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Governance of health in the WHO European Region

The WHO Regional Office for Europe has raised this topic in a number of documents over recent years. Broadly speaking, there are two aspects to governance of health: the international and the national dimension. At its fifty-eighth session, the Regional Committee extensively debated what Member States could do to strengthen the role and impact of health authorities, and in particular of ministries of health. Health systems are evolving and leading to new roles and responsibilities for governments in strengthening health and health systems at national and supranational levels. There are increasing numbers of mechanisms, strategies and tools at the disposal of Member States for achieving their health policy objectives.

At the international level, too, the governance of health is a critical element for the future of health in the WHO European Region. In that context, it is important to discuss the evolving role of the Regional Office, as part of one global WHO and in the context of relationships with WHO headquarters in Geneva and important ongoing activities with the European Union, the Organisation for Economic Co-operation and Development, and many other players such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the European Centre for Disease Prevention and Control. The debates at the current session of the Regional Committee will be shaped around the following questions: What role to be played by the Regional Office would be most beneficial for its Member States? How can the Regional Office best provide guidance, support and inspiration to Member States in this evolving governance scenario of globalization, international crisis and aspirations of equity? How can partnership with other international players be built up, in order to strive for "the attainment of the highest possible level of health" in the WHO European Region? Which organizational arrangements could help the Regional Office achieve these goals in a most efficient manner?

Discussion on this topic will be a two-stage process. The first stage of analysis and elaboration of proposals for the improvement of governance mechanisms will take place at the current session of the Regional Committee. Any decisions on such proposals could be taken by the Regional Committee at its sixtieth session next year, when the new Regional Director will be in post. There is accordingly no draft resolution for consideration by the Regional Committee at this stage.

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Introduction

1. How is health governed in the WHO European Region? To what extent are Member States responsible and accountable for the health of their populations? What processes do Member States want to follow in their health-related decision-making? The central thesis of this document is that WHO has an important role to play in supporting health governance in countries, but what roles would Member States prefer WHO (and other institutions) to play in support of their health-governing activities? What is the role of the International Health Regulations compared to other national and supranational regulations? Ideally, in order to answer these and similar questions, this paper should address: (i) the entire picture of the governance of health in Europe; (ii) the existing evidence on the consequences of such governance on the health of the European population; and (iii) the specific contribution of the WHO Regional Office and of other international organizations. Unfortunately those intentions exceed the scope of this paper and would also far exceed the existing evidence.

2. Discussions on governance within the health sector reflect recent wider academic, research and policy debates on the new constraints and challenges faced by modern states and on how the relationships between the state and society have evolved *(1,2,3,4)*. In response to such constraints and challenges, countries and supranational organizations have developed imaginative ways of promoting good governance *(5,6,7,8)*.

3. Although governance and stewardship – one of the four health system functions outlined in *The world health report 2000* – are not the same, they were taken as synonymous in the health field by the WHO Regional Committee for Europe at its fifty-eighth session, based on the arguments of those who found the latter term and its translation problematic. Governance was originally defined by the United Nations Development Programme as "the exercise of political, economic and administrative authority in the management of a country's affairs at all levels" *(6)*. Stewardship, in turn, had been defined as a "function of government responsible for the welfare of the population, concerned with the trust and legitimacy with which its activities are viewed by the citizenry" and more recently as "the role of the government in health and its relation to other actors whose activities impact on health" *(9)*.

4. Originally, governance and the stewardship function were mostly understood as catalysts for other health system functions. Governance was important because it was thought to modulate the interest of stakeholders and improve the performance of service production, financing and input generation. It was also seen as a mechanism to regulate the interactions between different parts of the system and different stakeholders in a context of transparency and accountability *(10)*. Recent research, however, is reaching beyond these explanations to formulate a direct relationship with health gain and other health system results such as responsiveness, financial protection and efficiency. This focus on the links between improved governance and the main outcomes of health systems connects directly with the Tallinn Conference on Health Systems, Health and Wealth *(11)*.

5. However, as is well known, health gain can be measured in terms of both levels and distribution. In relation to levels of health, a positive correlation has been found between good governance and better population health, and between good governance and lower infant mortality *(12)* but, as data from the European Region reveals, the situation is more complex in relation to health distribution. Despite clear improvements in indicators such as average life expectancy at birth and disability-adjusted life expectancy over the last few decades, enormous differences remain when data are broken down by strata *(13)*. Differences between social groups, between countries, between regions inside countries and between cities (and even neighbourhoods) exist in Europe, both inside and outside the European Union (EU), its richest club of countries. Worryingly, inter- and intra-Member State disparities are growing. Why are

health inequities such a "wicked problem" *(14)* and why are they so hard to overcome? Most of all, how are inequities related to governance? A deeper understanding of the topic is needed if effective action is to be launched.

6. Governance of health is therefore a critical element for the future of health in the WHO European Region – indeed in any society. That is why, in recent years, the Regional Office has produced a number of documents expressing commitment in the area of governance of health and of the health system:

- The future of the WHO Regional Office for Europe (EUR/RC56/11);
- The Health for All policy framework for the WHO European Region: 2005 update (EUR/RC55/8);
- declarations and charters, many endorsed by Regional Committee resolutions, setting the direction and laying out the strategies in various thematic areas: (the Budapest Declaration on environment and health, 2004 (EUR/RC54/R3); the Mental Health Declaration for Europe: Facing the Challenges, Building Solutions, 2005 (EUR/RC55/R2); the Warsaw Declaration for a Tobacco-free Europe, 2002 (EUR/RC52/R12); the Declaration on Young People and Alcohol, 2001 (EUR/RC51/R4); the European Charter on Counteracting Obesity, 2006 (EUR/RC57/R4); the Berlin Declaration on Tuberculosis, 2007; and the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia, 2004;
- The Tallinn Charter: Health Systems for Health and Wealth, 2008; and
- Stewardship/governance of health systems in the European Region (EUR/RC58/9) and the subsequent Regional Committee resolution (EUR/RC58/R4).

7. Other recent Regional Office publications have also addressed these topics from a theoretical perspective *(15)*. The Health in All Policies framework promoted by the EU during the Finnish presidency of the EU Council and endorsed by Member States at the joint WHO-EU meeting in Rome in 2007 *(16)* also emphasized the importance of good governance of intersectoral action for health, as did the Tallinn Charter on Health Systems, Health and Wealth, signed by a number of partners under the leadership of WHO.

8. This paper on governance of health in the WHO European Region should be seen as a general overview of key aspects and issues related to the topic, which are further illustrated and supported by specific area-related papers that will also be discussed at the current session of the Regional Committee, namely:

- Health in times of global economic crisis: Implications for the WHO European Region;
- Implementation of the International Health Regulations (2005) in the WHO European Region; and
- Health workforce policies in the WHO European Region.

9. This document will first analyse health governance from the policy theory perspective and apply that analysis to the role of the Regional Office, before proposing for consideration a set of recommendations and suggested specific changes in the Region. It will therefore consist of two main sections: (i) a brief theoretical review of governance of health in Member States and at supranational level; and (ii) an assessment of the governance of the WHO Regional Office.

10. Given the above-mentioned extensive and recent discussions within the Region, this document will adopt a mix of a (mainly) descriptive/analytical approach ("how things are") and a (less so) prescriptive approach ("how things should be"). It has been reviewed by the Standing Committee of the Regional Committee and is now being presented to the Regional Committee

at its fifty-ninth session. The document will be debated at the session in September 2009, although no conclusive decisions will be taken at that stage. The decisions on the recommendations made by the Regional Committee this year will be taken at its sixtieth session in Moscow in 2010.

Policy theory issues related to the governance of health in Member States and at supranational level

11. The concept of governance was originally developed by several social disciplines, mainly political science, organizational theory and economics *(17)*. It has consequently taken on different meanings, eventually becoming an umbrella concept that includes different phenomena. Many authors *(18)* give governance three meanings: (i) a theory that helps policy analysts understand new developments in the relationships between state and society; (ii) a dynamic outcome: the complex processes of steering, coordinating and goal-setting by means of which society is governed nowadays; and (iii) a structure: that is, the mixed system of hierarchies, markets, networks and communities involved in the delivery of broad services to citizens in modern society.

12. Do European Member States see the governance of health as an exclusive right and/or obligation or do they want to share it with the international community? And do they see governance of health more in terms of theory, processes or structures, or a combination of them? If understood as a theory, it is important to ascertain how health is governed in the WHO European Region: what roles and responsibilities do Member States really have and want to have in health and health systems governance at national and supranational levels? What, in their opinion, are the genuine roles of the state and of individual responsibility? As indicated, this paper and other publications already mentioned provide abundant material for addressing the topic in political terms but there is, as yet, little empirical evidence.

13. Taking governance as the dynamic process of steering and coordinating health policy, one first issue would be whether or not governments alone are able to improve the health of the population as traditionally understood. In fact, public opinion, the media and many national policy-makers most often ascribe to the government in general, and to the ministry of health and its leading team in particular, the health results of the country (and call for their resignation whenever a serious problem occurs in that sphere). A related, more nuanced question being asked is whether the overall power of government to lead and control the health policy process remains unrestricted or is being eroded by new social forces – and, in that case, how deep such erosion has been.

14. The answers to the questions above have different dimensions. First, even at national level, the very understanding of the determinants of health – genetics, the physical and social environment, behavioural aspects and health care, etc. *(19,20)* – would challenge a restrictive concept of governance of health in Member States and at supranational level; science and experience show that health is produced with the broad involvement of multiple public and private actors in other sectors (e.g. education, housing, employment, agriculture). A recent study confirms that indicators related to health care can explain between 44% and 57% of the variance in life expectancy as a measure of health, the rest being attributable to nonmedical determinants of health *(21)*. Also, no single country can be considered these days to be “fully responsible” for the health of its people, given the complexities of globalization *(22)*. States and the private sector at national and international levels have been and remain involved in complex health system reforms all over the world.

15. At a normative level, discussion of the role of Member States in health governance then turns to asking whether or not that role should shift towards steering and coordinating the contributions of multiple actors, rather than trying to monopolize interventions and strategies. Indeed, the doctrine of WHO has always been one of multisectorality, an idea now shared by many other stakeholders: see, for example, *Health Impact Assessment (23)* and the Health in All Policies declaration mentioned above. The same principle underlines the definition of a health system given by the Tallinn Conference.[1] Calls to governments to take the interests, opinions and expectations of stakeholders into account and, in particular, to make health systems more responsive to the voice and choice of citizens and the knowledge of health professionals are now widespread.

16. If governance is understood not as a theory or as a process but as a structure (hierarchies, markets, networks and communities), the question "What are Member States actually responsible for?" acquires a new light. Governments in Europe and throughout the world are working through different models, some involving direct hierarchical interventions whereas others rely comparatively more on market forces, public-private partnerships, etc. In that context, the mechanisms and strategies used by governments to achieve their health policy objectives have evolved to the extent that many commentators now refer to governance as "a range of old and new tools and instruments through which public policy goals may be delivered" *(24,25,26)*. Generating a coherent regulatory framework to ensure both the quality of services and the fair behaviour of the actors involved, as well as deciding whether this should be done through direct top-down regulation or by means of regulatory tools – including delegation of authority, incentives and sanctions – are therefore crucial components of stewardship. From this perspective, the challenge would be to achieve the right balance of incentives, targets and sanctions, and hence the deployment of old and new regulatory mechanisms, ranging from direct regulation by government to regulation by wholly or partially independent ("arm's length") bodies, self-regulation, co-regulation, etc. *(27)*.

17. A final related issue is how accountability is established so that the different actors – and indeed the State itself – are held accountable for their actions in a number of dimensions – financial, performance and political/democratic *(28)*. In summary, good governance of modern health systems requires that actors render account for processes and procedures as much as for results, outcomes and financial compliance *(29)*. Establishing "clear loci of responsibility, enough information and appropriate sanctions" *(30)* in this highly complex scenario with multiple ramified decisions and numerous agents is a critical challenge. In principle, the above should also apply in some way to the international governance of health.

18. The duty of international governance of health is most often ascribed only to the existing, purpose-built international agencies, but it has recently been proposed that the health stewardship function of governments could also be exercised at transnational level through assistance to other states in need or through any leadership in global health issues *(31)*. Could this mean that some international agencies might have a rather superficial kind of relationship whereas other agencies would have "deeper links"? A distinction could also be made between different supranational bodies in their relations with health; while some supranational organizations (e.g. the United Nations and the Organisation for Economic Co-operation and Development) have a mostly representational role and a moral/ethical influence on health, others do make governance decisions in areas with a clear direct and indirect potential impact on health. For example, European bodies (the EU and other institutions, including the European Commission (EC) and the Presidency of the Council of the EU) play a substantive role in

[1] "Within the political and institutional framework of each country, a health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health" *(11)*.

health, not only through their health systems (which within the EU are the primary responsibility of the 27 EU Member States, based on the principle of subsidiarity) but also through their action in areas that in turn affect health such as agriculture, trade and monetary policy.

19. Clearly, not enough is known about the impact of these policy dimensions on the health of EU citizens. It would be desirable to assess how national and supranational dimensions supplement each other in the pursuit of health and other health system goals such as financial protection or responsiveness. Studies of the experience of the recent EU enlargement could provide valuable lessons to the entire Region regarding the success or failure of particular policies (e.g. nutrition, environment). WHO could, for instance, carefully advocate the desirability of a systematic appraisal of such recent health policy developments at EC level, or participate in the follow-up to the Directive on cross-border health care.

20. Similar considerations apply to the work on health of the Commonwealth of Independent States (CIS) Council. The CIS Council has a comparatively lighter remit than that of the EU, but it would still be worth exploring the precise role it plays in the field of health and the impact on health of its common policies, and whether or not any assessment of that impact has been made. This paper does not address country membership of any other supranational group with a distinctive mandate other than health, although the very existence of subregional geographical groupings such as those involving the Baltic, Scandinavian, Balkan or Caucasian countries raises interesting challenges: in these countries, there already are institutions (such as the Nordic Council) exercising responsibility for sectors that influence the health of their citizens. Another example is the Shanghai Cooperation Organisation, where the Russian Federation cooperates with the central Asian countries and China on a wide range of issues, including public health. In practice, therefore, subregionalism is considered in this paper as neutral in terms of any specific effect on health.

21. As a final reflection, although substantial progress has been reported recently *(32)*, efforts to measure and assess governance at national and international levels are only in their early stages *(33)*. More work is clearly needed. Better understanding of, and an effort to express in both quantitative and qualitative terms, the relationships between health system functions and health system objectives have also, to a large extent, been the objective of the discussions since the Tallinn Conference. The governance perspective therefore gives a new dimension to the debate on health system performance indicators *(34,35)*.

Governance of the WHO Regional Office for Europe: an assessment

22. The policy questions this paper should address are: (i) is the current governance of health in the WHO European Region optimal? (ii) are there potential inefficiencies in the Regional Office that may erode its impact? and (iii) could better arrangements of all kinds improve results? In the absence of hard data measuring both the detailed role that Member States would prefer WHO to play and the effect of WHO's action, this section will mostly analyse the way in which the WHO Regional Office for Europe is governed.

23. WHO's influence does not derive from its involvement in any particular aspect of social or economic life such as agricultural, fiscal or trade policy (as is the case with the EU), but rather from its mandate as the specialized technical agency of the United Nations in the field of health. WHO is an intergovernmental organization to which Member States turn in search for guidance (norms and advice), support and inspiration in every health-related aspect of life. In short, its influence derives from its authority in leading Member States towards "the attainment of the highest possible level of health" *(36)*.

24. It is worth noting that WHO is the only United Nations agency with a highly decentralized structure: each of the six WHO regions has a "sovereign" Regional Committee and an elected Regional Director who is held accountable to it – an arrangement generally recognized as being an asset for the Organization, owing to the democratic impetus and closeness to the field that it gives. The WHO Regional Committee for Europe, the highest governance body of WHO in the European Region, is made up of representatives of each European Member State; it meets in September every year for three and a half days at sessions where the Member States formulate regional policies, make recommendations and oversee the work of the WHO Regional Office. The Regional Committee also considers the budget, and any views, comments and suggestions are subsequently conveyed to the Director-General for consideration during its finalization prior to approval by the World Health Assembly.

25. Any analysis of WHO governance at regional level has to be made in the context of the Organization's global governance mechanisms and institutions. For more than 60 years, the World Health Assembly, the Executive Board, the WHO Director-General and arrangements at WHO headquarters, as well as the corresponding policies and tools (the WHO Constitution, rules, standards, codes of conduct and the Global Programme of Work – GPW) have been key references for governance in the European Region. Recent decades have witnessed renewed efforts towards the objective of "One WHO". The current Director-General, Dr Margaret Chan, has put the task of improving coordinated efforts with the six regional directors at the forefront of her political action. Her recent political statements, in particular, leave no doubt as to "One WHO" being her main objective and the guiding principle that should help to overcome perceived and/or existing challenges arising from WHO's decentralized structure, as defined by its Constitution. Reciprocally, the European Region and all other regions participate in the life of the Organization at central level and fully endorse this coordinated approach.

26. The above defines the political legitimacy of the Regional Committee for Europe. Two pertinent additional policy questions to be addressed would be, first, the representational capacity of the Regional Committee and, second, its effectiveness.

27. Concerning representational capacity, there can be no doubt about Member States' interest in participating in the Regional Committee for Europe or about the quality of such participation. Sessions of the Regional Committee have taken place every year since WHO was founded, with negligible absence rates, without interruptions and without any major incident. A review of the participants also shows consistency in terms of high-level participation as an indicator of interest. The proportion of ministers of health leading their respective country delegation and attending at least part of the session in the past 10 years, for example, has been on average 38%. Member States, are by definition, entitled to raise any issues they deem of interest during Regional Committee sessions. Overall, the format of the sessions seems to meet the Member States' expectations of a totally free and frank debate, judging by the role played by their representatives and their positive contributions. Efforts have also been made in recent years to improve the level of participation: sessions have become more dynamic (shorter, sharper, with changed organization, etc.) and there are clear signals that Member States are becoming more involved. A more systematic approach would be needed to ascertain the effectiveness of the Regional Committee in recent years and to explore formats and mechanisms that could promote an even more participatory approach, e.g. give Member States more scope to suggest topics for discussion, or prepare specific presentations on selected topics in advance.

28. Concerning effectiveness, for an institution like the Regional Committee, effectiveness should be measured essentially by its ability to set the right vision and provide the right directions, in terms both of political leadership and of addressing critically important public health issues. This is in line with its mandate as the foremost governance body in the Region, rather than a club, academic forum or similar type of institution. From this point of view, effectiveness could be expressed in the number of resolutions adopted (ranging from 5 to 12 per

session, with an average of 8.4 over the past 10 years), the close links between these resolutions and global ones adopted during the annual World Health Assembly (see Annex 1), etc. It is worth mentioning the effort made by the Regional Committee at its fifty-eighth session to review the process of reporting back on resolutions adopted at previous sessions and to address the open-ended nature of a number of resolutions; this resulted in a requirement that all future resolutions should include a clearly defined reporting time-frame.

29. A review of the programmes of the last 10 Regional Committee sessions reveals a clear effort to combine discussions of the most pressing political issues of the day with consideration of "hot" technical matters. The involvement of Member States in running their own health systems (Strengthening European health systems as a continuation of the WHO Regional Office for Europe's Country Strategy), the need to improve equity in health in the Region (Millennium Development Goals), the values embodied in regional action (review of the Health for All policy) and several other issues belong in the first category. Similarly, the discussions on environmental policies, noncommunicable diseases, the health system stewardship function, or review of the situation regarding tuberculosis in the European Region are just a few examples of the latter.

30. Another crucial institution in the governance of the Region is the Standing Committee of the Regional Committee (SCRC). By explicit agreement, the WHO European Region has, since 1993, been governed, during periods between Regional Committee sessions, by the SCRC, a body made up of a chairperson and nine other representatives of Member States elected for that purpose by the Regional Committee, who meet five or six times (and no less than twice) per year (resolution EUR/RC42/R5, 1993). The SCRC is in charge of ongoing governance of the Organization, in close coordination with the Regional Director, and acts as a bridge between the Regional Committee and the Regional Office. It has a dual role of representing the Regional Committee between its annual sessions and of advising and counselling the Regional Office and the Regional Director by transmitting the views of Member States to the Secretariat.

31. In practice, all decisions submitted to the Regional Committee have been reviewed and approved beforehand by the SCRC *(37)*. The SCRC appears to be a cost-effective governance mechanism for leading the Organization. Although it has no decision-making powers, the SCRC helps to guide policy and programme development within the Region, and it seems to have been properly involved in generating the strategic decisions taken by the Regional Committee.

32. The Regional Director is, ex officio, the Secretary of the Regional Committee and of any subdivision of it, including the SCRC *(38)*. In practice, the entire Regional Office is understood to be "the Regional Committee Secretariat". Last year, for the first time, the Secretariat addressed Member States with a survey asking for their explicit opinions and expectations regarding cooperation with WHO. The response rate was 62%. It seems that, in general, Member States are positive about the way the Secretariat plays its role (around 85% of respondents). The suggestions for improvements mainly concern the areas of implementation of key values in practice, collaboration with other agencies, country office work, media and communication issues, specific public health areas, health systems and some other aspects (for a summary of the survey findings, see Annex 2).

33. Regional subcommittees are also relevant in the governance of the Region. According to the rules of procedure of the Regional Committee and the SCRC, both committees are supported in their action by a number of subcommittees (e.g. on environment and health, the Regional Search Group, and other ad hoc committees) that may be established "for the study of, and report on, any item on its agenda". The rules provide for no precise numbers or categories of such subcommittees and their status is fully dependent on Regional Committee and SCRC decisions.

34. Experience in recent years suggests the need for some systematic review of the results obtained by regional subcommittees and of their links with the SCRC and the Regional Committee. One relevant issue is whether the reporting lines are adequate. For example, the environment and health subcommittee does not report to the SCRC but rather directly to the Regional Committee, which somehow goes against the very nature of the SCRC; is this the best possible arrangement? Also, some subcommittees seem to have extended their existence over an extremely long period; should they rather have a well-specified duration, as resolutions do? In the case of other subcommittees (e.g. the Regional Search Group for candidates for the post of Regional Director), there is arguably not much room for action without either infringing the rights of the potential candidates or unnecessarily increasing bureaucracy in the democratic process. The SCRC also has the function of drawing up shortlists for the elections to various committees; how useful this is may also be discussed. In short, attention should be paid to elucidating the role of regional subcommittees in the future.

35. Another area that requires attention is that of the links between the Executive Board of WHO at global level and the work of the Regional Committee and the SCRC. The SCRC includes one representative of the European Executive Board members with observer status. The European Region currently has 8 representatives appointed to the WHO Executive Board, of a total of 34 members. It could be assumed that the concerns of the Regional Committee for Europe would be brought by those representatives to the Executive Board, and that the concerns of the Board would, in turn, be brought to the SCRC. However, while this seems to work well with the SCRC, it is not fully clear whether the European Executive Board members have the responsibility of putting the regional perspective and interests above other possible perspectives and interests when speaking at sessions of the Board, i.e. whether and with what degree of accuracy the Regional Committee for Europe and global Executive Board agendas are linked with each other through common European Executive Board and SCRC members.

36. Similarly, there is no legal doctrine or specification concerning whether European Executive Board members are supposed to represent the (fully legitimate) opinions of their Member States or the opinion of the Region, should one exist in that regard. Notwithstanding the right of individual members to defend their personal views and the perspective and interests of the Member States they represent, it seems that transparent mechanisms are needed to better ensure that the regional point of view is expressed whenever appropriate. In summary, it would be advisable to have more explicit coordination mechanisms with Executive Board members to ensure that they convey the European Region’s perspective.

37. Along similar lines, the emphasis given by the Regional Committee in recent years to efficient and value-adding partnerships raises additional questions. Attention must be paid to the way in which Member States in the European Region that also belong to other supranational agencies express their positions in the context of the Board and the Health Assembly and in other fora in general. This most notably concerns the EU, which shares 27 of the 53 members in the WHO European Region: for example, in discussions on “The future of the WHO Regional Office for Europe” at its fifty-sixth session, the Regional Committee identified the EU as a uniquely important partner. Specific coordination mechanisms with the EU exist, and the Regional Committee is regularly informed about them. Since it is not uncommon to have the EU as an institution speaking at sessions of the Executive Board through one or more Member States, careful analysis is required of possible options and their repercussions in terms of governance. In particular, careful coordination with non-EU members is advisable.

Issues and recommendations

38. What are the preferences of Member States regarding the governance of health in the European Region? What can be done to improve governance at country and international levels as well as within the Regional Office for Europe? It is expected that a better picture will emerge in the coming months after an eminently political debate. In the meantime, both content and process issues concerning general matters as well as Regional Office specifics will be addressed in this list of recommendations for the SCRC and the Regional Committee to consider. National specifics are critical but they will not be discussed (unless Member States would decide to share this information with other Regional Committee members). The Regional Committee is invited to focus on the international governance of health in Europe, to identify issues and to decide where to dig deeper for the future.

General issues regarding governance

39. The Regional Committee could commit itself to explicitly addressing the broader picture of health governance in the Region, by defining "good governance of health in Europe" both in conceptual terms (the essence) and, especially, in operational terms (the practice) at country and international levels. Those definitions could be framed according to the dimensions of governance defined in this paper – namely the theory, the dynamic process and the structures/tools involved. It would be important to give as clear as possible a delineation of roles and responsibilities of the actors involved.

40. The Regional Committee may wish to remind Member States that good governance does not necessarily entail excessive bureaucracy. Cost–effectiveness and intercountry equity (a light burden of regulation) should be taken into account when defining governance.

41. The Tallinn Charter is a very important instrument in terms of health governance. In that context, further research is needed to clarify the relationships between good governance and health. as well as between good governance and other health system results. The Regional Committee is encouraged to support the continuation of the work already carried out in the framework of the Tallinn Conference and to ensure stronger involvement of the European Advisory Committee on Health Research in this process.

42. The Regional Committee may wish to reiterate the resolution adopted by the Regional Committee at its fifty-eighth session identifying the need for tools to measure governance, while providing an approximate reference in terms of time and expected output.

43. The Regional Committee could consider launching a series of studies in the next few years to explore the content issues set out above and the contextual elements that promote good governance of health. Emphasis should be placed on assessing the influence of "good processes" per se in achieving success. One possible way of doing this would be by means of selected successful case studies of governance (measured by improved health outcomes, increased access, better social protection, etc.) in the Region. As indicated above, the groups of examples of good governance in the context of health systems reforms should include best practices in: (i) providing leadership; (ii) stakeholder and patient involvement; and (iii) transparency and intelligence-sharing.

WHO European Office governance issues

44. The Regional Committee is advised to review the number, purpose, status and ways of working of the existing subcommittees and act expeditiously in areas where action would be advisable. For example, the added value/impact of the Regional Search Group for candidates for

the post of Regional Director could be assessed. The same could apply to the role of SCRC in elections to various subcommittees. Also, all subcommittees should systematically report to the SCRC and have a clearly defined period of operation.

45. The Regional Committee is advised to study improvements in mechanisms for coordination with the Executive Board and the World Health Assembly, as well as with other similar gatherings. This could include inviting Executive Board members to convey the European Region's perspective, wherever appropriate; enhancing the role of the European representative of the Executive Board in the SCRC; ensuring that meetings during the World Health Assembly are better prepared; and ensuring better coordination with the EU so that the views of other countries in the WHO European Region are also taken into consideration.

46. The Regional Committee is invited to commission the SCRC to report at the next (sixtieth) session, proposing a few, clearly focused initiatives to improve governance in the WHO European Region, to be followed up on as appropriate.

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Annex 1

Links between resolutions adopted by the WHO Regional Committee for Europe and by the World Health Assembly in the period 2004–2008

An attempt was made to establish a link between resolutions on public health themes adopted by the Regional Committee in the last five years (2004–2008) and the relevant global resolutions adopted by the World Health Assembly over the same period. As shown in the table below, there is a strong link. However, only 34% of resolutions adopted at global level can be linked to resolutions adopted by the Regional Committee; this could, to some extent, be explained by resolutions on themes of lesser importance for the WHO European Region.

Resolutions adopted by RC	**WHA resolutions**
Environment and health (2004, EUR/RC54/R3)	Strategic Approach to International Chemicals Management (2006, WHA59.15) Climate change and health (2008, WHA61.19)
Prevention and control of noncommunicable diseases in WHO's European Region (2004, EUR/RC54/R4) Prevention and control of noncommunicable diseases in the WHO European Region (2006, EUR/RC56/R2)	Cancer prevention and control (2005, WHA58.22) Outcome of the first session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control (2006, WHA59.17) Prevention and control of noncommunicable diseases: implementation of the global strategy (2007, WHA60.23) Prevention and control of noncommunicable diseases: implementation of the global strategy (2008, WHA61.14)
Framework for alcohol policy in the WHO European Region (2005, EUR/RC55/R1)	Public health problems caused by harmful use of alcohol (2005, WHA58.26) Strategies to reduce the harmful use of alcohol (2008, WHA61.4)

Resolutions adopted by RC	**WHA resolutions**
European strategy for child and adolescent health and development (2005, EUR/RC55/R6)	Family and health in the context of the tenth anniversary of the International Year of the Family (2004, WHA57.11) Working towards universal coverage of maternal, newborn and child health interventions (2005, WHA58.31) Infant and young-child nutrition (2005, WHA58.32) Infant and young child nutrition (2006, WHA59.21) Better medicines for children (2007, WHA60.20) Infant and young child nutrition: biennial progress report (2008, WHA61.20)
Strengthening national immunization systems through measles and rubella elimination and prevention of congenital rubella infection in WHO's European Region (2005, EUR/RC55/R7)	Global immunization strategy (2005, WHA58.15) Global immunization strategy (2008, WHA61.15)
Strengthening European health systems as a continuation of the WHO Regional Office for Europe's Country Strategy "Matching services to new needs" (2005, EUR/RC55/R8)	Sustainable health financing, universal coverage and social health insurance (2005, WHA58.33) United Nations reform process and WHO's role in harmonization of operational development activities at country level (2005, WHA58.25) Emergency preparedness and response (2006, WHA59.22) Health systems: emergency-care systems (2007, WHA60.22)
Prevention of injuries in the WHO European Region (2005, EUR/RC55/R9)	Road safety and health (2004, WHA57.10)
Health workforce policies in the European Region (2007, EUR/RC57/R1)	International migration of health personnel: a challenge for health systems in developing countries (2004, WHA57.19) International migration of health personnel: a challenge for health systems in developing countries (2005, WHA58.17)

Resolutions adopted by RC	**WHA resolutions**
The Millennium Development Goals in the WHO European Region: Health systems and health of mothers and children – lessons learned (2007, EUR/RC57/R2)	Accelerating achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration (2005, WHA58.30) Working towards universal coverage of maternal, newborn and child health interventions (2005, WHA58.31) Monitoring of the achievement of the health-related Millennium Development Goals (2008, WHA61.18)
Follow-up to the WHO European Ministerial Conference on Counteracting Obesity and Second European Action Plan for Food and Nutrition Policy (2007, EUR/RC57/R4)	Global strategy on diet, physical activity and health (2004, WHA57.17) Infant and young child nutrition 2006 (2006, WHA59.21) Infant and young child nutrition: biennial progress report (2008, WHA61.20)
Stewardship/governance of health systems in the WHO European Region (2008, EUR/RC58/R4)	International migration of health personnel: a challenge for health systems in developing countries (2005, WHA58.17) Monitoring of the achievement of the health-related Millennium Development Goals (2008, WHA61.18)
Behaviour change strategies and health: the role of health systems (2008, EUR/RC58/R8)	Public health problems caused by harmful use of alcohol (2005, WHA58.26) Strategies to reduce the harmful use of alcohol (2008, WHA61.4)

Annex 2

Executive summary and key findings from the Member States' satisfaction survey

Executive summary

Following the recommendation of the Regional Committee and in line with the Regional Office's efforts to further optimize its performance, a Member States' satisfaction survey was undertaken in 2008. The main purposes of the survey were to assess the opinion of Member States about their cooperation with the Regional Office and their level of satisfaction with the way the Regional Office is carrying out its Country Strategy.

Member States were asked to complete a specifically designed questionnaire covering various aspects and dimensions of the Regional Office's work in and with the countries in the WHO European Region. Thirty-three Member States responded, which gives a 62% response rate.

The main results of the survey are presented in the table below.

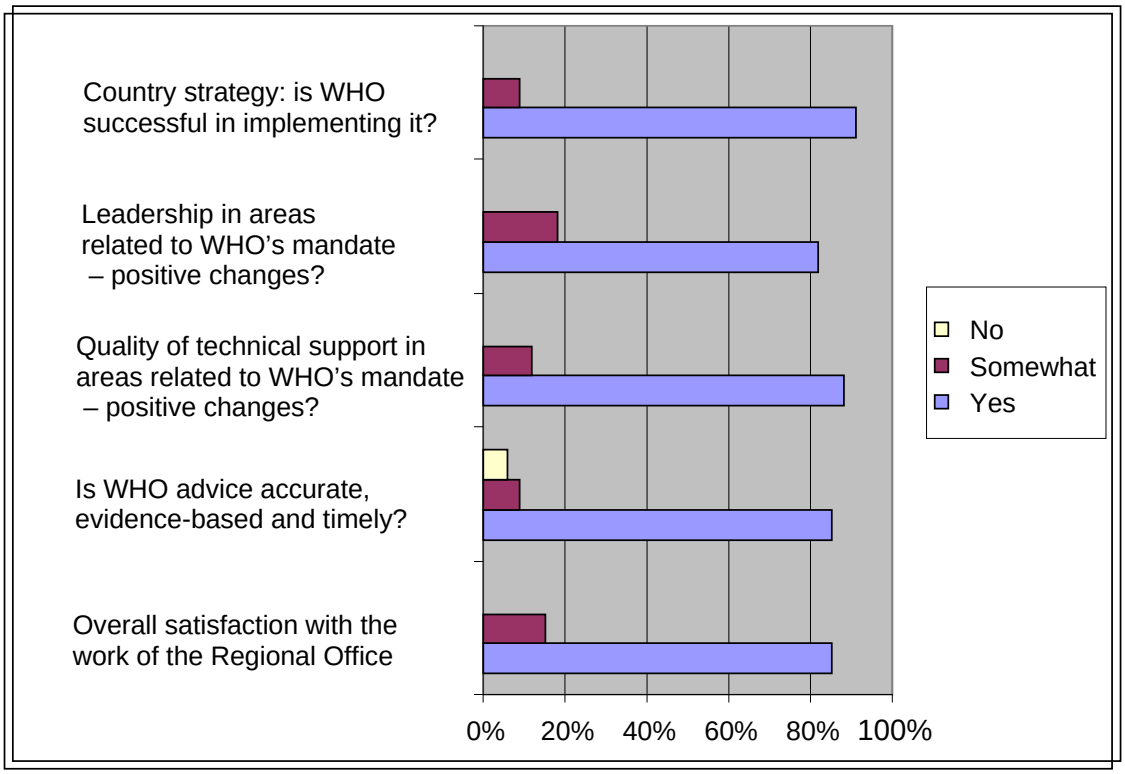
Feature	Yes	Somewhat	No
Country strategy: is WHO successful in implementing it?	85%	15%	
Leadership in areas related to WHO's mandate – have there been positive changes?	85%	9%	6%
Quality of technical support in areas related to WHO's mandate – have there been positive changes?	88%	12%	
Is WHO advice accurate, **evidence-based and timely**?	82%	18%	
Overall satisfaction with the work of the Regional Office	91%	9%	

This survey will in future be conducted on a biennial basis. The Regional Director and the management team at the Regional Office will ensure that follow-up and action are taken in response to the opinions expressed by Member States.

Key findings

The overall response rate to the survey was 62 %, with 33 Member States having responded by 31 March 2009.

A **quantitative** summary of the Member States' responses is presented in the diagram below.



A summary of the **qualitative** comments received from Member States is given below.

Do you consider that the Regional Office has been successful in the overall implementation of its Country Strategy?

- Yes: 85%
- Somewhat: 15%

What WHO does well:

- it provides assistance with and expertise for the preparation of national health policies and strategies on various thematic areas (e.g. public health, alcohol abuse, mental health, malaria, avian influenza);
- it provides advice on and analysis on health systems development;
- it maintains the Country Strategy's focus on strengthening health systems (the Tallinn Conference) and WHO's country presence;
- it shares best practices and solutions, and disseminates evidence-based information;
- it provides quality technical assistance in particular areas (health economics and financing, health systems performance assessment, prevention and control of communicable diseases, International Health Regulations, national drug policies, hospital preparedness and response);

- it provides high-quality technical assistance for the development of a number of important programmes: reproductive health strategy, Integrated Management of Childhood Illnesses, Making Pregnancy Safer, national immunization plans, tuberculosis control, cancer programme, HIV/AIDS/sexually transmitted infections, and tobacco control;
- it was very responsive during a mumps outbreak, provided assistance during floods and supported a national coordination centre for public health emergencies and disasters; and
- it supports the development and introduction of comprehensive programmes of reforms in public health.

What could be improved:

- attention should be focused more sharply on achieving appreciable practical results in implementing the Country Strategy;
- a strategy should be developed for effective communication with the mass media during the health reform process;
- technical expertise should be strengthened and continuity ensured through the recruitment of highly qualified and internationally recognized specialists on a long-term basis; divergences between priorities set and the expertise available in the Organization should be avoided;
- internal human resource/recruitment procedures should be optimized to ensure timely recruitment, continuity and expertise in line with organizational priorities;
- a stronger stance should be developed to avoid issues related to health policy being taken over by other interests e.g. economic/financial;
- more WHO-supported projects should be implemented in industrialized countries;
- problem-solving capacity should be improved, with both targets and results quantitatively measured and verified; evidence-based reasoning should be provided for national health policies target-setting;
- more attention should be paid to the Climate change and health programme; and
- (a number of Western countries): WHO assistance is of less relevance and activities at country level are limited, although its importance for the Region and overall WHO leadership in health is recognized; collaboration with western European countries needs to be specifically tailored to their needs and requires more attention and resources.

Specific dimensions of implementing the Country Strategy (leadership, technical support)

Do you consider that there have been positive changes in the way the Regional Office has provided and maintained *leadership* in areas related to WHO's mandate?

- Yes: 85%
- No: 6%
- Somewhat: 9%

Do you consider that there have been positive changes in the way the Regional Office has provided *technical support* in areas related to WHO's mandate?

- Yes: 88%
- Somewhat: 12%

What WHO does well:

- it fulfils its leadership role well, in a consultative rather than a prescriptive manner;
- it provides valuable information and technical support for the inclusion of local experts;
- it shares the right information: relevant, high quality and timely;
- it supports policy design at country level;
- it develops technical guidance/models of best practice;
- it provides "hands-on" support;
- it promotes strengthening of health system stewardship and leadership;
- it organizes and implements biennial collaborative agreements (BCAs);
- it promotes communication/web site;
- it collaborates closely with the European Union (EU) and other United Nations agencies;
- it gives value for money;
- it arranges international meetings and conferences that provide a forum for important discussions;
- it carefully selects Regional Committee topics that correspond to priority topics;
- it provides technical support in the prevention and control of noncommunicable diseases, tobacco control, environmental health, medicines policy, planning of human resources for health, development of e-health, strengthening of capacities for crisis management in health sector, and tuberculosis-related issues; and
- it has a particularly positive record of leadership and technical competence in the areas of malaria, mental health and patient safety.

What could be improved:

- statements in crisis situations should be clearly worded;
- it should provide fewer vague philosophical explanations and, rather, place emphasis on strong implementation capacity and rapid action in times of crisis;
- it should ensure that work is coordinated with relevant EU activities and reduce duplication of effort with the European Centre for Disease Prevention and Control (ECDC);
- it should produce less printed material and more electronic publications;
- it should be less politically active and take on more technical advisers;
- it should engage local experts, not only external ones;
- it should further promote models of good practice at national and intersectoral level in the countries; and
- it should provide stronger leadership and technical capacity in the area of gender health.

Service provided: quality of interaction and collaboration

Do you receive accurate technical information and reliable evidence-based advice on *technical and/or policy issues, in a timely manner, in response to Member States' request?*

- Yes: 82%
- Somewhat: 18%

What WHO does well:

- it shows readiness and ability, and provides timely responses;
- it provides a high quality of services, its staff are greatly appreciated, competent, efficient and highly skilled;
- it has shown a clear improvement in collaboration in respect of responsiveness;
- it provides accurate technical and reliable evidence-based advice on technical and policy issues;
- it has produced the Health for All (HFA) database;
- it maintains WHO's values;
- its collaboration with the EU is noteworthy and to be commended; and
- it has successfully implemented various projects on e.g. medicine policy, national child injury prevention action plans and disaster management in hospitals.

What could be improved:

- contact details for WHO staff members should be made available on the web site;
- conclusions and forecasts should be based on updated statistical data;
- interactions could be managed more efficiently;
- sources of data should be clearly stated;
- the quality of information needs to be improved;
- data should be aligned with those of other international organizations;
- fewer short deadlines for meetings should be given and documentation provided earlier;
- questionnaires should be evaluated quickly; otherwise results are no longer or only partially relevant for Member States;
- reaction times should be speeded up in crisis management;
- expert visits should be organized; and
- economic effectiveness should be improved: results do not always correspond to the expected outcomes.

General satisfaction with the work of the Regional Office

- Satisfied: 91%
- Somewhat satisfied: 9%

What the Regional Office continues to do well:

- constant process of evaluation and improvement; and
- dialogue with Member States.

Priorities for improving the work of the Regional Office in and with Member States

Organizational:

- strengthen and better integrate public health programmes with health systems and with WHO headquarters' programmes;

- strengthen the area of economic evaluation at regional level, improve cost–effectiveness of operations, avoid excessive preparatory meetings; and
- provide a more transparent and clear organigram, to guide Member States through the Organization to the right contact.

Policy advice:

- evidence-based recommendations with a focus on measurable results;
- guidance on how to implement key values (equity, solidarity) effectively;
- further development of the Country Strategy;
- system-wide approach, including other government ministries;
- education/training for politicians;
- assistance with implementation of the Tallinn Charter;
- health security – how can WHO engage constructively with the EU;
- more clarity on the roles of WHO and ECDC;
- cooperation in research;
- more wide-ranging collaboration with other international organizations.

Focus on country needs:

- bridge the gap between western and eastern European Member States – broader consultation with Member States;
- further strengthen WHO country offices, including their role in carrying out their United Nations mandate;
- consider country needs deriving from the process of EU accession;
- provide help with priority programmes, including training of WHO staff and local specialists on these priorities at country level;
- ensure timeliness and adherence with regard to BCA implementation;
- establish a forum to meet the needs of nongovernmental organizations, in order to strengthen their role at country and regional levels; and
- meet the constant need for coordination between all United Nations agencies in the country.

Programmes:

- primary health care, health inequalities, integrated care and disease management (annual meeting on objectives could be usefuls); and
- HIV/AIDS, communicable diseases in general, with a focus on eastern and south-eastern Europe.

Communication/intelligence:

- ensure more visibility in local media
- further improve the Regional Office web site
- further improve the HFA database
- explore the wider possibilities for sharing relevant experiences.

Annex 3

Distribution of European seats on the Executive Board and criteria for selection

Background and introduction

1. An evaluation of the process of filling vacant seats on the Executive Board (EB) was carried out by the Tenth Standing Committee of the Regional Committee (SCRC) and the results of this evaluation were endorsed by the Regional Committee for Europe at its fifty-third session (resolution EUR/RC53/R1). In this resolution, the Regional Committee requested the SCRC to assess the experience gained in implementing the recommendations and to report its findings to the Regional Committee at its sixtieth session (RC60) in 2010.

2. With RC60 in mind, the Sixteenth SCRC started discussing this issue in preparation for the review. This work will be continued in the coming year by the Seventeenth SCRC.

3. The practice has been for the SCRC to recommend a proposed shortlist to the Regional Committee based not only on criteria related to the Member State and the individual candidate but also (and strongly) on geographical groupings. The SCRC has aimed to produce a proposed shortlist, which is distributed on the first morning of the Regional Committee session, with an equal number of names as there are vacancies.

4. This way of working has sometimes resulted in dissatisfaction on the part of Member States who were not put on the shortlist, since they are required to withdraw their candidatures at the last minute and do not always fully understand the process. SCRC members often find it unpleasant to have to speak to those Member States who have not been shortlisted and try to convince them to withdraw their candidates. The Member States have a sense of frustration and lost expectation and often complain that they have not been given an equal opportunity.

5. The review carried out by the Tenth SCRC and its subsequent endorsement also included recommendations regarding semi-permanency of three European Member States on the EB. It is also time to review this arrangement – as called for in resolution EUR/RC53/R1.

6. As a report needs to be made to RC60 in September 2010, it was felt opportune to start assessing current practice and analysing the criteria used, both implicit and explicit.

Criteria applied so far

Criteria regarding the Member State		**Comments**
1.	Member State entitled to designate a person to serve on the Board should appoint a person technically qualified in the field of health, as spelled out in Article 24 of the WHO Constitution.	

Criteria regarding the Member State		Comments
2.	Previous representation on the Board: - country never represented on the Board (although a member of WHO before 1991) - country represented on the Board more than 20 years ago.	The SCRC has been taking this into account. At the time it discusses the nominations received, it has details available of the Member State's previous membership of the EB and other committees in recent years (mid-1990s onwards). Experience has shown, however, that this has been taken into account to a lesser degree than geographical considerations or the nominee's experience and qualifications.
3.	No country should be a member of the Board and the SCRC at the same time.	This is adhered to although, in the case of the semi-permanent members of the EB, there may be an unavoidable overlap of a few months owing to the fact that the EB year starts in May while the SCRC year finishes in September.
4.	Having already been a member of the SCRC is an asset.	It is preferred that the country has already been a member of the SCRC when applying to the EB, since familiarization with the work of WHO and regional issues forms an excellent knowledge base for work on the EB.
5.	Having ratified amendments to Articles 24 and 25 of the WHO Consititution should be taken into consideration.	This criterion could possibly be dropped – the European Region now has 8 seats on the EB as a result of having reached, in September 2005, the necessary number of countries that were required to deposit their Instrument of Acceptance of the amendments. Since this time, the SCRC has not taken this criterion into account.

Criteria regarding the candidate		Comments
(a)	Current position in the health administration in his/her country (or the position held in the near past) close to the political decision-making level.	This has been a major criterion when considering nominations received. However, the current curriculum vitae (CV) template does not allow for any details or elaboration of the nominee's current post which would give the SCRC an idea of how well versed the nominee is, not only in his/her own country's programmes and political standpoint but also in activities throughout the Region. Experience has shown that it is normally through the working or personal contacts of one or more SCRC members that the real quality of a candidate is brought to the attention of the SCRC as a whole.
(b)	Experience of working with international organizations, WHO or other United Nations organization.	This criterion has been applied to a lesser degree, although those having this kind of experience are likely to be better known to the SCRC – making it easier for the SCRC to make an assessment. This kind of experience gives a good understanding and sense of the complexities of being a member of the Executive Board.
(c)	Ability to collaborate, coordinate and communicate within the country and between the countries.	Nominations are normally received from countries for candidates at a high level in the health system – this would assume they have the necessary ability in this area. This criterion is difficult for the SCRC to assess unless one or more SCRC members have professional knowledge of the candidate.
(d)	Experience of coordinating high-level political and/or technical programmes, nationally (interregional, interministerial) or internationally (bilateral or intercountry).	Most nominees have at least some international experience, although the extent various greatly. The current CV template only allows for a list – which often merely states nominees' position on various programmes and does not give a true sense of the extent of their experience. This has been applied as a lesser criterion.

Criteria regarding the candidate		Comments
(e)	Availability and commitment	Generally, most EB members attend on a regular basis and are only absent in cases of unexpected emergencies. For the SCRC, the letter sent to a Member State upon election could reiterate the commitment required and the need for the designated member to keep dates of meetings free and to set aside time to read the background material, in order to be well prepared for active participation in meetings.
(f)	Gender (female candidates encouraged)	This has been taken into consideration; however, it has been difficult to apply this criterion above those concerning the quality of candidates or geographical distribution.

7. In addition to the above, there are some other criteria that could have been taken into account but which would require the CV template to be expanded or, alternatively, entail the provision of further information that would only be available to the SCRC.

Other Criteria		**Comments**
(i)	Field of expertise	Expand on areas in which nominees have particular knowledge and experience. Up to now, expertise has been assessed based on SCRC members' individual knowledge.
(ii)	Languages	Level of fluency in each of the working languages (possibly refining the current form in order to give different levels within each category – speak, read, write – and a guideline of what would be considered an appropriate level against each rating). Although languages are included in the current CV template, it is very difficult to assess the level of competency (and therefore the ability of a proposed candidate to actively participate in discussions).
(iii)	National experience	A more in-depth description could be requested. The CV template currently asks for the five most recent positions held in their professional career to be listed. Up to now, expertise has been assessed based on SCRC members' individual knowledge.
(iv)	International experience	A more in-depth description could be requested. The CV template currently asks for a list of experience of working for and with international organizations. Up to now, expertise has been assessed based on SCRC members' individual knowledge.
(v)	Specific WHO experience (both regional and global)	Further specific background information would be useful; currently, it is covered under the general heading of experience of working for and with international organizations. Up to now, expertise has been assessed based on SCRC members' individual knowledge, sometimes requesting background from the Secretariat.

Other Criteria		Comments
(vi)	Past history of having pro-actively participated in boards and committees, having recognized the need to voice the needs and views of the Region in WHO's global decision-making processes.	This may be difficult to quantify and may rely on the personal experience of SCRC members.
(vii)	A list of achievements in previous or current positions on boards and committees for which the nominee feels he/she has had a certain influence or responsibility.	It is currently difficult to anticipate how proactive a designated member will be. These details may give a sense of the ability and capacity of a proposed candidate.
(viii)	List of publications	Not necessarily a relevant criterion for the purpose of exercise.
(ix)	Prizes	Prizes awarded to the candidate.
(x)	Other activities	At present, the CV template restricts the amount of information being presented. Countries often ask if they may submit further details. Should the SCRC decide to expand the list of criteria, space for additional information could be added (for SCRC use only, in order to retain a manageable RC document going to Member States).

8. The rapid analysis set out above suggests that competency is difficult to assess. If the SCRC decides to strengthen the importance attached to this criterion, one option could be to consider having an informal meeting with candidates during the World Health Assembly. However, it would need to be borne in mind that this could create a negative reaction from the Member State if its nominee was not shortlisted.

9. The fact that a Member State applied the previous year(s) and has not been successful is not considered to be a criterion for shortlisting.

10. In order to avoid the frustration experienced by Member States in not being shortlisted and then being expected to withdraw their nomination, the following options could be considered: (i) the SCRC does not make any recommendation for the shortlist and the RC votes on all nominations received, or (ii) the SCRC makes a recommendation for a number of candidates equal to the number of vacancies but the RC votes on all nominations received.

Geographical groupings

11. If the aim is to have the best possible candidates and if the practice of shortlisting should continue, more weight may need to be given to personal criteria and the criterion of country groupings softened, with the SCRC monitoring developments to ensure that a reasonable overall geographical distribution is maintained.

12. In any event, the geographical groupings need to be reviewed and a proposal made concerning possible redistribution of countries. For example, historical groupings (e.g. the Commonwealth of Independent States) should be reviewed and due account taken of the possible effect of more countries joining the European Union.

"Semi-permanent" membership of the Executive Board

13. According to resolution EUR/RC53/R1, RC60 is also due to review the decision that the periodicity of Board membership for those Member States in the European Region that are permanent members of the United Nations Security Council be extended to three out of six years.

14. With the number of Member States in the European Region having increased to 53, many countries feel that this practice makes it difficult for all countries in the Region to have an equal opportunity to serve on the EB.

15. It is also opportune to review the practice of the three Member States having a place on the General Committee of the World Health Assembly. Here again, many Member States feel they do not have an equal opportunity to serve on the General Committee.

16. Advice regarding elective posts was previously sought from Legal Counsel in 2004, as the Eleventh SCRC was unsure as to whether the RC was actually aware that, by adopting resolution EUR/RC53/R6, it was in fact approving the recommendations of the subgroup of the SCRC concerning elective posts on committees of the Health Assembly.

17. Legal Counsel advised that the practice of "semi-permanency" and its relevance for candidatures to elective posts in WHA committees is indeed just a practice, rather than the object of a legal obligation or a legal entitlement. "Semi-permanency" is a practice based on political and historical, rather than legal, considerations, whereby the Regional Committee agrees to support the candidature to the Executive Board of the three Member States which are permanent members of the Security Council with a certain frequency, and accepts that they are candidates for membership of the General Committee at every session of the World Health Assembly. Yet there is no legal obligation on the Regional Committee, the SCRC or the Health Assembly for that matter to continue to follow this practice – regardless of whether the Regional Committee did, or did not, adopt the view of the subgroup on the question of semi-permanency in the Health Assembly committees.

Preliminary recommendations and Issues and matters to be addressed

18. It is the Member State that holds the seat on the Executive Board and, prior to formal election by the World Health Assembly (which confirms the RC nomination the previous September), countries are only asked at that stage to confirm the name of their candidate. During the course of the three-year term of office, changes in government or other reasons can cause a change in the person designated as a country's representative on the EB. These cases are very rare, but it does needs to be borne in mind that, no matter how carefully the CVs are studied, there could ultimately be a change in a country's designated member.

19. Some matters may need to be addressed prior to RC60 in 2010:

- Is a change required to the criteria for nomination of EB members?
- Is a change required in the composition of the country groupings?
- Should the criterion of country groupings be softened?
- Proposed shortlist – should this contain not only the SCRC's proposal but also all nominations received? i.e. should the RC vote on all nominations received?

20. Consideration could be given to following options:

A) Discontinue the practice of making shortlists by the SCRC and have the RC vote for all applicants (with or without SCRC initial assessment)

or

B) Remove the criteria of geographical grouping of countries and focus mainly on the quality of candidates when making an SCRC shortlist based on:

(1) the CV of a candidate (consider expanding a template):
   (i) background
   (ii) achievements/experience
   (iii) international experience;

(2) country-related criteria:
   (i) previous membership of the country in the SCRC or EB.