the WHO, making it difficult to readjust spending priorities. Introducing new priorities will be difficult and requires the support of the governing bodies and donors of the organisation.

4 INTERACTION OF WHO EURO WITH THE EU

(2009), *Der Einfluss von Stakeholder-Gruppen auf den Strategieprozess: Kanalisierung von Emergenz am Beispiel externer Stakeholder*, Diplomica Verlag.

³⁰ WHO Proposed Programme Budget 2010-2011, Financial Table, cf. http://apps.who.int/gb/ebwha/pdf_files/MTSP2009/PPB5-en.pdf

³¹ In the period 2006-2007, 58 million dollar were assessed contributions and 142 million were voluntary contributions. In the 2008-2009 budget 63 are assessed contributions and 211 million are voluntary contributions.

The most prominent organisation active in the EURO region on health issues is the EU. From the 53 WHO EURO member states, 27 are EU member states³², 3 are official EU candidate countries and at least 5 others have expressed a desire to become EU member states in the future.³³ Others have closely aligned their policies to those of the EU³⁴ or are part of the European Neighbourhood Policy.³⁵ As the EU has expanded, so have its borders moved, and new interregional alliances and programmes have been created. In addition, the EU has a number of important strategic partnerships within Europe, such as with Russia. The EU is frequently referred to as a “soft” or structural power, exerting its influence mainly through economic policies.³⁶

When the EU obtained a mandate in the field of health in 1993, the question was raised whether it could replace the function of WHO EURO for EU member states.³⁷ However, it is important to underline that WHO EURO and the EU are two very different types of organisations with very different roles and tasks. WHO EURO is a UN body solely dedicated to promoting the health of all people. It is an international organisation whose legitimacy is based on its world wide membership and its ability to provide leadership on international health issues. Its authority and credibility rests on its role in setting both formal and informal norms for health that are adhered to. But, there is no compliance mechanism through which WHO Member States can be sanctioned if they fail to abide to what they have agreed upon within the World Health Assembly or Regional Committee.

The EU is a regional integration organisation with supranational features in a large number of policy areas, notably those related to the economic activities of its member states. In these areas, EU legislation superseded national legislation, something which can be enforced by financial penalties given by the European Court of Justice.³⁸ In other policy areas, such as social policy, the EU has an advisory role. In external relations, the EU is more than a close coalition; on issues where member states have transferred legislative competences to the EU, representation through a single voice is obligatory. Currently, the EU is in a process of transformation with the implementation of a new Lisbon Treaty that creates some new competences in the field of health and reforms its system for external relations. It is relevant to consider to what extent the EU is responsible for, or is influencing, health-related issues, which in the non-EU states are the sole responsibility of the state governments.

³² EU Member States are: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the United Kingdom.

³³ The candidate countries are: Croatia, FYR-Macedonia and Turkey. The potential candidate countries are: Albania, Bosnia and Herzegovina, Iceland, Montenegro and Serbia.

³⁴ Liechtenstein and Norway are part of the European Economic Area and with Switzerland bilateral agreements with a similar content have been agreed upon.

³⁵ ENP countries that are part of WHO EURO are: Armenia, Azerbaijan, Belarus, Moldova and Ukraine.

³⁶ Cf. Keukeleire, S. and J. MacNaughtan (2008), *The Foreign Policy of the European Union*, Palgrave Macmillan.

³⁷ Cf. Godlee, F. (1995), WHO in Europe: does it have a role?, *British Medical Journal* 310: 389-93.

³⁸ See for more information: Egenhofer, Kurpas and Van Schaik (2009), *The Ever-Changing Union - An introduction to the History, Institutions and Decision-Making Processes of the European Union*, Brussels: Centre for European Policy Studies, <http://www.ceps.eu/node/1613>.

4.1 THE EU ROLE IN HEALTH

The EU sets standards in the fields of health where it has competence, it gathers data and advises EU member states on aspects of their health policy through the open method of coordination (OMC), and it finances health activities within EU member states through its budgets for research, its health programme and regional policy, and outside its territory through accession, neighbourhood and development cooperation funds. In Annex 1 the role of various EU actors is described.

EU competence in health: Formally the EU only has a complementary competence for the issue of public health, as is codified in the Treaty on the Functioning of the European Union (article 6, TFEU). This means that, in accordance with the principle of subsidiarity, the EU can only act in areas where its involvement creates clearly identifiable added value. As a result, the definition of health policy and the organisation and delivery of health services and medical care have remained a responsibility of the member states, which the EU is not allowed to engage in (cf. article 168:7, TFEU). Article 168 of the Treaty on the Functioning of the European Union allows for EU regulation in three specific fields: veterinary and phytosanitary standards; organs, substances of human origin and blood; and medicinal products and devices for medical use. It allows the EU to set up spending programmes aimed at reducing tobacco and alcohol use. It also contains a provision on monitoring, early warning of and combating serious cross-border threats to health.

Health in other EU policies: Notwithstanding the limited mandate, a considerable amount of EU legislation affects health issues. One of the reasons is that many diseases and their causes do not stop at national borders which have been removed between EU countries. Within the EU, the potential spread of disease is amplified by the internal market and the free movement of people, goods and animals, which increases flows and reduces the options for controlling communicable diseases.³⁹ EU legislation in other fields affects health issues. The recognition of health worker qualifications, healthcare for travellers, working hours for doctors and laws banning (the transportation of) unhealthy products, foodstuffs and animals, are all areas affected by EU regulation. It is important to realise that EU legislation is also implemented in countries wanting to join the EU or having agreed to align their policies. This widens the sphere of influence considerably.

Limited EU expertise in the field of health. The EU's expertise on health is relatively limited in comparison to available expertise in the combined EU member states. Only about 80 staff work on health issues in DG SANCO. More expertise is available in the EU agencies⁴⁰, but only with regard to their specific remit. In fields where the EU does not have a legislative competence, such as social and health policy, the objective is to stimulate policy learning among its member states. This occurs through the so-called method of open coordination (OMC) that is somewhat similar to peer review processes of other international organisations,

³⁹ Guigner, S. (2009), *Health: A vital issue for Europe*. Studies & Research No. 68, Notre Europe

⁴⁰ In the field of health three EU agencies exist: EMEA, EFSA and ECDC. See for their role Annex 1

notably the OECD. An example of an issue where OMC is used concerns the issue of health inequity.⁴¹ In a more indirect way, the EU supports the development of health expertise by funding public health research projects and pan-European health federations and NGOs.

EU financing for health

The EU provides funds for health research, and health is included within the regional, accession, neighbourhood and development funds. During the aftermath of the changes following the break-up of the Soviet Union significant funds for health were also made available through the EU. In Annex 2 an overview is given. Research funds are disbursed by DG Research. The other funds by DG Europeaid. In addition, the EU Health Programme finances projects to improve citizens' health security, to promote health (including the reduction of health inequities), and to generate and disseminate health information and knowledge. The programme has a budget of 321.5 million Euros for the period 2008-2013 and is also open to (potential) accession and neighbourhood countries.⁴²

4.2 THE RELATIONSHIP BETWEEN THE EU AND THE WHO

Looking back: The WHO has a long-standing relationship with the European Commission, dating back to an exchange of letters in 1972, 1982 and in 2000. This last exchange identifies various priority areas, including health information, communicable diseases, tobacco control, environment and health, sustainable health development, health research, and outlines practical procedures for cooperation. At high level, meetings between the Commissioner responsible for health and consumer policy and the WHO Director-General take place regularly. There are also WHO EURO projects that are co-financed by the European Commission.⁴³ With ECDC a memorandum of understanding is in place which provides a framework for collaboration, inter alia through a joint coordination group.⁴⁴ The WHO has an office in Brussels and the EU delegation in Geneva has a health attaché.

The relationship between the WHO EURO and the EU poses a number of key questions:

- How and on which issues can two such different organisations work together?
- How can this cooperation benefit all 53 EURO member states and beyond?
- Given the majority of EU member states in the WHO EURO regional committee, how can the balance within the organisation be ensured?

Two areas deserve particular attention:

⁴¹ Commission Communication (2009), *Solidarity in Health: Reducing Health Inequalities in the EU*, Brussels, COM (2009) 567 final.

⁴² Decision No 1350/2007/EC of the European Parliament and of the Council of 23 October 2007 establishing a second programme of Community action in the field of health (2008-2013).

⁴³ DG Sanco and WHO Regional Office for Europe signed in March 2007 contracts to jointly fund seven projects that will be implemented by WHO EURO over a period of three years. They cover European health policy priorities on environment and health, injuries, equity in health, health security, health services, alcohol and emergency medical service. The overall budget of the package is €4.232.963. The EU's Public Health Programme will cover 60% of the cost.

⁴⁴ Cf. The First Memorandum of Understanding between WHO EURO and the ECDC of September 2005.

a) Although the formal competence of the EU in the field of health remains rather limited, the EU's role in health has increased through competences in other fields. Here the question arises whether for issues regulated by the EU, the WHO EURO should directly liaise with the European Commission, which is the EU institution responsible for initiating new policy initiatives and overseeing policy implementation, or with the EU Council, where member states decide upon the common policies.⁴⁵

b) With regard to the EU's role in financing health activities within the EU and beyond, and its role in analysing national health policies, it seems important to avoid unnecessary duplication, create synergies and decide on areas where the activities of both organisations can best complement each other. These tasks are mainly conducted by the European Commission. With regard to analysis, a political question though is if EU countries would perhaps be more comfortable with WHO monitoring their health policies or aspects of it, and if for this reason parts of this task could better be performed by WHO EURO than by the European Commission. In that case, other WHO EURO member states would be able to benefit from mutual learning exercises as well.

The EU's role in WHO EURO decision making

In WHO EURO most issues are decided by a consensus among the member states, but – formally- it is possible to take decisions by a simple majority of the votes.⁴⁶ EU countries are legally obliged to operate on the basis of a common position on issues where the EU has competence to legislate.⁴⁷ Particularly with the entry into force of the Lisbon Treaty, it is clear that EU competence exists not just in areas that are related to trade, such as intellectual property rights and food, but also in purely health issues, such as combating the spread of communicable diseases. Even on issues related to development cooperation and research, the EU may need to come up with a coordinated position. If no EU competence exists, EU countries are allowed to take care of their own external representation (e.g. on finance of WHO EURO or on political questions such as aid to Palestine).

Within the RC the EU has become more dominant in the last decade, since it increasingly operates with a coordinated position and holds the majority after its 2007 enlargement. Although consensus is the rule, the possibility of voting, still influences the dynamics of the negotiations on new resolutions. In addition, the necessary coordination meetings among EU member states often consumes much of the available time outside the official meetings which makes consultations with non-EU members more difficult. It is critical that preferences of non-EU states are considered appropriately in order to ensure a strong backing for resolutions

⁴⁵ For most issues the EU Council shares its decision-making powers with the European Parliament (EP), but since the countries that form the EU Council are also WHO EURO members it seems most relevant to liaise with them and not with the EP where EU -WHO matters are concerned. See also Annex 1.

⁴⁶ Cf. Rule 23 of the Rules of Procedure of the Regional Committee for Europe and of the Standing Committee of the Regional Committee for Europe, Copenhagen, 2001.

⁴⁷ For issues where the EU has exclusive legislative competence, the mandate of the EU for the negotiations even can be decided upon by qualified majority voting, meaning that (a minority of) individual EU member states, can be outvoted.

by all WHO EURO Member States, as this is a precondition for effective implementation. While in terms of outright voting the majority threshold could be increased, the procedures for finding consensus on major issues – also taking into account that not all EU member states always agree – becomes very important. One way to do this would be for the SCRC to obtain a stronger role with regard to informal consultations on WHO EURO business in order to facilitate consensus during the preparations for the RC.

External representation and the possibility of EU membership of the WHO

A related issue is that competence implies a role for the European Commission in the EU's external representation. On this issue, it depends if the thrust of the competence is with the EU or with the EU countries (in case the issue covered is subject to both EU and national policy). The presidency of the EU used to represent the EU countries on these issues. It is yet unclear whether the new rules of the Lisbon treaty will change this practice. Whether the EU High Representative of the Union for Foreign Affairs and Security Policy (HR) will take over the role of the country holding the rotating presidency appears to depend on whether the issues being discussed within the WHO are defined as foreign policy. If they will be labelled as (international) health policy or the external dimension of EU health policy, the situation may remain as it is today.

The need for a common representation, and particularly if voiced through (a representative of) the HR, poses furthermore the question whether the EU would seek to become a Member of the WHO, as it is already in other international organisations (e.g. WTO, FAO and the Codex Alimentarius Commission). Currently the EU only has observer status and EU membership would raise the issue of the amount of votes the EU would be entitled to have, a particularly pertinent question for WHO EURO decision-making. Thus far, the amount of votes has equalled the number of EU countries in the circumstance of EU membership of international organisations. The question of EU representation in the UN system is politically delicate and might have to be addressed in general. Would other countries accept that the EU becomes a member with the right to vote, while EU member states retain their right to vote?

The strategic response:

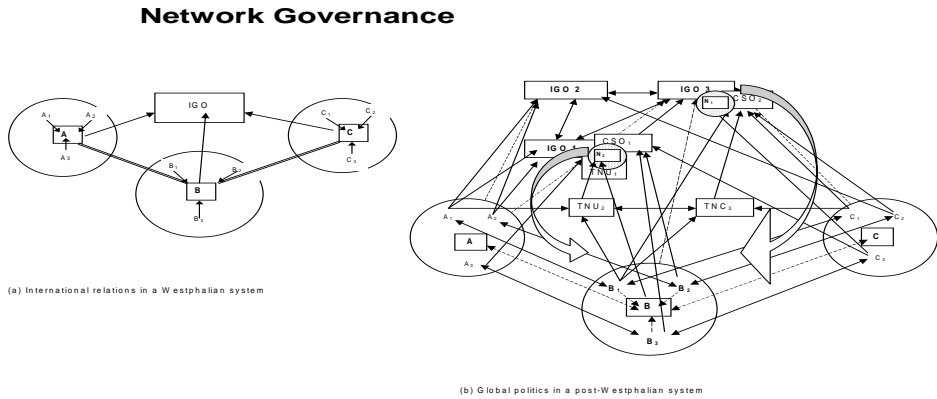
The range of issues that emerge through the presence of a key player in health, such as the EU within Europe – but also globally – clearly implies that the relationship between the two organisations needs to be taken beyond the agreements that exist up to now and be turned into a formal alliance for health. This would also follow from the EU goal to reinforce what it terms “effective multilateralism” by clearly supporting not only the work, but also the values of the WHO in health. The move towards such a strategic partnership would also strengthen the position of health in the broader post-Lisbon Treaty EU foreign policy framework - following the recommendation of the UN Assembly resolution on global health and foreign policy.⁴⁸ The EU has created the instrument of *strategic partnerships* with third parties (both

⁴⁸ UN resolution 63/33, Global health and foreign policy, 27 January 2009.

countries and organisations) and it would seem most appropriate if such a strategic partnership for health be put in place to structure and guide the cooperation between the two players, recognising each of them in their specificity. WHO and the EU would agree to work together to achieve a common purpose as well as to jointly undertake specific tasks and by that process extend their respective technical and operational resources. For the European level, the strategic priorities that come to mind are to ensure health security and reduce health inequalities in Europe.

5 WHO EURO AS A NETWORKED ORGANISATION

The relevance of WHO EURO is defined by how EURO is linked in many directions; to WHO HQ Geneva, to other players in global health and to the European stakeholders. In terms of governance this means to understand WHO EURO as a networked organisation. In the literature, this has been described as an organisation “where independent people and groups act as independent nodes, link across boundaries, to work together for a common purpose; it has multiple leaders, lots of voluntary links and interacting levels.”⁴⁹ Wolfgang Hein⁵⁰ has illustrated this in the following way:



For WHO EURO there is both a need to govern the different parts *within* the organisation in a more synergistic network and to strengthen its network function regarding *external* actors active in the fields of health in the European region. Internally, more links will needed to bind the organisation together and flatten the hierarchical structure and culture of the Copenhagen Office as is appropriate to a networked organisation.

The real challenge for the WHO EURO in relation to the external actors is to become the recognised hub of health expertise in the European region. In a knowledge society such hubs

⁴⁹ Lipnack, J. and J. Stamps (1994), *The age of the network: Organizing principles for the 21st century*, Oliver Wight Ltd Pub.
⁵⁰ Hein, W. (2008), *Governance and Health*, in: Martin Exner et. al., *Towards Sustainable Global Health*, Bonn: United Nations University, Institute for Environment and Human Security, pp. 86-97

establish their authority through both providing expertise and bringing relevant stakeholders together. WHO EURO would become a central hub in a network of different nodes that mobilise resources, ideas, technologies and carry out health activities in the European region. These nodes may include international organisations, donor agencies, public health institutes, private sector, civil society organisations, individuals, and so on. Coordination of these nodes would not always require formal structures and should not become a goal in itself. Rather it would require a good and regularly updated insight into relevant networks (e.g. good databases) and a continuous consideration of issues that could benefit from bringing actors together. Restructuring into a networked organisation should help WHO EURO to improve its ties with its Members and WHO HQ, and to manage the rise of powerful non-state actors and the rapid dissemination of knowledge around the globe. Transforming WHO EURO into a networked organisation requires changes with regard to the structure of the organisation, the build-up and sharing of expertise and contacts throughout it, and ways to institutionalise new networks without them becoming static.

The existing WHO Collaborating Centres (WHO CCs) constitute a good basis for the establishment of such a networked organisation. The WHO CCs should however be brought more in interaction with each other. Not all partners in a networked WHO Euro, need to have a formal status like WHO CCs.

Adjusting the organisational structure

A first requirement seems to be to strengthen the “hub” - the Regional Office in Copenhagen. The current decentralised model with many country offices and GDOs demands time consuming oversight, extra costs for operating offices and has reduced the available expertise in Copenhagen. If the GDOs and country offices operate too independently, there is furthermore a risk of not achieving WHO EURO priority objectives and giving mixed messages to other actors active in the field of health in the European region. The ongoing review missions are likely to give a more comprehensive overview of the added value of the specific GDOs and country offices for WHO EURO.

A considerable amount of expertise on health resides within the countries of the WHO EURO region, in health ministries, national institutes, universities and other organisations. This information could be tapped by the WHO Country Office, but also by organising meetings and platforms where national experts can exchange experiences with each other and staff of WHO EURO and possibly other international organisations (e.g. OECD, EU, World Bank). Units within WHO EURO should be made responsible for linking with existing networks and, where appropriate, setting up new networks in their fields and to make sure that contacts and key expertise (data, papers) are made available and kept updated.

With regard to the relationship to other international actors active in the field of health in the European region, it is needed to have a good insight in what they are doing, what their remit is in terms of membership and issues covered, and how much capacity they have for carrying out their work. Below and in the annex we make a first attempt to identify the core business of

other actors, but more work is obviously needed in order to single out the position of WHO in relation to other actors. This is needed in order to define in which fields sharing of information could be expanded, where policy objectives are similar or different and where a common approach would be beneficial and at what stage. When building networks, consideration must also be given to representatives of vulnerable groups.

WHO EURO would thus bring together various levels of governance, sectors and actors to improve health. Managing these networks would become a key function of all units of the WHO EURO office, whereby cutting edge ICT could facilitate the management and sharing of contacts and expertise. Networks could first be (re)established or strengthened in those areas where WHO EURO has a comparative advantage. It will be particularly important to establish networks that reach beyond the health sector in order to be able to address issues of equity and the social determinants of health and take into account the political and economic dimensions of health. This may require new resources and funding or linking with already existing networks of other sectors.

6 INTERACTION OF THE WHO REGIONAL OFFICE WITH OTHER INTERNATIONAL ACTORS IN HEALTH GOVERNANCE IN EUROPE

Just two decades ago, the WHO was the leading organisation for health in the European region. Today, a plethora of actors is active in the field of health in the European region. Some of these are traditional partners with whom WHO EURO has a long-standing cooperation.⁵¹ Others are relatively new. The development mirrors one that has taken place at the global level from the late 1970s onwards. Two major factors initiated the change⁵²: the rise of development assistance and the rivalry between those advocating comprehensive versus those advocating selective primary health care. Within the UN family, UNICEF started to provide large scale immunization programmes and the World Bank started to invest in health, and to stimulate the establishment of market-based health care systems. This was followed by the rise of the civil society organizations, initially organised around women's health, HIV/AIDS and human rights and health, but expanding into ever more areas of action and advocacy.

Within the European region, the Western countries started to provide public donor money for health projects. In these countries fund-raising by private donors also started to take off, although it has never reached the level of the US. The transition from communism to market-based based economies in the Eastern part of the region lead to a surge of activities by the World Bank. In recent years this organisation has been scaling back its activity in those

⁵¹ The WHO (EURO) has formalised agreements with the OECD, ECDC, European Commission, International Organization for Migration, International Federation of Red Cross and Red Crescent Societies, the World Bank (through a general framework agreement between the WB and the UN), and the Council of Europe.

⁵² Kickbusch et al. (forthcoming), Addressing global health governance challenges through a new mechanism: the proposal for a Committee C of the World Health Assembly.

countries which have become more prosperous (e.g. some of the countries that joined the EU). Also civil society organisation became active in the region, but perhaps to a lesser extent than in for instance Sub-Saharan Africa. With the financial and economic crisis, the situation again has changed. Countries, such as Hungary and Latvia, recently had to resort to the IMF, and other countries are hit hard as well.

In annex 3, we describe the organisations with most relevance for the EURO region, in particular their core activities in the field of health and their cooperation with WHO EURO. In this chapter we will briefly discuss who sets standards for health policies, who contributes to data analysis, knowledge and advises national authorities on health policy, and who is financing health activities in the WHO EURO region.

6.1 INSTRUMENTS TO SET HEALTH STANDARDS

A key role for WHO EURO is to provide guidance regarding health standards. It has various instruments at its disposal to do this (see box 1) . Some of them are legally binding (‘hard law’), while others rely on political agreement (‘soft law’). For all instruments, WHO has little mechanisms at its disposal to enforce compliance besides “naming and shaming”.

Box 1 - WHO Instruments

Category	Current Examples
Conventions and Agreements * + (Articles 2 (k),19-20)	Framework Convention on Tobacco Control
Regulations * + (Articles 2 (k), 21-22)	International Health Regulations (2005)
Recommendations + (Articles 2 (k), 23)	Global strategy and plan of action on public health, innovation and intellectual property
Nomenclatures # (Article 2 (s))	International Nonproprietary Names
Standards # (Article 2 (u))	Codex Alimentarius Commission

*These are usually regarded as 'binding instruments'

+ These are described in the functions of WHO, and the functions of the World Health Assembly, indicating the requirement for inter-governmental process.

These are described in WHO functions, but not WHA functions, leaving the need for intergovernmental process optional (though Regulations may be adopted for Nomenclatures and Standards in accordance with Article 21).

There are a number of other actors that set regulatory framework or (informal) norms and standards affecting health issues in the countries of the WHO EURO region. These include the **traditional international organisations**, such as WTO rules on sanitary standards and

intellectual property rights, ILO guidance on labour conditions, UN and OECD guidance on development cooperation spending, etc.

Organisations specifically setting rules for the health sector exist as well. As we have seen above, the **EU** is increasingly expanding its health mandate. Another organisation that sets standards is the Strasbourg-based **Council of Europe**, which concentrates on standards for blood infusions and transplantation. It could moreover be argued that the **World Bank** implicitly sets standards in the countries it is active in by proscribing policies in return for its loans. At country level, WHO officials often find themselves in competition with the World Bank: while the World Bank has a mandate that also includes influencing and interacting with the more powerful trade and financial ministries, WHO's mandate tends to be restricted to the health sector.⁵³ This is problematic when the World Bank urges budget cuts and market-oriented health sector reforms in a situation where WHO would advise differently. It is the question whether the Shanghai Cooperation organisation, or even the G20 or OECD will also engage in standard setting in the field of health in the future.

6.2 DATA GATHERING, POLICY ANALYSIS, GIVING ADVICE

With regard to data gathering and analysis, in particular the OECD has become more active in the previous decade. It argues that *“improving health is a key concern of OECD societies, as it can contribute to higher economic growth and improved welfare.”* Work on health is undertaken by different bodies of the OECD, for example on health indicators⁵⁴, health policies, the determinants of health, the economics of health, and the environment and health. It regularly publishes OECD health data, the analysis of health systems of OECD countries and provides up to date comparable data on different aspects of the performance of health systems in OECD countries. It organized in October 2010 for the second time a meeting of health ministers following a meeting in 2004 which has gained high importance.

As health gains in economic relevance, a clear trend can also be seen towards major private consultancies offering advice governments on the organisation of health systems. The EU also provides an extensive amount of health data both in relation to the general status of health in the EU and also in relation to specific health issues and challenges. As regards the WHO EURO the European Observatory on Health Systems and Policies aims to provide the analytical basis for this work. The relation between WHO EURO and the Observatory with its own governance structure should be clarified though. Since WHO EURO embarks on the process of developing a new health policy for Europe, it will be necessary to investigate how data gathering, analysis and monitoring will be provided and what partnerships emerge to continuously update and improve a common system of health information for Europe, possibly building on the existing collaboration between WHO, OECD and Eurostat.

6.3 FINANCING HEALTH IN THE WHO EURO REGION

⁵³ Global Health Watch, 2006

⁵⁴ The collaboration between WHO, OECD & Eurostat on health statistics is a positive example of collaboration between international organisations.

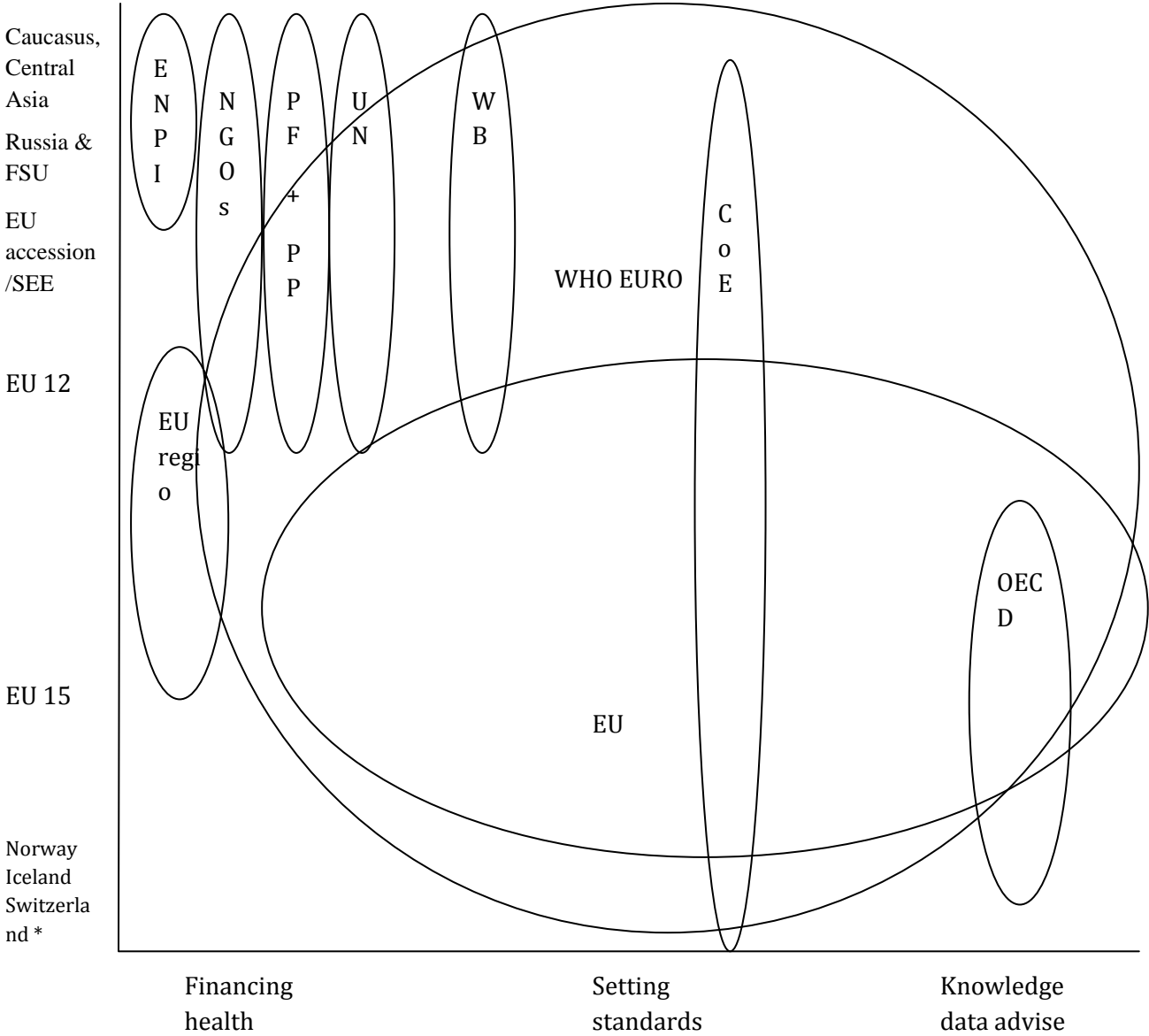
A lot of actors finance health activities in the less affluent countries of the WHO EURO region, the EU, UN agencies, the development agencies of EU member states, the US, private foundations, the public private partnership and foundations. Here similar questions as to the effectiveness and sustainability of the activities of health donors and their accountability can be raised as at the level of global health.⁵⁵ Here too there seems to be a considerable overlap in activities and sectors in which the donors are active in (e.g. a focus on the provision of AIDS medicines, whilst ignoring the general level of health care provision). It would seem appropriate for WHO EURO together with Ministries of health to provide guidance and technical advice on where the resources should go and what are the most appropriate and effective interventions.⁵⁶

Figure 1 summarises activities of actors within the different parts of the region. It is realised that all countries in the region are subject to a different mix, but for reasons of simplicity the countries are grouped into Iceland, Norway and Switzerland, the EU-15, the EU-12 (countries that joined in 2004 and 2007), the EU accession countries and South East European (SEE countries), Russia and Former Soviet Union (Belarus, Moldova and Ukraine), Caucasus and Central Asia.

⁵⁵ Szlezák, N.A. et. al. (2010), *The Global Health System: Actors, Norms, and Expectations in Transition*, in: *Plos Medicine*, vol 7, issue 1.

⁵⁶ House of Lords (2008), *International Health: the Institutional Labyrinth*; Kickbusch et al. (forthcoming), *Addressing global health governance challenges through a new mechanism: the proposal for a Committee C of the World Health Assembly*.

Figure 1 – Schematic overview of the activities of health actors in the European region



*This category also applies to: Andorra, Israel, Monaco and San Marino.

7 EUROPE’S VOICE IN GLOBAL HEALTH GOVERNANCE

Europe is part of global health

Global Health must not be misunderstood as health action in developing countries. Global health is about tackling global health challenges and about tackling health in a global context. According to Anders Nordstrom, the Director General of the Swedish International Development Agency (SIDA) “we should stop talking about global health as being different

from health. With climate change we are much closer to realising that this is a job for everyone”.⁵⁷

*Global health refers to those health issues which transcend national boundaries and governments and call for actions to influence the global forces that determine the health of people. It requires new forms governance at national and international level which seek to include a wide range of actors*⁵⁸. European health action is part of global health. What Europe does within its own sphere impacts on the health of others and is in turn influenced by the global environment as described in the early parts of this paper. It must therefore seek policy coherence within its own sphere of responsibility to ensure:

- better health security and population health outcomes for each of the countries (thus serving the national and the global interest)
- improving the relations between the states and strengthening the commitment of a wide range of actors to work to improve health
- joint action to protect health as a human right and a commitment to social justice by delivering results that are deemed fair by increasing equity in health within and between countries.

The European office of the WHO could see as one of its aims to strengthen Europe’s willingness to be as proactive in health as a global issue. It needs to be conscious of the global environment in which it operates and could mobilise the diversity of European members to contribute to global health goals. This means to support the growing understanding that health is part of other policies, such as trade , security and foreign affairs, social and migration policies, labour policies and environmental policies.⁵⁹ It can help develop insights in how a multilateral world order may provide a new opportunity for regional health governance, on the new interfaces between regional and global health governance and on the interface between global impact and global responsibilities. Together with other organisations and with WHO headquarters, it should help to harness the intellectual resources available in the European region in a way that could promote partnerships with the developing world, for example by creating capacity-building programmes and increasing local competence.

Need for policy coherence

In response to this kind of thinking some European member states⁶⁰ have embarked on a process of developing and implementing “*national global health strategies*” which aim to create policy coherence between a wide range of sectors and between domestic health goals,

⁵⁷ Nobel Forum Seminar: The European Union as a Global Health Actor, Event Report by Karolinksa Institutet, Swedish EU presidency and Global Health Europe, 4 December 2009, Stockholm, Sweden.

⁵⁸ Kickbusch, I. and G. Lister (2006), *European Perspectives on Global Health: A policy Glossary*. Brussels: European Foundation Centre.

⁵⁹ See also the Declaration on “Health in all Policies”, signed by the Italian Ministry of Health, the European Commission and WHO-EURO, Rome, 18 December 2007.

⁶⁰ E.g. the Swiss Health Foreign Policy and the UK Strategy „Health is Global“

challenges in health arising from globalization and development goals in health, such as the MDGs. Ideally, such attempts at coherence are also be reflected in the positions taken at various levels of governance within the WHO and within other organisations. This is becoming increasingly important in view of the interconnected global issues affecting the health of populations around the world as well as in the European region, such as climate change and the social determinants of health. In view of the growing global market in health products and health services, global agreements on product quality and safety, professional and patient mobility and agreed ethical guidelines in innovation and health research will also increase in importance.

Commitment to effective multilateralism

WHO Euro is part of a global organisation and many of the other health actors in Europe are active on a global level, such as the development agencies or European member states that support health programmes in the region, such as the World Bank, UNAIDS and others. A recent development has been the more active role the EU has taken in foreign policy overall and in global health in particular. The global health should always consider that voluntary contributions to WHO from EU Member States account for 43% of total Member States contributions⁶¹ (with other non-EU European Members accounting for an additional 10%). A strong European commitment to effective multilateralism could spearhead innovation for the Organization as a whole – for example by tackling new issues for exploring new partnerships and alliances.

Health in foreign policy

All countries in the WHO EURO region are subject to a changing nature of foreign policy, in which the lines between the domestic and the foreign are less clearly drawn, also in health – they all need to be engaged in transnational policy making and those states that are part of the EU are also engaged in defining a new combination of internal European policy making and a common external role that is yet to be more clearly defined: will the role of health change in the relationship between the EU member countries and the EU or between the Council and the Commission? Will health be more present in the 128 delegations the EU has around the world and at international organisations (for example at the WTO and the OECD)? How will European countries approach health matters in the G20? Will European countries allow for the adaptation of international institutions to the growing importance of the emerging economies as global actors? Will this affect the health agenda?

The system of multilateral negotiations is facing major problems, as experienced in both trade and climate change negotiation. But, negative externalities of activities pursued by the more

⁶¹ Voluntary contributions in 2008-2009: Total EU Member State contributions accounted for US\$ 617 million, with non-EU Member States adding a further US\$ 144 million, out of a total of US\$ 1436 million. In addition, US \$ 94 million came from the European Commission. In the Council Conclusions of 7 May 2010 (adopted in Foreign Affairs Council of 10 May 2010), EU Member States are requested to gradually move away from earmarked WHO funding towards funding its general budget.

prosperous peoples of this world cannot just be ignored. Inequities, pollution, and a scramble over natural resources, including food and energy, have negative effects for the health of all people. Pandemics are difficult to counter if governance capacities are weak.⁶² Taking global responsibility in health still seems a good way to combine a moral duty with self interest.

New types of inter regional exchanges

As an increasing number of countries around the world are shaping their health systems in new ways and ministers of health around the world are seeking to speak with their counterparts, not with development agencies. This can be clearly seen in the increasing importance placed on bilateral cooperation in health between countries, and the attendance of ministers of health at board meetings of the Global Fund, governance meetings of the World Bank, participation in meetings of the OECD, etc. There will be an increasing interest by emerging economies in European health systems – what works and what has failed. Through its work, the European office should be able to contribute constructively to such a global search for best solutions. There should also be room in the context of the European office to discuss more actively with development agencies – both on their work within the region – for example in the Asian republics - and their focus globally. The European countries must be a strong voice for good global health governance and a powerful advocate for a sustainable political and financial European commitment to global health in both its key dimensions: health security⁶³ and health equity.

⁶² House of Lords (2008), *Diseases Know No Frontiers: How effective are Intergovernmental Organisations in controlling their spread.*

⁶³ Health security refers to the first line of defence against health threats that can devastate people, societies and economies. Such public health emergencies include emerging disasters (e.g. sudden acute respiratory syndrome (SARS), avian (H5N1) influenza and pandemic (H1N1) influenza, 2009), natural disasters and large-scale accidents, conflicts, complex emergencies and health risks from the effects of climate change.

ANNEX 1 – EU ACTORS

Key actors and decision-making procedures in the EU's health policy

Within the **European Commission** the Directorate General for Health and Consumers (DG SANCO) is responsible for health policy. Its public health division with about 80 staff members is based in Brussels and partially in Luxembourg. The Commission's main tasks are to propose new legislation in the field of health and to promote coordination of national health policies.

Three **EU agencies** exist in the field of health, in addition to a small executive agency that disburses funds for health and consumer protection.⁶⁴ The European Medicines Agency (**EMA**) employs about 530 people and is based in London. It is responsible for the scientific evaluation and marketing authorization of medicines. It thereby enables the functioning of the internal market for medicines. The European Food Safety Authority (**EFSA**) is the EU risk assessment body for food and feed safety. It provides independent scientific advice to risk managers. It was established in reaction to food-related scares, such as the BSE-crisis ('mad cow disease') in 2002 and employs about 400 people. For its risk assessments it also relies on a network of about 1200 external scientific experts. The European Centre for Disease Prevention and Control (**ECDC**) was created in 2005. It is based in Stockholm and has a staff of about 300. It works to intensify the fight against communicable diseases by supplying scientific data, monitoring health risks, launching alerts, and by coordinating national alert networks, as well as national policies aimed at responding to epidemics and bioterrorist attacks.

The **EU Council**, or Council of Ministers, as it is commonly referred to is the supreme decision-making body for EU health policy. With regard to EU legislation, it has to share its powers with the European Parliament. The Council is the place where EU member states meet. It is composed of various layers. Ministers meet in the Health Council⁶⁵ that meets 2 to 4 times per year. Its meetings are prepared by the working party on health that meets much more often and is composed of health experts from the EU member states.⁶⁶ It is here, where most of the negotiations between EU member states on EU health legislation take place. As with all Council business, a senior committee composed of the deputy permanent representatives of the EU member states to the EU (COREPER I) operates as interlocutor between the working party and Council level. Most Council bodies, including the ones mentioned are chaired by the country holding the half-yearly rotating **presidency of the EU**.

⁶⁴ Executive Agency for Health and Consumers (EAHC)

⁶⁵ Officially this Council configuration is called the Employment, Social Policy, Health and Consumer Affairs Council. Health Ministers participate in its meetings if health issues are on the agenda.

⁶⁶ Usually, diplomats and attachés of the permanent representations take part in working parties. Sometimes they are replaced or seconded by civil servants from national (health) ministries.

Since the entry into force of the Lisbon treaty, the Foreign Affairs Council, where Foreign Ministers meet, is chaired by a new actor, the High **Representative of the Union for foreign affairs and security policy**. She is also vice-President of the European Commission and responsible for the consistency of EU external action, and coordinating aspects of it. Another provision is the set-up of a **European External Action Service (EEAS)**, which is composed of civil servants and diplomats from the European Commission, Council and EU member states. The EU delegations in third countries will report to the EEAS, which falls under the responsibility of the High Representative.

Within the **European Parliament** health issues are discussed within the committee on Environment, Public Health and Food Safety composed of about 60 Members of the European Parliament from different political fractions and nationalities. It has so-called co-decision powers with regard to EU legislation in the field of health. On the EU's external policies it only has advisory powers, but it has the powers of assent over international agreements when they are ratified by the EU, which means it can vote them down. The EP also approves the EU budget.

ANNEX 2 – EU FUNDING FOR HEALTH

EU = a considerable funder of health research

The EU is particularly active in the area of research. The European scale enables it to conduct broad epidemiological studies and to compare disease patterns and policies used in the different EU member states. A prominent example where EU research has made a difference is a research project on cancer that was conducted jointly with WHO in the 1990s.⁶⁷ This extensive research project demonstrated the positive effects of fruit and vegetables on certain cancers and, conversely, the devastating effects of tobacco and alcohol.⁶⁸ Another example is a smaller-scale research programme recently established to investigate the impact of marketing on children's diets.⁶⁹ The EU has also been active in the field of research into rare diseases, where research at the EU level is more appropriate given the size of the population in relation to the occurrence of the disease. Within the EU's 7th Framework Programme for Research, covering the period 2007 to 2013, health is the second largest budget item, accounting for up to 6 billion Euros.⁷⁰ The aim is to improve the health of EU citizens, to boost the competitiveness of health-related industries and businesses, and to address global health issues.

Funds for health in the regional policy

Investment in infrastructure and human resources for health, as well as improved cooperation in border regions, is included in the EU's regional funds or cohesion policy. Around € 5 billion (1.5% of the total available) from the funds is allocated to health for the period 2007-2013. The use of the funds is hampered by national health Ministries insufficiently being aware of the opportunities provided.

EU (pre-) accession funds

The WHO EURO MS that are EU candidate countries are: Croatia, FYR-Macedonia, Turkey, The WHO EURO MS that are potential candidate countries are: Albania, Bosnia & Herzegovina, Montenegro, Serbia and Iceland. Through the instrument of pre-accession assistance (IPA) funds are provided to all of these countries, except from Iceland. Funds can be used for health care sector reform, public health and plant and animal health.⁷¹

EU neighbourhood policy funds

⁶⁷ This project is known as the European Prospective Investigation into Cancer and Nutrition (EPIC).

⁶⁸ Guigner, 2009a

⁶⁹ This project is known as the Assessment of POLicy Options for MARKeting Food and Beverages to Children (PolMark).

⁷⁰ Presentation by the Directorate General for Research at the launch of the 7th Framework Programme. Available at http://ec.europa.eu/research/fp7/pdf/fp7_press_launch.pdf. The largest budget item is information and communication technologies (ICT).

⁷¹ cf. http://eur-lex.europa.eu/LexUriServ/site/en/oj/2007/l_170/l_17020070629en00010066.pdf

Health activities are included in the European Neighbourhood Policy (ENP). The WHO EURO MS covered by the ENP and the EU's Eastern Partnership are: Armenia, Azerbaijan, Belarus, Georgia, Moldova, and Ukraine. Under the main instrument the European Neighbourhood Partnership Instrument (ENPI) financial contributions can be received for measures "supporting policies to promote health, including not only measures to combat the major communicable diseases and non-communicable diseases and disorders, but also access to services and education for good health, including reproductive and infant health for girls and women".⁷² In context of the Eastern Partnership 600 million Euro is earmarked for the period 2010-2013. No adequate overviews seem to exist on how much is spend on health.

EU development cooperation funds for the health sector

WHO EURO MS that can obtain funding from the EU's Development Cooperation Instrument are: Kazakhstan, Kyrgyz Republic, Tajikistan, Turkmenistan and Uzbekistan. Health is one of the key priorities of development cooperation. EU member states channel about one-sixth of development aid through the EU. For the health sector, this figure is roughly the same.⁷³ Priorities are the fight against poverty diseases and rights for reproductive and sexual health. It is not clear how much of the funding for central Asia is for health.⁷⁴ The total amount of aid for the region is approximately €250 million per year.⁷⁵

EU Public Health programme

The second health programme that was adopted in 2007 funds projects in the period 2008-2013.⁷⁶ A total budget of 321.5 million euros is available. The objectives are:

- to improve citizen's health security
- to promote health, including the reduction of health inequities
- to generate and disseminate health information and knowledge

The priority areas and criteria for funding actions under the programme are set out each year in a work plan.⁷⁷ In addition to the EU Member States, the programme is open to the EEA countries (Iceland, Liechtenstein and Norway), and to organisations based in accession and candidate countries, European Neighbourhood and western Balkan countries, provided agreement establishing the principles for their participation have been signed with the

⁷² Cf. Regulation (EC) No 1638/2006 of the European Parliament and of the Council of 24 October 2006 laying down general provisions establishing a European Neighbourhood and Partnership Instrument: article 2:2j.

⁷³ Kates et al, 2009

⁷⁴ Cf. http://ec.europa.eu/external_relations/central_asia/rsp/07_13_en.pdf

⁷⁵ Own calculations on the basis of information provided on: http://ec.europa.eu/europeaid/where/asia/country-cooperation/index_en.htm

⁷⁶ Cf. Decision No 1350/2007/EC of the European Parliament and of the Council of 23 October 2007 establishing a second programme of Community action in the field of health (2008-2013).

⁷⁷ Cf. the Work Plan of 2010: Commission decision of 18 December 2009 on the adoption of the Work Plan for 2010 for the implementation of the second programme of Community action in the field of health (2008-2013), on the selection, award and other criteria for financial contributions to the actions of this programme and Community payment to the WHO Framework Convention on tobacco control

authorities of each country concerned. The WHO can also obtain funding from the programme.

ANNEX 3 - ACTORS ACTIVE IN THE FIELD OF HEALTH IN THE WHO EURO REGION

A vast amount of actors is active in the field of health in the WHO EURO region. Here we have made a first attempt to give an overview of the most important ones, with an exception made for the EU that was described separately in this report. The overview is by no means exhaustive and includes information on membership, core activities and funds where this information could be obtained from the internet. The overview should be considered just a first attempt which could be the starting point for a thorough analysis of the relevant players in WHO EUROs network.

Worldbank (EBRD)

In recognition of the fact that health is crucial for the (economic) development of a country, the World Bank is quite active in the field of health. In its Europe and Central Asia (ECA) region it is active in 29 WHO EURO MS, where it is involved through policy and investment lending and cross-sectoral analytical work. Other WHO EURO, like France, Germany, Italy, the Netherlands and the UK, take a more prominent role in the Executive Board of the World Bank and could therefore be considered quite influential in setting its priorities.

The extent to which the World Bank is involved in the ECA countries depends on whether the country is categorised as low-income, middle income or high-middle income country. The objective of lending operations in most countries is to modernize public health services and to support the state to allocate scarce resources based on evidence and need. The World Bank became active in the region after the collapse of the Soviet Union. Its focus was, and still is, on how to maintain a good and affordable level of health for all people during the transition process towards a market economy, with activities ranging from combating HIV, offering help to the Roma, advising of health insurance systems, etc. The most recent strategy paper of the World Bank for the ECA region dates from 2003.

According to its website the World Bank currently supports a portfolio of 24 projects (under implementation) in the Health sector in the ECA region representing US\$809.3 million.

Organisation for Economic Cooperation and Development (OECD)

The OECD's most important task is to collect health data of its 30 Member States of which 23 are also members of WHO EURO. It's Health Committee looks primarily at the economics of health systems in relation to their performance. This is perhaps not surprising when realising that OECD members spend about 8-10% of their GDP on health. It was realised that it would be useful to share these insights with non-OECD members, notably the WHO EURO Member States. A framework for co-operation to achieve this was signed in 1999. Since the OECD has strengthened its work on health policy in recent years, it seems logic to revise and update this co-operation agreement.

The OECD also provides on information on health aid. Its Development Assistance Committee (DAC)

measures, and sets out criteria for what qualifies as ODA. In addition to providing statistics, it analyses the effectiveness of aid and related issues.

Council of Europe (CoE)

Few international organisations are under so much pressure as the Council of Europe. Established after the second world war to be a bridge between East and West Europe, the organisation lost much of its relevance after the fall of the Berlin Wall. The authority of its Human Rights Court is still respected, but funding for the organisation is decreasing and some of its tasks are taken over by the EU.

Despite the decline of the CoE as such, it has so far tried to maintain activities in the field of health. On the basis of the premise that health protection is a fundamental human right, the organisation has worked on issues such as blood transfusion, transplantation, palliative care, mental health, health for vulnerable groups and good governance in health care.

Specific mentioning deserves its European Directorate for the Quality of Medicines and Health Care (EDQM); an organisation created in 1996 that closely cooperates with the European Commission and its agency EMEA, and is involved in harmonisation, regulation and quality control of medicines, blood transfusion, organ transplantation, pharmaceuticals and pharmaceutical care. It is recognised as a WHO Collaborative Centre for International Standards for Antibiotics.

Another CoE initiative is the Pompidou Group on combating drug abuse and drug trafficking. It has a membership of 35 states and organises Ministerial conference every 4 years. Cooperation between the WHO and CoE dates back to an exchange of letters in 1952.

United Nations Development Programme (UNDP)

UNDP's activities in the area of health are confined to its contributions for achieving the health-related MDGs: MDG 4 - reduce child mortality; MDG 5 - improve maternal health and MDG 6 – combat HIV/AIDS, malaria and other diseases.

UNDP is particularly concerned about combating HIV/AIDS in developing countries. It is a partner and co-sponsor of UNAIDS, and stimulates countries to: put HIV/AIDS at the centre of national development and poverty reduction strategies; build national capacity to mobilize all levels of government and civil society for a coordinated and effective response to the epidemic; and protect the rights of people living with AIDS, women, and vulnerable populations. UNDP supports these national efforts by offering knowledge, resources and best practices from around the world.

United Nations Children's Fund (UNICEF)

United Nations Children's Fund (UNICEF) was created by the UN to work with others to overcome the obstacles that poverty, violence, disease and discrimination place in a child's path. Child health is one its main concerns. It is active primarily in the Eastern part of the region.

Joint United Nations Programme on HIV/AIDS (UNAIDS)

UNAIDS is a joint venture of the United Nations family, bringing together the efforts and resources of ten UN system organisations in the AIDS response to help the world prevent new HIV infections, care for people living with HIV, and mitigate the impact of the epidemic. UNAIDS works on the ground in more than 80 countries. Eastern Europe and Central Asia are considered together because of their physical proximity and their common epidemiological characteristics. Epidemics in this region are primarily driven by transmission during injecting drug use. Coherent action on AIDS is coordinated in countries through the UN theme groups, and the joint programmes on AIDS. Cosponsors of UNAIDS

include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank.

G-8/ G-20

WHO EURO Members of the G20 are France, Germany, Italy, Russia, Turkey, the United Kingdom and the European Union. The G-20, that might replace the G-8, is the premier forum for international economic development and is composed of the world's largest economies. It promotes open and constructive discussion between industrial and emerging-market countries on key issues related to global economic stability. By contributing to the strengthening of the international financial architecture and providing opportunities for dialogue on national policies, international co-operation, and international financial institutions, the G-20 helps to support growth and development across the globe.

In previous years health was discussed in the context of G-8/G-20 meetings. It is not yet fully clear whether the issue will also receive much attention in the "new G-20". For the time being its primary focus seems to be on improving economic and financial conditions.

Shanghai Cooperation Organisation (SCO)

The SCO is a permanent intergovernmental international organisation created in 2001. In addition to China, it is composed of the WHO EURO Member States Kazakhstan, Kyrgyzstan, Russia, Tajikistan and Uzbekistan. There are 4 observer countries: India, Iran, Mongolia and Pakistan.

The SCO's main goals are strengthening mutual confidence and good-neighbourly relations among the member countries; promoting effective cooperation in politics, trade and economy, science and technology, culture as well as education, energy, transportation, tourism, environmental protection and other fields; making joint efforts to maintain and ensure peace, security and stability in the region, moving towards the establishment of a new, democratic, just and rational political and economic international order.

Although the SCO's main objectives seem to lay in the field of security and economic cooperation, in 2008 it was agreed to cooperate on health issue as well. In particular it was agreed to cooperate in the field of healthcare, to establish partnership ties among the relevant medical institutions of the SCO member states, and to taking stronger joint preventive measures to fight against infectious diseases. A Joint Statement on fighting against infectious diseases in the SCO region was adopted.

On 1 April 2009 senior officials from the health ministries of the SCO member states met to consider issues concerning the preparation of a plan of multilateral cooperation in the field of healthcare, the holding of a meeting of health ministers of the SCO member states and the possibility of creating a working group on healthcare cooperation. They also exchanged opinions over the issue of establishing interaction in prevention and fight against the spread of infectious diseases in the SCO region.

South-eastern Europe (SEE) Health Network

The SEE Health Network is a political forum set up to coordinate, implement and evaluate the commitments of the Dubrovnik Pledge and its regional projects for developing health policy and services. The Network was founded in Sofia, Bulgaria, in April 2001 by the signatories of the Dubrovnik Pledge: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Romania, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia. At its fourth meeting in May 2002, the Network was further strengthened when joined by the Republic of Moldova and three neighbouring and donor countries: Greece, Hungary and Slovenia.

The Network comprises both representatives from the ministries of health of its member countries and representatives of intergovernmental organizations. The Network operates under the auspices of the Social Cohesion Initiative of the Stability Pact. Network meetings are held twice a year and decisions are based on the agreed principles of cooperation.

The projects developed by the Network are coordinated by regional project managers and implemented by country project managers. In addition, technical advisers and other experts are connected to each project. This means that more than 150 people are involved in the Network at different political and technical levels.

The Network is supported by a secretariat run jointly by the Council of Europe and the WHO Regional Office for Europe.

International Federation of Red Cross and Red Crescent Societies (IFRC)

The IFRC coordinates the world's largest group of humanitarian organizations, providing assistance without discrimination to those in need. It comprises 186 member societies. The organisation runs a vast amount of health programmes. It operates in all countries of the region. The organisation has a comprehensive programme for the European region for the two-year period 2010-2011 for which a budget of EUR 2,251,745 is planned. With WHO EURO a partnership agreement is in place.

International Organisation for Migration (IOM)

The IOM is an intergovernmental organization focussed on the humane management of migration and supporting international cooperation on this issue. It aims to promote migrants' health, also in the European region. With the WHO a partnership agreement is in place.

Public Private Partnerships (PPPs) and partnership of public organisations

The Global Fund To Fight AIDS, Tuberculosis and Malaria (GFATM)

The Global Fund is a public/private partnership dedicated to attracting and disbursing resources to prevent and treat HIV/AIDS, tuberculosis and malaria. This partnership between governments, civil society, the private sector and affected communities represents a new approach to international health financing. The Global Fund works in close collaboration with other bilateral and multilateral organisations like the WHO to supplement existing efforts dealing with the three diseases.

Since its creation in 2002, the Global Fund has become the main source of finance for programmes to fight AIDS, tuberculosis and malaria, with approved funding of US\$ 18.7 billion for more than 572 programs in 140 countries. It provides a quarter of all international financing for AIDS globally, two-thirds for tuberculosis and three quarters for malaria. The Global Fund employs about 335 staff, who work at the Secretariat's headquarters in Geneva.

Global Fund financing is enabling countries to strengthen health systems by, for example, making improvements to infrastructure and providing training to those who deliver services.

International Health Partnership

The *International Health Partnership+* aims at coordinating the activities of all relevant donor organisations. It is a flexible mechanism to put the principles on good donor behaviour and coordination enshrined in the Paris Declaration into practice at the country level.

GAVI (formerly the Global Alliance for Vaccines and Immunisation)

The GAVI alliance was established in 2000 and is composed of National Governments, UNICEF, WHO, the World Bank, the Gates Foundation, the vaccine industry, research and technical health institutions, and civil society organisations.

GAVI's mission is to save lives and improve health by increasing access to immunisation in poor countries through the raising and disbursement of funds for the purpose. By the end of 2007, GAVI had received funds and long-term pledges from donors exceeding \$ 7.5 billion. WHO estimated that in the first seven years of its existence GAVI has averted 2.9 million future deaths.

As part of its drive to find new ways of raising and disbursing funds for immunisation, GAVI has helped to develop the International Finance Facility for Immunisation (IFFIm) and Advance Market Commitments (AMCs). With the former, donor countries make 10-20 year, legally-binding aid commitments, against which IFFIm borrows on capital markets. AMCs are mechanisms to attract private sector investment into new vaccine products for poor countries by guaranteeing purchase volumes at agreed prices over time.

European Observatory on Health Systems and Policies

The observatory supports evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe. It is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Norway, Slovenia, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. Headquartered in Brussels its web site provides analyses of health systems in 53 WHO European Region countries and others.

UNITAID

UNITAID is an international drug purchasing facility funded by a wide range of agencies and public private partnerships and headquartered in Geneva. It is aimed at providing long term sustainable and predictable funding for purchase of drugs for HIV/AIDS, malaria and tuberculosis in resource poor countries. Its website provides news and updates.

Others

In addition, there are many other public-private partnerships and partnerships of public organisations active in the region, such as the Drugs for Neglected Diseases Initiative (DNDI), International AIDS Vaccine Initiative (IAVI), Medicine for Malaria Venture (MMV), Roll Back Malaria Partnership, Stop TB Partnership and UNITAID (International Drug Purchase Facility)

Foundations active in Europe

Various private foundation are engaged in health projects in the WHO EURO region. Here we describe briefly the Gates Foundation, but it is important to reiterate that there are many other foundations active in the European region, such as for instance the Calouste Galbenkian Foundation, the King Baudoin Foundation, the Volkswagen Stiftung, the AIDS Foundation East-West, the World Heart Federation and the Open Society Institute.

The Bill and Melinda Gates Foundation

The Gates Foundation was established in 2000 and is composed of three programmes: Global Development, Global Health, and United States. The mission of its health programme is to encourage the development of life-saving medical advances and to help ensure they reach the people who are

disproportionately affected. It focuses its funding on two main areas: (1) access to existing vaccines, drugs and other tools to fight diseases common in developing countries, and (2) research to develop health solutions that are effective, affordable and practical. The importance of The Gates Foundation in the global health landscape stems, in particular, from the scale of funds it makes available for investment. For the year ended December 2007, grants paid for the global health programme totalled around \$916m out of a total of some \$2 billion across all programme areas. As at 31 March 2008, the Foundation had around 540 employees and supported work in more than 100 countries. The Gates seems somewhat less active in the WHO EURO region than it is in other regions of the world, such as Sub-Saharan Africa and Latin America.

Development aid agencies

A number of development agencies of EU member states is active in countries of the European region, as well as USAID. Examples include SIDA, DFID, and Europeaid.

Health care industry

Private companies and their federations are important players in the area of health. Within the European Region the European Federation of Pharmaceutical Industries and Associations (EFPIA) and its members, such as GlaxoSmithKline and Novartis stand out.

Development and health non-governmental organisations

There are a great number of such organisations. Important examples include Oxfam, the European Public Health Alliance, and Médecines Sans Frontières

Table : State of the art collaboration with key partners in the WHO European Region

Partner institution	Main collaborator within partner institution	Key areas of collaboration	Mechanisms of collaboration
European Union			
European Commission	DG-SANCO Collaboration with other DGs, i.e. Research, Environment, Europeaid	<ul style="list-style-type: none"> - Human resources - Access to medicines - Tobacco Control - Response to health threats - Obesity and physical activity - And others 	<ul style="list-style-type: none"> - Exchange of letter (2001) - High level dialogue between senior officials - Joint programme of work - European Observatory on Health Systems and Policies - South Eastern Europe health network - International Health Regulation - Framework Convention for Tobacco Control - Country cooperation
Other health related EU institutions ECDC EMEA, EFSA, EEA, EMCDDA, ECSA and OHSA	Senior management and technical level	<ul style="list-style-type: none"> - In all relevant areas - Example ECDC: - Surveillance and development of a single European reporting system, and coordination of joint responses to health threats - Implementation of the IHR - Technical areas: airborne diseases, vaccine preventable diseases, sexually transmitted and blood-borne diseases, environmental diseases, anti-microbiological resistance and nosocomial infection, travel-related health issues 	<ul style="list-style-type: none"> - Example ECDC: Memorandum of Understanding (2005) - Joint Coordination Group - Annual collaboration plan - Exchange/secondment of staff - Development of joint methodology and assessment tools - Joint field visits
EU Presidency		<ul style="list-style-type: none"> - Number of technical areas dependant on the priority of the Presidency 	<ul style="list-style-type: none"> - Joint events, advocacy
Intergovernmental Organizations			

Council of Europe	Health Committee of the Council Secretariat (CDSP), European Directorate for the Quality of Medicines and Health Care (EDQM)	<ul style="list-style-type: none"> - Health information and health promotion - A large number of technical areas 	<ul style="list-style-type: none"> - Exchange of letters (2001) - Joint programmes including Health Promoting Schools and South Eastern Europe network - Expert Committee Membership
World Bank	Health Sector Lead for Europe and Asia Region	<ul style="list-style-type: none"> - All health system related areas including health accounts - Influenza and pandemic preparedness, road safety, food safety at country level - Focus at country level 	<ul style="list-style-type: none"> - Collaborative projects - European Observatory on Health Systems and Policies - GAVI joint regional working group
OECD	Directorate for Employment, Labour and Social Affairs, Health Div.	<ul style="list-style-type: none"> - Health systems in OECD countries - Health data in OECD countries - Environment and health 	<ul style="list-style-type: none"> - Exchange of letters (1999) - Collaborative projects
IOM	All levels	<ul style="list-style-type: none"> - Migrants health 	<ul style="list-style-type: none"> - MoU at global level 2005 - Joint projects, input to publications
Northern Dimension	All levels	<ul style="list-style-type: none"> - Various public health issues 	<ul style="list-style-type: none"> - Strategic exchange, hosting of events, joint projects
Shanghai Cooperation Organisation (SCO)			
G 20	High level	<ul style="list-style-type: none"> - High level advocacy on relevant topics 	<ul style="list-style-type: none"> - Advocacy
United Nations			
UNICEF	Technical Staff members and members of the IAG	<ul style="list-style-type: none"> - Infant feeding and nutrition - Child and adolescent health - Humanitarian assistance - Information, publication and advocacy strategies 	<ul style="list-style-type: none"> - UN Interagency Group on Young People's Health (IAG) - GAVI Joint regional working Group - Joint missions - Joint training - Coordination meetings - Joint media events
UNAIDS	Collaboration at all levels of the organization	<ul style="list-style-type: none"> - Recommendations on HIV/AIDS prevention and control - HIV/AIDS Statistics - Declarations 	<ul style="list-style-type: none"> - Joint publications - High level dialogue - Programmatic collaboration
UNDP	UNDP country representatives	<ul style="list-style-type: none"> - UN Millennium Development Goals - Health and Development Statistics 	<ul style="list-style-type: none"> - Country based UN coordination platforms - Joint publications

UNFPA	Regional and country level	Regional Joint project “The European Magazine for Sexual and Reproductive Health – Entre Nous; school health services, human rights based policy review on young people’s access to health services, maternal mortality and morbidity audit	- Joint programmes/projects
UNODC	Regional and country level technical collaboration	Prison Health, Harm Reduction	- Joint programmes/projects
UNECE	Regional level technical collaboration	Secretariat to the Task Force on Health of the Convention on Long Range Transboundary Air Pollution; joint administration of Health and Environment Pan European Programme (The PEP); Co-Secretariat of Protocol on Water and Health; health statistics/data harmonization and exchange	- Joint programmes/projects
UNEP	Technical collaboration	Health-related aspects of Barcelona Convention	- Joint programmes/projects
UNHCR	Technical collaboration at country level	Refugee health	- Joint programmes/projects
FAO	Technical collaboration	Codex Alimentarius; food safety	
ILO	Technical collaboration	Occupational health at regional and country level	
IAEA	Technical collaboration	Programme of Action for Cancer Therapy	- Collaborative projects
World Bank	Health Sector Lead for Europe and Asia Region	<ul style="list-style-type: none"> - All health system related areas including health accounts - Influenza and pandemic preparedness, road safety, food safety at country level - Focus at country level 	<ul style="list-style-type: none"> - Collaborative projects - European Observatory on Health Systems and Policies - GAVI joint regional working group
Public private partnerships /Global Health Partnerships			

GAVI	GAVI secretariat and technical staff	<ul style="list-style-type: none"> - Vaccine preventable diseases - Health Systems 	<ul style="list-style-type: none"> - Technical support to countries in application development, implementation and evaluation,; support to multi-year planning processes in all GAVI countries; liaison with GAVI and technical guidance. - Joint regional GAVI working group with UNICEF and WB.
Global Fund (GFATM)	Global Fund secretariat	<ul style="list-style-type: none"> - AIDS, Tuberculosis, Malaria, Health Systems 	<ul style="list-style-type: none"> - Technical support in application development, implementation and evaluation of grants; liaison with GFATM and technical exchange and guidance to GFATM
UNITAID		<ul style="list-style-type: none"> - AIDS, TUB and Malaria medicines 	
International Health Partnership (IHP+)	WHO HQ and World Bank joint secretariat of IHP	Donor coordination. None of the EURO Member States has signed up for IHP+ yet. Tajikistan may in the future	<ul style="list-style-type: none"> - Joint secretariat function of WHO HQ and World Bank
Non-government partners			
IFRC	Euro Zone Office in Budapest, HQ in Geneva	TB, Blood Safety, Emergencies, Social Determinants of Health and others	<ul style="list-style-type: none"> - Global and Regional MoU
International Committee of the Red Cross (ICRC)	Technical level	<ul style="list-style-type: none"> - Health in Prisons 	
Rotary	All levels	<ul style="list-style-type: none"> - Polio 	<ul style="list-style-type: none"> - Joint projects, advocacy
SOROS	All levels		<ul style="list-style-type: none"> - Projects
Gates Foundation	Via WHO HQ, Gates Foundation	<ul style="list-style-type: none"> - Communicable diseases 	<ul style="list-style-type: none"> - Projects
AIDS Foundation East West	Technical level	<ul style="list-style-type: none"> - HIV/AIDS, Harm reduction, Health in Prisons 	<ul style="list-style-type: none"> - Joint projects and advocacy
South Eastern European Health	All levels	<ul style="list-style-type: none"> - Communicable diseases - NCDs, Mental Health - Blood safety 	<ul style="list-style-type: none"> - The Council of Europe and EURO co-hosted the SEE's secretariat until 2009 - Joint projects and advocacy

Network			
European Forum of National Nursing and Midwifery Associations and WHO	All evels	- Nursing	- Joint projects and advocacy

Note: WHO Regional Office for Europe also works with a large number of international, regional and national NGOs