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Midterm progress report on implementation of the European Action Plan for Strengthening Public Health Capacities and Services

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Midterm progress report on implementation of the European Action Plan for Strengthening Public Health Capacities and Services

This midterm report describes progress in implementing the European Action Plan for Strengthening Public Health Capacities and Services (EAP-PHS) endorsed by the 62nd session of the Regional Committee for Europe in resolution EUR/RC62/R5.

This report is informed by the results of two surveys designed to identify important developments made by Member States and partner organizations from 2012–2015 and by a series of case studies on the self-assessments of essential public health operations (EPHOs) undertaken by Member States since the adoption of the EAP-PHS in 2012.

The midterm progress report summarizes developments and achievements in line with the commitments undertaken in Regional Committee resolution EUR/RC62/R5, and reiterates the need to rethink, realign and renew public health capacities and services in the WHO European Region.

This progress report on the EAP-PHS supplements the Midterm progress report on Health 2020 implementation 2012–2016 (document EUR/RC66/16), which assesses the progress of Health 2020 implementation from 2012 to 2016. Document EUR/RC66/16 is accompanied by a draft resolution that requests the Regional Director to submit the vision for Health 2020 implementation for the period 2017–2020 for consideration by the 67th session of the Regional Committee in 2017.

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Key messages

- The Member States of the WHO European Region and the WHO Regional Office for Europe have realized a number of important achievements in strengthening public health services in 2012–2015.
- The European Action Plan for Strengthening Public Health Capacities and Services (EAP-PHS) has been well received by a number of Member States, and is considered useful and helpful to countries seeking to promote and develop public health and the organizations that deliver public health services.
- Nevertheless, the potential of the EAP-PHS has remained largely unrealized, and there are indications that its visibility has been suboptimal in many Member States. There also seems to be a gap between the stated level of political commitment and the actual resources allocated to strengthen public health services.
- It appears that the evidence for the high cost–effectiveness of public health interventions is not broadly known, and Member States need further support in making the case for investing in public health services within their governments, particularly to ministers of finance.
- For the EAP-PHS to achieve its full potential, Member States and the Regional Office must work together to coordinate implementation, raise awareness of its existence and make known its continuing relevance to the challenges facing public health.
- Member States could consider assigning responsibility for the development of national action plans, and the oversight, coordination and monitoring of their implementation, to national organizations. Similarly, the Regional Office and Member States could take on a more active role in monitoring and coordinating implementation of the EAP-PHS at the regional level. Partner organizations should be invited to play a more active role in implementation.
- The Regional Office and its partners need to provide longer-term support to Member States throughout the implementation process. The divisions and programmes of the Regional Office should make a concerted effort to deliver a coherent package of technical assistance to support implementation.
- The following areas are of particular importance and could therefore be the focus of future efforts:
 - governance for health and health equity;
 - the public health workforce;
 - financing of public health services;
 - organizational models for the delivery of public health services; and
 - public health legislation.

Background

1. The European Action Plan for Strengthening Public Health Capacities and Services (EAP-PHS) (1), endorsed by the 62nd session of the WHO Regional Committee for Europe in resolution EUR/RC62/R5 in 2012, is a major pillar in the implementation of the Health 2020 policy framework (2). Health 2020 establishes strategic objectives to improve health in the European Region, while the EAP-PHS lays out 10 avenues for action by which Member States can strengthen the public health services and capacities deployed in pursuit of these strategic objectives. These avenues are mirrored by a set of 10 essential public health operations (EPHOs) that provide the unifying and guiding basis for any health authority in the European Region to set up, monitor and evaluate policies, strategies and actions to reform and improve public health.

2. In September 2015, the United Nations General Assembly adopted the 2030 Agenda for Sustainable Development (3). The Sustainable Development Goals (SDGs) put forth in the 2030 Agenda will guide policy development and implementation over the next 15 years. The SDGs present a unique opportunity for Member States to renew national commitments to public health and to seek intersectoral synergies to advance health priorities in the Region towards 2030. Health 2020 is consistent with the health-related aspects of the 2030 Agenda in its aim and approaches, and the implementation of Health 2020 and the EAP-PHS is expected to contribute to the achievement of more than half of the SDGs.

3. The EAP-PHS is designed to be an action-oriented initiative: its development and implementation reflect the values and principles enshrined in Health 2020, which sets out the vision and policy focus for health in the European Region in the 21st century. Both Health 2020 and the EAP-PHS call for a commitment to improving health and well-being and addressing health inequalities by the whole of society and whole of government, with health improvement as part of all health governance activities, and decision-making that reflects the underlying principles of human rights, social justice, participation, partnership and sustainability.

4. To support the development of the Midterm progress report on the implementation of the EAP-PHS, the Regional Office commissioned surveys of Member States and partner organizations (4) and a series of case studies on EPHOs self-assessments undertaken by Member States in 2012–2015 (5). The full results of these studies are reported in information documents EUR/RC66/Inf.Doc./3 and EUR/RC66/Inf.Doc./4.

5. The main objectives of these studies were to identify trends and developments in the institutionalization of public health in the European Region and to identify success factors and barriers in different contexts and options for strengthening the former and overcoming the latter.

6. After presenting the broader context from which the need to strengthen public health services and capacities emerges, the midterm progress report reviews the Regional Office's activities to support the implementation of the EAP-PHS. It then presents the results of the studies carried out, and the implications for further implementation of the EAP-PHS in the Region.

The broader context driving the need to rethink, realign and renew public health organizations

7. Cardiovascular diseases, cancer, respiratory diseases and diabetes currently account for 77% of the burden of disease and almost 86% of premature mortality in the European Region. Important inequities in health persist both between and within countries, and this gap is increasing in some countries of the Region. The financing of public health services represents a small and, in some countries, declining fraction of total government spending on health, despite compelling evidence that core noncommunicable disease (NCD) interventions and services for disease prevention and health promotion are highly cost-effective means of reducing the burden of disease.

8. The coverage of core NCD interventions and services for populations and individuals remains limited and patchy in many countries. Recent health emergencies – such as the Ebola outbreak in western Africa, flooding in the European Region and the Zika virus outbreaks in the Americas – have highlighted important deficiencies in the ability of national health systems to provide all-hazards core capacity to prepare for and respond to public health emergencies, as stipulated in the International Health Regulations (IHR) (2005) (6).

9. A competent public health workforce is key to the delivery of effective public health services, but in some instances a significant proportion of the public health workforce is either on the verge of retirement or has already retired. This situation represents both a threat of understaffing and an opportunity for refocusing and reshaping the workforce. The realignment of public health services often necessitates reskilling the public health workforce; the potentially large number of jobs affected may make this endeavour a highly political issue in many countries.

10. There are indications that in several Member States of the European Region, there is a misalignment between strategic priorities in health policy and:

- (a) the allocation of human and financial resources within public health services;
- (b) the services provided by public health organizations, particularly in the areas of health promotion and disease prevention (NCDs, mental health, violence and injuries);
- (c) the ability of primary care to deliver appropriate primary and secondary services for disease prevention and health promotion;
- (d) the effectiveness of current efforts to foster community resilience and citizen engagement and empowerment;
- (e) the effectiveness of current efforts to work across sectors; and
- (f) the skill mix of the workforce.

Regional Office activities to support implementation of the EAP-PHS (resolution EUR/RC62/R5)

Key publications and tools

11. Since 2012, the Regional Office has focused on the production of publications to support Member States in the strategic development of their policies to strengthen public health services, including:

- (a) a joint policy summary by the Regional Office, the European Observatory on Health Systems and Policies, and the Organisation for Economic Co-operation and Development on the economic case for health promotion and disease prevention (7);
- (b) a policy summary by the Regional Office on the case for investing in public health (8);
- (c) a comparative study by the Regional Office and the European Observatory on Health Systems and Policies on organizing and financing public health services (9,10); and
- (d) a joint policy summary by the Regional Office, the European Observatory on Health Systems and Policies and the Association of Schools of Public Health in the European Region on addressing needs in the public health workforce in Europe (11).

12. In parallel, the Regional Office has invested considerable effort in further development of the EPHOs self-assessment tool to ensure that it more closely matches the specificities and challenges of health systems in the European Region. The Regional Office published the newest version of the EPHOs self-assessment tool (12) in the last quarter of 2015. The tool is available in both English and Russian.

13. Another important achievement is the production of a web-based version of the EPHOs self-assessment tool (13). This online resource is being used for the EPHOs assessment process currently under way in Kyrgyzstan.

Direct technical assistance

14. Since 2012, the Regional Office has supported a number of Member States in their self-assessments of public health services and capacities. The following Member States have conducted or are conducting EPHOs self-assessments: Armenia, Bosnia and Herzegovina, Cyprus, Kazakhstan, Kyrgyzstan, Poland, the Republic of Moldova, the Russian Federation, Slovakia and the former Yugoslav Republic of Macedonia. To evaluate the impact of the EPHOs self-assessments and identify the causes of success or failure and any trends in the results, the Regional Office commissioned a multicountry study. The findings of that review (document EUR/RC66/Inf.Doc./4) supplement this report to the 66th session of the Regional Committee in September 2016.

15. The technical assistance provided by the Regional Office aimed mainly at facilitating the EPHOs self-assessment process, for example, by co-organizing launch and progress monitoring workshops and advocacy activities to ensure not only high-level support for assessment processes but also consideration of assessment outcomes in

policy development. During 2012–2015, 83 WHO staff members and international experts spent a total of 146 days on missions in Member States or at international events to further the implementation of the EAP-PHS.

Summary of findings from surveys and EPHOs case studies

16. A total of 23 responses to the survey was received from Member States. There was a slight bias towards Member States in central and eastern Europe (14 responses) compared with Member States from the rest of the Region (9 responses). Eighteen responses were received to the partner organizations survey. Case studies of EPHOs self-assessment processes were developed for seven Member States: Cyprus, Estonia, Poland, the Republic of Moldova, Slovakia, the former Yugoslav Republic of Macedonia and Uzbekistan.

Engagement with the EAP-PHS and level of political commitment

17. Respondents to the Member State survey referred to the EAP-PHS as an important resource, for example, in the preparation of the national institute of public health's development strategy for 2016–2025 in Slovenia. Bulgaria used the EAP-PHS when developing the national programme for the prevention of chronic NCDs for 2014–2020. The Netherlands used the EAP-PHS and EPHOs as a checklist when drafting a vision of securing strong and well-functioning public health for its parliament. In Romania, the EAP-PHS was used to develop priorities for European Union Structural Funds activities for the 2014–2020 financing period. Poland's Ministry of Health reported that its act on public health and the national health programme for 2016–2020 are consistent with the EAP-PHS.

18. Respondents reported that the EAP-PHS has also influenced the development of subnational health plans, such as that of Portugal's Northern Region (14).

19. Commenting on the level of political commitment to and leadership for strengthening public health services, 80% of respondents to the Member State survey believed progressive public health actions had been taken, particularly in regard to intersectoral collaborative work at the political level and advances in developing public health strategy and policy.

20. Although the majority of respondents from Member States considered the EAP-PHS to have been useful, two thirds were unsure whether a particular organization in their country was in charge of overseeing its implementation. This suggests that the level of political commitment to the implementation of the EAP-PHS in Member States was relatively low.

21. About half of the respondents thought that a significant fraction of the key public health actors in their countries were unaware of the EAP-PHS and the EPHOs, and slightly more than half reported that fewer than seven organizations in their countries could be expected to be familiar with the EAP-PHS as a result of having been involved in discussions about it or being otherwise exposed to it. At the national level, the EAP-PHS had low visibility with limited involvement by public health organizations.

22. The findings on the relatively low level of political commitment to implementation and relatively low visibility of the EAP-PHS were supported by the results of the partner organizations survey. While a few respondents agreed that there had been some commitment in the European Region, the majority did not believe that enough had been done and felt that adequate national political commitment was lacking.

23. There was a gap between stated political commitment and the actual resources available to strengthen capacities and improve services. One respondent regretted the absence of a lead organization at the country level to ensure that the EAP-PHS was widely known. Some momentum had been lost since 2012 because the EAP-PHS had not been sufficiently supported; for example, a monitoring and support system had not been part of the EAP-PHS when it was adopted.

Key developments on implementation of the EAP-PHS in the European Region

24. The surveys revealed a number of important developments since 2012, mainly in the areas of monitoring and evaluation, public health policy and public health organizations.

25. The developments cited most frequently in the survey of Member States were in the areas of monitoring and responses to public health emergencies such as outbreaks of the Ebola and Zika viruses. Spain, for example, had appointed focal points with the capacity to manage public health emergencies of international concern. Belgium reported that, as a result of the Ebola crisis, it had significantly improved its general organizational preparedness for health emergencies.

26. Respondents offered a series of recent examples of new policy initiatives and assessments undertaken since 2012 to strengthen public health services. These included the Croatian strategic development plan for public health for 2013–2015, the Latvian public health strategy for 2014–2020, the evaluation of the monitoring system of the 2013 national public health policy in Sweden and an assessment of the United Kingdom's performance against the Global Health Security Agenda in June 2015.

27. Since 2012, Member States have adopted new public health policies covering a number of priority areas, including diabetes (Malta), tuberculosis and cancer (Turkey), tobacco (Estonia, Turkey) and alcohol consumption (Estonia, Romania), prevention of drug abuse (Estonia), water quality (Serbia) and antimicrobial resistance (Austria). In addition, legal reform has paved the way for changes in public health services. Bulgaria, following the example of many other Member States, introduced a full ban on smoking indoors and a partial ban on smoking outdoors.

28. Another significant development was the establishment or reform of public health bodies. The Public Health Agency of Sweden, Public Health England, Santé publique France (France's public health agency) and the Centre for Disease Prevention and Control of Latvia were all created after 2012. The Belgian Government announced its intention to create a national institute for public health and the health system in Belgium. Restructured organizations were seen as another significant development, with examples including the Institute of Health Information and Statistics of the Czech

Republic and the restructuring of sanitary-epidemiological (sanepid) stations in Armenia.

29. Emerging findings from the comparative study on organizing and financing public health services by the Regional Office and the European Observatory on Health Systems and Policies (9,10) suggest that the organization of and scope for public health services differ widely among the nine Member States examined in the study: England (United Kingdom), France, Germany, Italy, the Republic of Moldova, the Netherlands, Poland, Slovenia and Sweden. A number of Member States employ a top-down approach for agenda-setting and governance, while others emphasize local governance, networks and intersectoral work. These different approaches influence the way in which public health problems are addressed.

30. The comparative study also indicates variations in the extent to which the private sector is involved in policy formulation and implementation, sometimes to the detriment of public health (9,10). As a percentage of total health expenditure, funding for designated public health programmes and services is low in the nine Member States examined. Member States vary considerably in how public health services contribute to addressing obesity, alcohol consumption and antimicrobial resistance, with the latter most commonly involving public health services in a more systematic way. Even in the area of antimicrobial resistance, however, there is a lack of coordination between different tiers of public health services; policies are underdeveloped, and the contribution of public health services is most often confined to the collection of data.

Success factors enabling the implementation of the EAP-PHS

31. A number of responses from Member States referred to the use of scientific evidence to support policy formulation as a key success factor, naming the WHO Commission on Social Determinants of Health as an example.

32. With regard to securing adequate financing for public health services, an interesting example put forth by Lithuania was the establishment of the national public health promotion fund. The fund was set up to support health promotion and health and well-being activities, disease prevention projects, social advertising and scientific research.

33. Another success factor identified was the increase in cooperation occurring as part of a crisis response. Examples include the strengthening of national planning for communicable disease preparedness and response that was required as a result of the Ebola outbreak. A key respondent from Germany observed that the migration crisis was likely to generate a renewed interest in public health services in the country, with a renewed interest in collaboration among public health agencies.

34. The ministries of health of a number of Member States were reported to have prioritized services for health promotion and disease prevention, and had made efforts to ensure that they became a political priority within government. For example, the Spanish Ministry of Health, Social Services and Equity pushed for health promotion and disease prevention to be recognized as a political priority, and Turkey reported on the successful leadership of the Ministry of Health in positioning public health on the political agenda.

35. The most salient of the factors cited by partner organizations in support of strengthening public health services since 2012 was the availability of committed and qualified public health professionals. Other factors mentioned included public health reform, research funding, interagency and intersectoral collaboration and political support.

Barriers hindering the implementation of the EAP-PHS

36. Barriers hindering the implementation of the EAP-PHS centred on four overarching themes: resources, politics, collaboration and evidence.

37. The resources barrier refers to a general lack of resources at various levels of government to strengthen public health. Several respondents mentioned the issue of staffing, which included understaffing, lack of qualified personnel and an ageing health care workforce. Many projects and activities were reported as underfinanced, including those of public health institutions. Respondents pointed out the disparity between the budget allocated to and the needs of public health programmes. They also noted that the global financial crisis had affected public health funding, but that one of the biggest increases in expenditure resulted from the risk of the emergence and spread of new communicable diseases related to increased migration. Despite the aforementioned success with health crisis management, comments were made about the recent Ebola and current Zika virus outbreaks, both of which had created demands on the emergency funding sources of health regulatory bodies around the world.

38. A second key barrier identified by respondents was the uncertain and often turbulent political context existing in many Member States, which made it difficult to implement and sustain change. One respondent suggested that the position of health minister was the most tenuous in the government, as there had been six ministers of health since 2012. Constant changes in government were noted as contributing to another barrier: delays in implementing public health reform. Continual change in the policies and organization of health systems makes intersectoral coordination and interagency collaboration particularly difficult to achieve; political turnover was viewed as a persistent barrier to achieving health goals.

39. A third key barrier was the lack of collaboration among the various levels of government (national, regional and local) and among different organizations. Respondents considered the need to strengthen intersectoral cooperation for health, in order to align with Health 2020 (2) and address competing priorities, to be of paramount importance.

40. A fourth key barrier was evidence. Respondents reported that common criteria for both evidence and real-world experience were lacking on issues such as the cost-effectiveness of preventive measures. This in turn makes public health a low-visibility issue.

41. Responses to the partner organizations survey confirmed many of these barriers. The barriers most often cited by partner organizations were a lack of investment in human resources, poor communication, insufficient financial support, a poor evidence base, political instability and weak public health legislation.

EPHOs self-assessments by Member States

42. The review of the EPHOs self-assessments in seven Member States shows clear strengths as well as room for improvement across EPHOs at the country level. Areas for improvement include: a more integrated public health surveillance system; fundamental adjustments to the requirements of IHR (2005) (6); better intersectoral coordination between governmental departments for health protection; a sharper focus on tackling health inequities; improved primary health care; and NCD prevention activities.

43. Other priorities for Member States that emerged from the EPHOs self-assessments include: the development of health impact assessments on national policies and plans; the reskilling of public health workers and the formulation of national strategies for human resources for public health; the development of strategic communication and social mobilization for health; and the appropriate application of research-generated public health evidence to inform policy development and services delivery. There was evidence of consistently weak development in these areas in all or most of the seven Member States analysed, suggesting that these may be common challenges across much of the Region.

44. In Member States where the EPHOs self-assessment process received high-level political attention, substantial reforms were implemented following the assessment; in some cases the design of reforms could be directly linked to the conclusions and recommendations emanating from the EPHOs self-assessment process.

45. The EPHOs self-assessment process has proved to be a valuable means of strengthening relationships and collaboration between key public health actors, both within and beyond the health sector. The self-assessment requires considerable effort to conduct, however, and some Member States felt that more support in planning and carrying out the process was needed.

Support provided by the Regional Office

46. Respondents to the Member States survey widely acknowledged the support provided by the Regional Office in relation to EAP-PHS implementation. They highlighted six areas in which the Regional Office delivered technical support to Member States: developing policy; developing strategy; developing collaborative agreements; facilitating research; providing an evidence base; and advancing public health reforms. The Regional Office was recognized for its impact via IHR (2005) (6) and the WHO Framework Convention on Tobacco Control (15). Poland also acknowledged the Regional Office in relation to the development of its public health act and national health programme for 2016–2020.

47. Respondents identified a number of areas where they felt the Regional Office could support Member States in strengthening public health in the future: the availability of resources for strengthening public health services; collaboration; sharing of good practices; research; up-skilling; the development of tools such as the EPHOs self-assessment; and garnering political support. One key respondent noted that the Regional Office should maintain cooperation and follow-up in the longer term, and pointed out the lack of financial support for EPHOs-related activities and an absence of monitoring. The result was a perceived weakening of the importance and value of the

EAP-PHS. With public health services in many Member States increasingly underfunded, the ability to act is limited. The Regional Office is unable to compensate for such deficits. Another respondent suggested that there is a discrepancy between the high esteem in which the Regional Office is held and the reality of its impact on the ground. The Regional Office might consider decentralizing to the country level, deploying high-level staff to work in certain Member States and supporting national networks more actively.

48. A popular suggestion was to increase collaborative efforts within the European Region, as it was felt that organizations were working in isolation. Respondents noted that working conjointly with others could facilitate knowledge sharing, capacity-building and the exchange of experiences and lessons learned. Closer cooperation and strategic alignment between the Regional Office and the European Union, for example, could enhance opportunities for financial and policy support to increase public health capacities and use available resources more efficiently. A key respondent supported such efforts, adding that commitment to the EAP-PHS could be improved by rotating the coordinating role among the Member States. This could stimulate the coordinating countries to merge resources and improve cooperation across Member States and organizations. Public health services, it was suggested, must cooperate closely with other sectors in times of financial hardship and a general lack of resources.

49. The monitoring of implementation of whole-of-government strategies linked to health, well-being, social equity and environmental sustainability was suggested as a useful way to strengthen public health services. An example given from the United Kingdom was the Well-being of Future Generations (Wales) Act 2015 (16).

50. Overall, the respondents consulted during the case studies of EPHOs self-assessments were very positive about the Regional Office's work – particularly the ongoing collaboration with WHO country offices – and were eager both to deepen existing collaboration and to create new partnerships. A number of proposals and needs emerged from both the key respondents and the case studies (Box 1).

Conclusions and implications

51. A key message is that the potential of the EAP-PHS has remained largely unrealized. There are indications that the visibility of the EAP-PHS has been low in many Member States, as has the level of political commitment to implementing it.

52. Nevertheless, in spite of the apparently low visibility of and political commitment to the EAP-PHS, survey results indicate that it has in general been well received by Member States, and it has proven useful for countries seeking to promote and develop public health and the organizations that deliver it.

53. For the EAP-PHS to have the impact its architects envisioned, raising awareness of its existence and making known its continuing relevance to the challenges facing public health must be priorities. This requires committed political leadership at all levels of government. The issue of political will is not new, but its absence is probably the most important factor in the EAP-PHS having had less impact than it could or should.

Box 1. Proposals for support from the Regional Office

Provide supporting materials and documents for the current EPHOs self-assessment tool, such as:

- a glossary of key terms;
- additional guidance on organizing the assessment, particularly on achieving optimal stakeholder involvement and performing prioritization exercises;
- a standard template for EPHO self-assessment reports, including sections dedicated to cross-cutting priority recommendations and EPHOs-specific recommendations.

Consider areas for future development of the EPHOs self-assessment tool, such as:

- the development of an agile, web-based tool that is closely aligned with public health concepts and sensitive to different organizational structures and contexts;
- the generation of a streamlined package of EPHOs, for example, with selected sub-operations from the intelligence (1,2) and enabler (6–10) EPHOs that could be applied at the health systems level or to specific vertical programmes.

Provide technical assistance during the EPHOs self-assessment, such as:

- adequate preparation for the assessment (agreeing on goals with national partners and managing expectations of the resources needed);
- professional training and support for experts in the countries to lead and participate in self-assessments;
- support for generating human and logistical resources to carry out the self-assessment, including through direct funding, grants or temporary contracts for in-country experts.

Adapt and realign the EAP-PHS to focus on:

- regional advocacy for strengthening health systems' core capacities to prepare for and respond to public health challenges, particularly NCDs and public health emergencies (in accordance with International Health Regulations (2005));
- operational guidance on incorporating a whole-of-government, whole-of-society perspective to addressing health inequity and the social determinants of health;
- political support for key adjustments, such as increasing the budget allocated to core NCD interventions and services for health promotion and disease prevention.

Increase advocacy and guidance at the national and regional levels by:

- raising awareness and visibility of public health among national leaders through advocacy from the Regional Office;
- providing tools for ministries of health and other health authorities to demonstrate the value of public health services, for example, through cost-effectiveness studies;
- providing specific guidance and assistance for the creation of intersectoral governance mechanisms, as well as other national priorities as they emerge.

54. To address the situation, Member States could consider assigning responsibility for the development of national action plans to strengthen public health capacities and services – and the oversight, coordination and monitoring of their implementation – to national organizations. Similarly, Member States could take a more active role in monitoring and coordinating the implementation of the EAP-PHS.

55. Another key barrier to realizing the full potential of the EAP-PHS is the limited resources available for public health in many Member States. This includes shortages of both financial and human resources. In many Member States, the public health workforce lacks both adequate staffing levels and the optimal skill mix.

56. The EPHOs self-assessment tool (12) was well received by the seven Member States in the case study. They found monitoring the performance of public health organizations useful, and the tool challenged countries to improve the performance of their public health organizations.

57. Key issues concerning the value of EPHOs for policy and practice echoed the concerns about the EAP-PHS in general. Committed leaders, who are prepared and empowered to act on the results of the EPHOs self-assessment tool, are needed. Where such leadership exists, the value of the tool is evident.

58. Another key issue is the ownership of the EPHOs self-assessment process by all sectors affected by it, and not simply those located in government. This links to the importance of the health-in-all-policies (HiAP) approach in Member States and the need to better understand how to include health on the agendas of other policy sectors, such as education, housing, transport and regional planning.

59. While survey respondents and key respondents who contributed to the development of the case studies acknowledged and welcomed the efforts of the Regional Office to provide technical support, a general view emerged that more could and should be done.

60. In particular, the Regional Office should provide longer-term support to Member States to assist them with the necessary change process identified through the EPHOs self-assessment and related action plans. Without such a commitment, there was a perception that the EAP-PHS was not viewed as important. This also raised the issue of the credibility of both the EAP-PHS and the Regional Office. Promising more than could be realistically delivered risked raising expectations that could not be met. Member States would therefore value a committed and coordinated implementation of the EAP-PHS by the Regional Office as part of its commitment to Health 2020.

61. At a time when resources are limited in both Member States and the Regional Office, there may be added value for the Regional Office to act as a clearing house or enabler by establishing a community of practice and encouraging learning across Member States, drawing on experiences of what had worked, what had not worked and the lessons learned in each case. Acting as an information broker in such discussions might help to fast-track solutions to problems that are common across Member States.

62. There may also be merit in joining up initiatives within the Regional Office that can be seen as linked. For example, the work to develop leadership and other skills to advance the HiAP agenda, following the publication of the HiAP training manual (17), links directly to both the EAP-PHS and the overall policy framework set out in Health 2020. Similarly, much of the work by the WHO Evidence-Informed Policy Network (EVIPNet) Europe to strengthen evidence-informed policy-making could be seen as a direct response to calls for evidence presented in ways that policy-makers can more readily access in a timely fashion. Although the Regional Office has contributed to producing evidence on cost-effective interventions to strengthen public health, survey respondents suggested that more effort would be required to effectively disseminate this information and engage those actors best placed to make use of it.

63. The conclusions on the broader context and the need for change remain the same today as when Health 2020 (2) and the EAP-PHS (1) were adopted. A concerted effort is required on behalf of Member States to adapt public health organizations and the broader systems within which they are embedded:

- (a) to strengthen analytical, technical and political capacities to support whole-of-society approaches to pursuing health and health equity at both the national and subnational levels;
- (b) to strengthen public health capacities at the community level and empower citizens;
- (c) to strengthen capacities for health promotion and disease prevention in order to increase coverage of core services for populations and individuals that address NCDs, targeting the relevant organizations and services provided;
- (d) to further strengthen core capacities and emergency and outbreak-response capacities required to implement IHR (2005); and
- (e) to reduce fragmentation and improve coordination and intersectoral cooperation in order to increase efficiency in services delivery.

64. The divisions and programmes of the Regional Office must continue to strive to collaborate and coordinate their efforts. A concerted effort is required to support Member States:

- (a) to generate political support for change and create a mandate for public health through:
 - targeted advocacy efforts at the level of ministers and heads of government;
 - consensus-building efforts at the technical level;
- (b) to enshrine the mandate for change, for example, by contributing to the preparation of national development policies, health policies and public health legislation;
- (c) to manage the change process and successfully implement reforms, for example, through leadership training;
- (d) to strengthen governance capacities in Member States, for example, by sharing experiences with organizational models and the resources required for governance for health at both the national and subnational levels;

- (e) to ensure the allocation of adequate human and financial resources for public health services that are aligned to strategic priorities in health policy; and
- (f) to strengthen the public health workforce.

65. Partner organizations – such as the Association of Schools of Public Health in the European Region, the European Centre for Disease Prevention and Control, the European Commission, the EuroHealthNet, the European Observatory on Health Systems and Policies, the European Public Health Alliance, the European Public Health Association, the International Network of Health Promoting Hospitals and Health Services and various WHO collaborating centres – have all played a catalytic role, and this collaborative effort should be systematized and scaled up to further advance the implementation of the EAP-PHS in the European Region.

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