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Opening of the session

The fifty-ninth session of the WHO Regional Committee for Europe was held at the WHO Regional Office for Europe in Copenhagen, Denmark from 14 to 17 September 2009. Representatives of all 53 countries in the WHO European Region took part. Also present were observers from two Member States of the Economic Commission for Europe and one non-Member State, and representatives of the International Office for Migration, the World Bank, the Council of Europe, the European Commission (Directorate-General for Health and Consumers and European Centre for Disease Prevention and Control) and of nongovernmental organizations (see Annex 3). Her Royal Highness Crown Princess Mary of Denmark, a patron of the WHO Regional Office for Europe, graced the session with her presence.

The first working meeting was opened by Mr Alexander Kvitashvili, outgoing President.

Election of officers

In accordance with the provisions of Rule 10 of its Rules of Procedure, the Committee elected the following officers:

Dr Christos Patsalides (Cyprus)	President
Dr Bjørn-Inge Larsen (Norway)	Executive President
Dr Vladimir Lazarevik (The former Yugoslav Republic of Macedonia)	Deputy Executive President
Dr Narine Beglaryan (Armenia)	Rapporteur

Adoption of the agenda and programme of work

(EUR/RC59/2 Rev.1 and EUR/RC59/3)

The Committee adopted the agenda (Annex 1) and programme of work.

Address by the Regional Director

In his last address to the Regional Committee (Annex 4), the Regional Director presented the Regional Office's work in the previous 12 months from two perspectives: in the light of the ten years since he had taken office and as reflecting the European Region's specific characteristics within WHO's general programme of work.

The most significant events of the past year were pandemic (H1N1) 2009 influenza and the global economic crisis. The former had become the first public health emergency of international concern under the International Health Regulations (2005) (IHR). While both national authorities and WHO had rightly chosen a transparent approach, that had aroused the public's concern and generated extensive media coverage. WHO's mission was to maintain close surveillance, provide accurate information both to reassure the public and encourage compliance with health guidance and to prepare carefully for the next phase: immunization. Pandemic (H1N1) 2009 influenza required a response that intelligently integrated individual and collective measures; the Regional Committee's discussion of the issue could allow Member States to harmonize their views of the situation.

In response to the global economic crisis, WHO had created a global working group, which he co-chaired, and had held a high-level consultation in Geneva in January 2009. A high-level meeting for the WHO European Region, held in April 2009 in Oslo, Norway, had seen the recognition that the health sector must assert its contribution to the development of society, including the economy, and that health ministries' policies, often made in conjunction with WHO and particularly those taking a primary health care (PHC) approach, were good responses to the crisis. In addition, the Regional Office had helped, thanks to its contacts in Israel, to facilitate the shipment of drugs supplied by Turkey to the population of the Gaza Strip.

The WHO European Ministerial Conference on Health Systems, held in Tallinn, Estonia in June 2008, had been followed up by national and regional measures focused on health system performance assessment and strengthening stewardship. In addition, the Tallinn Conference and the need to strengthen health systems had underlain many other Regional Office activities, such as the celebration of World Health Day, contribution to the draft global code of good practice on health workforce migration and commemoration of the thirtieth anniversary of the Declaration of Alma-Ata on PHC. Finally, the European Observatory on Health Systems and Policies – through its publications, its summer school and its support to reform in several countries – had helped to ensure continuity and sustained progress after the Tallinn Conference.

The Regional Office's activities in public health addressed communicable and noncommunicable disease, along with the social determinants of health. In addition to influenza, its work on communicable diseases included organizing the fourth European Immunization Week, strengthening the commitment to tackling tuberculosis (TB) made at the WHO European Ministerial Forum in Berlin, Germany in 2007 and making progress towards eliminating malaria from the Region. The Regional Office gave high priority to noncommunicable diseases (NCD) and work on maternal and child health. The new Athens office, expected to open at the end of 2009, would strengthen the Regional Office's capacity and stimulate implementation of the European strategy for the prevention and control of NCD. In October 2008, the Regional Office had launched its report on policies and practice in mental health in the European Region. In addition, it had held meetings to prepare for the Fifth European Ministerial Conference on Environment and Health, to be held in Parma, Italy in 2010. Finally, the Regional Office had on numerous occasions presented the report of the WHO Commission on Social Determinants of Health for discussion by academics, policy-makers and international organizations, as well as organizing a conference on women and prison in Kyiv, Ukraine in 2008.

Partnerships – with other United Nations organizations and governmental and nongovernmental bodies – had maintained their importance. The Regional Office and the European Union (EU) continued to develop their relations to benefit Member States. That included work with various directorates-general of the European Commission (EC), six technical agencies addressing health and the French, Czech and Swedish presidencies of the EU. Continued collaboration with other partners included work with the World Bank, the United Nations Children's Fund (UNICEF), the United Nations Population Fund and the Organisation for Economic Co-operation and Development (OECD). In addition, the Regional Office had helped Member States obtain funds from the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria, and had taken part in work to improve coordination in the United Nations system, particularly in Albania.

As to the internal life of the Regional Office, the results of a survey of Member States' satisfaction with its services would be used to guide their further development. The introduction of the Global Management System was expected to change the way the Office worked, and the experience of WHO headquarters and other regions would be drawn on to ease the transition. Under the Director-General's leadership, WHO was realizing his dream of a unified and decentralized organization that efficiently served its Member States. The most recent meeting of

the Director-General with the regional directors, in Albania, had showed the Regional Office's achievements at country level.

In conclusion, the Regional Director pledged to make the transition to his successor as smooth as possible, thanked the European Member States and the SCRC for their support to him and the work of the Regional Office, and paid tribute to the staff for their devotion to WHO.

Report of the Sixteenth Standing Committee of the Regional Committee

(EUR/RC59/4, EUR/RC59/4 Add.1, EUR/RC59/Conf.Doc./1)

The Chairman of the Standing Committee noted that the Sixteenth SCRC had met five times during the year, as well as holding a telephone conference in June 2009, and that its reports were available on the Regional Office's web site. In addition to reviewing the action taken by the Secretariat to follow up resolutions adopted by the Regional Committee, the SCRC had been involved in selecting and preparing technical and policy subjects for discussion at the current session. Individual members of the SCRC would present its views on those subjects under the corresponding agenda item.

The Standing Committee had had to respond to two major challenges during the year: the global economic crisis and the pandemic (H1N1) 2009. It had accordingly recommended that they should be included in the agenda of the current session. For the former, the explicit objective was to support European Member States of WHO in developing the health dimension of their response to the ongoing crisis, while the latter would be taken up during a debate and exchange of experiences, supplemented by a technical briefing.

A number of Member States had expressed their willingness to host future sessions of the Regional Committee. The SCRC had carefully reviewed the offers made, and its proposals would be debated later in the session. Equally, the SCRC had drawn up a recommended shortlist of candidates for membership of various WHO bodies, and its successor body would continue its work to ensure that all Member States in the WHO European Region had an equitable opportunity, over time, to participate in the work of the Organization.

He invited all Member States to suggest any technical or policy items that they would like to see included in the agenda of future sessions of the Regional Committee.

The Committee adopted resolution EUR/RC59/R7.

Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board

(EUR/RC59/6)

The European member of the Executive Board designated to attend sessions of the SCRC as an observer reported that the Sixty-second World Health Assembly had adopted 16 resolutions, 8 of which were of major importance for the WHO European Region. Among other topics, they related to the prevention of avoidable blindness and visual impairment; pandemic influenza preparedness; primary health care (including health system strengthening); reducing health inequities through action on the social determinants of health; and prevention and control of multidrug-resistant and extensively drug-resistant tuberculosis.

Owing to the evolving situation with the pandemic (H1N1) 2009, the World Health Assembly had been shortened to just five working days. A considerable number of items had accordingly been postponed for consideration by the Executive Board at its 126th session in January 2010 or the Sixty-third World Health Assembly in May 2010.

General debate

In the general debate that followed, a representative speaking on behalf of the EU, the candidate countries of Croatia, the former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilization and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Armenia, Georgia, the Republic of Moldova and Ukraine, which aligned themselves with the statement, highlighted the importance of health to the WHO European Region and its populations, and noted that the majority of health needs in the Region were common to all Member States. For example, pandemic (H1N1) 2009 affected all countries, and they would have to be flexible and attentive in planning to achieve the best possible preparedness. The current situation underlined how important it was to have both accurate and up-to-date information, and how continued efforts were required to implement the IHR fully. The EU appreciated the global leadership WHO had exercised from the outset, remained committed to global solidarity and would continue to seek ways to support the international community in dealing with the pandemic.

It was important to address the many ways in which the economic downturn could affect population health. Challenges to European health systems included the economic and practical problems arising from the ageing of populations and the migration of health workers. As to the latter, the status of European Member States as destination countries, countries of origin or both showed the complexity of the problem and the need for concerted approaches. The EU looked forward to working with the Regional Office on that issue, with due attention to the various legitimate interests. Further, the financial crisis highlighted the importance of the efficient operation of the health sector, particularly in the light of the spread of pandemic (H1N1) 2009 and antimicrobial resistance. Sweden would host an EU conference on the latter topic later in the month.

The Regional Office's linking of the social determinants of health with the economic crisis underlined the relationship between health and economic resources. Joint development and implementation of policy by many non-health sectors needed to be promoted in order to address the continuing inequities in the Region, and policies on public health and health systems needed to lead to greater equity in health. The Regional Office was expected to take the lead in showing how to integrate the findings of the WHO Commission on Social Determinants of Health into Member States' efforts. In addition, owing to the importance of climate change, the EU looked forward to both the United Nations Climate Change Conference in Copenhagen, Denmark in December 2009 and the Fifth European Ministerial Conference on Environment and Health, to be held in Parma, Italy in 2010.

Because NCD were the most important causes of the disease burden in the Region, health promotion and disease prevention, particularly systematic and population-based programmes for elderly people, were needed to combat them before they occurred. Combating NCD was one of the EU's top priorities; the Regional Office should commit resources at a level that matched the severity of the challenge, beginning by reinforcing the European strategy on NCD. The EU conferences on alcohol to be held later in the month in Stockholm, Sweden, including one co-sponsored by WHO, would give an opportunity for in-depth discussion of a main source of ill health.

The EU welcomed the Regional Committee's planned discussion of progress towards achieving the Millennium Development Goals (MDGs). That remained a considerable challenge, which the EU was committed to addressing despite the economic downturn. Continued action on TB, particularly multidrug-resistant TB (MDR-TB), was needed, along with the integration of TB and HIV programmes at all levels. The momentum created by the Berlin Declaration needed to be sustained. The EU strongly supported the Regional Office's efforts and leadership in that regard. Further, in 2010, the EU would adopt a policy on global health, focusing on equity, coherence and knowledge.

The EU thanked the Regional Director for his work over the previous 10 years; the legacy for his successor to take forward included examining the social determinants of health, breaking new ground on health and the environment, and exercising leadership in addressing lifestyle factors to combat NCD. The EU looked forward to working with the Regional Office as the nexus for health cooperation in the Region, with a crucial role in developing the knowledge base. It was ready to contribute to a sound and efficient Regional Office and to work dynamically with the new Regional Director.

A representative speaking on behalf of the South-eastern Europe (SEE) Health Network expressed the nine member countries' appreciation for the Regional Office's leadership and support since 2001 and thanked their partners for their support: both Member States and international organizations (the Council of Europe and its Development Bank, the Stability Pact and the EC). The Network had risen from the ashes of conflict in the 1990s to become a sustainable common platform for development, building public health policy and reforming health systems. It was planned to be self-sustaining by 2010, with the secretariat and a regional development centre in the former Yugoslav Republic of Macedonia and two other centres in Croatia and Romania. It was extending its partnerships to include the Northern Dimension Partnership in Public Health and Social Well-being.

Many speakers addressed the effects of the economic crisis on health and health systems. They described their countries' commitment to strengthening health systems and their successes in preserving their gains in health and improvements in health systems. Those included increasing or prioritizing resources, strengthening the infrastructure and increasing staffing, improving planning and training, maintaining a focus on the values of the Tallinn Charter and on PHC as the basis of the health system, making all ministries health ministries and increasing the involvement of international donors. Several representatives welcomed WHO's guidance and called for consensus on responses to the crisis or for cooperation to protect health structures and programmes. Others emphasized the role of health systems as a resource to society, particularly in pursuing equity and coping with aging populations, and the need to ensure the efficient use of resources and good functioning of systems. Speakers noted the importance of health worker migration, and one called for the Regional Committee to try to agree on common principles to bring to the discussions at the Executive Board and the World Health Assembly. A representative called on countries to adapt their health systems to changing demographic and disease patterns, identified PHC and prevention as key aspects and urged WHO to take the lead in that regard.

Several speakers noted the progress made in the European Region against pandemic (H1N1) 2009, praised WHO's work and leadership and recommended a range of further steps, including full implementation of the IHR, adherence to the principle of transparency and support to WHO's efforts to create a system for sharing viruses and access to vaccines, as well as dialogue between countries to ensure reasonable use of vaccines. Two speakers wondered whether the current understanding of the pandemic was correct and how vaccination programmes would be carried out. Representatives noted that WHO would hold a workshop on vaccine deployment in October in Turkey, while Germany would hold a follow-up conference on TB.

Representatives identified NCD as the main threat to health in the Region and called for the Regional Office to give them top priority and for countries to take action, including sharing national cancer strategies and continuing work on the marketing of foods and non-alcoholic beverages to children. A speaker thanked the Regional Office for supporting his country's successes in fighting tobacco use, which furnished a useful example to other countries.

Commenting on the work of the Regional Office, some speakers cited the usefulness of biennial collaborative agreements (BCAs), while others praised its activities on the social determinants of health and gave examples of their countries' cooperation with WHO on issues such as tackling obesity, helping medicines reach the population of the Gaza Strip and choosing Moscow as the site of the next Regional Committee session. Representatives suggested that the Regional Office should give NCD equal status with communicable diseases, and that WHO might increase its effectiveness with limited resources by accelerating global governance to avoid excessive decentralization. One speaker commended the Regional Office's work on health security and stressed the need to protect the health of Israelis and Palestinians. All speakers praised the Regional Director for his ten years in office and many of them pledged their continued support for the Regional Office and his successor.

In reply, the Regional Director thanked Member States for supporting of the Regional Office and hoped they would continue to do so. He noted that the SEE Health Network showed that health could be a bridge to peace, and he endorsed representatives' comments on the main issues in the Region. Countries indeed shared many problems, and solidarity led to increased security. The health sector needed a combative spirit to stress its contribution to society and economic improvement. Transparency was essential in dealing with pandemic (H1N1) 2009 influenza, but knowledge had to be accompanied by action.

WHO would continue its work on health workforce migration. Developed countries should discourage active and commercial recruitment of skilled staff in developing countries. The Athens office would give the Regional Office new opportunities to combat NCD. Finally, as patron of the Regional Office, the Crown Princess of Denmark had raised its profile and given its work a human face.

Address by Her Royal Highness Crown Princess Mary of Denmark

The Crown Princess welcomed the opportunity to address the representatives of the 53 Member States in the WHO European Region. Since becoming patron of the Regional Office, she had focused primarily on raising awareness of vaccine-preventable diseases and immunization. While immunization was the safest and most effective health intervention in reducing diseases and mortality, after the provision of safe drinking-water, discrepancies in the coverage of population groups and unvaccinated children could still be found in Member States. European Immunization Week was an important Regional Office initiative to promote and strengthen immunization programmes. During Slovenia's Presidency of the EU, she had launched the Week in 2008 with the First Lady of Slovenia. Similarly, she had issued a statement supporting the 2009 European Immunization Week, which had been launched with a very popular new video on the Regional Office web site. She looked forward to continuing her involvement in that successful initiative.

She would also support the efforts that Member States and the Regional Office were making to achieve the MDGs, focusing on the health of women and children. Reducing health inequities among women, within and between Member States, and ensuring their access to well-performing health systems and good reproductive health services were issues affecting the entire Region. Even some wealthier European countries struggled to reduce maternal deaths among vulnerable and marginalized groups, and maternal mortality was one of the world's most

overlooked catastrophes. The Crown Princess would support the Regional Office in assisting countries in their efforts to achieve the MDGs at the national and regional levels, and would like to contribute at the global level to achieving those related to women's and children's health. Although improving health and reaching the MDGs was a challenging task, she looked forward to supporting Member States and WHO in that endeavour.

Address by the Director-General

The Director-General expressed appreciation for the achievements of the Regional Director and the European Region, which had expanded the health agenda in ways that benefitted international public health and that had become more relevant and more attractive to non-health sectors as means of coping with current and future global crises. The Region had raised issues that currently ranked among the world's top concerns for public health, such as the needs to prevent NCD and to tackle the social determinants of health through policies aimed at promoting social cohesion and protection. Political and economic transition in the Region had sharpened the focus on the links between wealth and health and showed the need to reform and strengthen health systems to secure more equitable health outcomes. The Regional Office had responded by helping to found the European Observatory on Health Systems and Policies, which supplied evidence on the issue, and by holding the European Ministerial Conference on Health Systems, resulting in the Tallinn Charter, which gave a coherent framework for action. Its ideas had entered the vocabulary of international health development at a time when multiple crises were priming world leaders and non-health sectors to listen closely.

A Regional Committee document and the report of the Commission on Social Determinants of Health stressed the dependence of health outcomes on economic factors and the need for economic systems to include moral values such as solidarity, equity and social justice. The MDGs were a corrective strategy for inequitable policies and systems, but they did not address the causes of disparities in health outcomes. Making equity an explicit policy objective was the only way to bridge those gaps and build fair health systems. In the health sector, that view dated back to the Declaration of Alma-Ata. The global financial crisis was encouraging world leaders to seek the kind of value system that PHC had always represented. At the summit of the Group of Twenty (G20) finance ministers and central bank governors in April 2009, they had called for the re-engineering of international systems to incorporate a moral dimension and to be responsive to social values and concerns.

Pandemic (H1N1) 2009 influenza was a watershed affecting the whole world, demonstrating the need to include health in all policies and to build fundamental health capacities at a time when heads of state and the finance, trade and tourism sectors were ready for the health sector's message. The pandemic was tragically likely to show how poorly functioning and inequitable health systems could cost lives, by increasing maternal mortality, particularly in developing countries, where 99% of such deaths already occurred. In November 2009, WHO headquarters would publish a report stressing the need for renewed commitment to PHC, in order to underpin efforts to improve women's health. As the European Region had done for health systems, WHO needed to make the agenda for women's health look manageable, with clear policy options and solid evidence to justify greater investment.

In conclusion, the Director-General praised the Member States in the Region for interpreting privilege as responsibility and for placing values at the heart of their contributions to better health in Europe and the world.

A representative speaking on behalf of the EU, the candidate countries of Croatia and Turkey, the countries of the Stabilization and Association Process and potential candidates Bosnia and Herzegovina and Serbia, as well as Armenia, Iceland, Norway, the Republic of Moldova and

Ukraine, which aligned themselves with the statement, noted that the Director-General had touched on two urgent challenges to health that had emerged since the previous session of the Regional Committee: pandemic (H1N1) 2009 and the global financial crisis. The former had placed health at the centre of the attention of governments, parliaments, the media and citizens. WHO had been key to developing strong preparedness, and the EU thanked the Director-General and her staff for excellent global management of the outbreak. The financial crisis carried the risk that decreasing public financing would affect health systems' performance and that rising unemployment and poverty would affect people's health and well-being. Those two challenges were reminders of the importance of developing strong health systems and working preventively, targeting the social determinants of health. Globally and in Europe, WHO had scaled up its efforts to address both those areas. The EU commended WHO's efforts and would continue to be its strong and determined partner.

One speaker noted that many countries were struggling with health system reform and asked whether they could help each other and what role international organizations should play. Because health care was the second-largest market in the world, it was attracting interest from academia, foundations and agencies such as OECD. WHO had missed an opportunity to add values to the debate, although it had stressed them in an audit of his country's health system; another representative noted that values were also important in ensuring health system responsiveness. To combat vested interests opposing reform, WHO should resume and strengthen its debate with health professionals' associations, including values in their discussions, and should consider taking on a larger role as an advocate for populations' interests.

In addition, while the IHR were a useful tool in tackling epidemics, the global threat of pandemic (H1N1) 2009 created the need for WHO to take on a new role as the advocate of all countries in negotiations with pharmaceutical manufacturers for the vaccine needed, perhaps seeking a graduated scale of costs commensurate with country resources.

The Director-General recognized the contribution of all partners in fighting the pandemic, particularly Member States' donations in cash and in kind, the latter including the services of national influenza centres and laboratories and WHO collaborating centres. Countries' work on preparedness was paying off, despite the very rapid spread of the virus.

The main question about health systems was how to make sure that every country, no matter its level of development, could protect the health of its people. She invited Member States to challenge WHO to take on vested interests. WHO could not dictate to countries; it would provide evidence and best practices that countries could apply in ways suitable for their circumstances. Health system audits in several countries gave good examples of the honest discussion required. If countries were serious about reform, WHO would work with them, along with academics and professional associations, to benefit the health of the whole world.

Policy and technical topics

Health in times of global economic crisis: implications for the WHO European Region

(EUR/RC59/7, EUR/RC59/Conf.Doc./2)

A member of the Standing Committee of the Regional Committee, presenting the SCRC's views on the subject, said that in the past year the global economy had experienced its deepest and most widespread recession since the Second World War. Although complete financial meltdown had been prevented, unemployment was soaring and the living conditions of millions of people were seriously affected. The economic outlook remained uncertain, and public deficit and debt had increased significantly. That had long-term implications for health and health

systems and posed many urgent questions for Member States and for WHO. Some lessons had already been learned. There were three main things that a solid health system should do: it should protect equal access for all, particularly those most in need; it should work across sectors; and it should be a "wise actor" in terms of investment, expenditure and employment. It was important to adhere to the values of equity, solidarity and participation emphasized in the Tallinn Charter.

The Head of the WHO Barcelona Office for Health Systems Strengthening said that the economic crisis had affected growth, trade, confidence, exchange rates, poverty and employment. The symptoms varied across countries, but in all societies the poor were most vulnerable and governments faced an increased risk of social disruption, with political consequences. The recovery would be uneven in breadth and depth, and unemployment in particular was unlikely to recover quickly. Many of the current information and monitoring systems were insufficient to meet policy-makers' needs, but it was clear that reduced resources would mean increased challenges to health services, and that unemployment led to a deterioration of living standards and increased stress. However, those impacts were not inevitable, and most countries had acted quickly to protect and maintain their health budgets.

In the crisis, the Tallinn Charter had increased relevance. The contribution of health to wealth provided an important guide for action towards economic recovery, with investment in health acting as an economic stimulus. The 12 recommendations that had emerged from the April 2009 meeting in Oslo underlined the importance of health investment being accompanied by commitments to accountability and performance. Health concerns should be integrated into all public policies. Explicit pro-poor policies should be adopted to protect the vulnerable, aiming for increased equity through universal coverage. It was possible that the crisis could provide opportunities for reform.

In the following panel discussion, moderated by the Director of the European Observatory on Health Systems and Policies, the Parliamentary State Secretary of the German Federal Ministry of Health pointed out that the groups who were suffering most were the least able to do anything about it, and the whole idea of social security, including housing, was at risk of being undermined. Some new measures being taken in Germany targeted those most in need and aimed to reduce unemployment. They included lowering the health insurance contribution rate; introducing an employment programme for health workers which would create 17 000 jobs; carrying out training programmes, and bringing hospitals up to date.

The Chief Medical Officer of the United Kingdom said that since the crisis began, a lot of money had gone into shoring up the economy. While there were many demands on public expenditure, the measures which needed to be taken in health had already been under way and would now have a higher profile: improving and protecting services, responding to rising public expectations and meeting the needs of an ageing population. The primary care gatekeeper system had already been subject to reforms but those needed to go even further, to reduce costs arising from excessive use of hospitals. Health promotion and disease prevention needed to be tackled in a serious way. Quality of care could be improved and costs reduced at the same time. One way of doing that was through increased self-care, so that patients with diabetes, for example, were equipped and supported but looked after themselves more independently.

The Chief Medical Officer and Director-General of the Danish National Board of Health said that investment in the health sector was part of the solution, not part of the problem. His country had moved from a large surplus to a large deficit by adopting an expansive strategy which included reductions in income taxes, early lump sum payments from pension funds, and more resources for renovation, regional investment, hospital investment and buildings. The health budget had been increased by 3% per annum for the present year and the coming two years. Protecting budgets and focusing on core values in the health sector provided a good point of

departure. That was taking place in the context of efficiency measures: two years earlier, 285 municipalities had been reduced to 98 and 14 regions to 5.

The Deputy Minister of Health and Social Development of the Russian Federation said that her country had increased funding in 2009 by 8%, a figure that was due to rise again the following year. Health and social programmes had not been cut. Demographic policy was top priority. Other priorities included health promotion, preventive programmes for high-risk groups, mother and child health protection, and tackling widespread diseases. There was also a focus on improving efficiency and ensuring the transparency of financial flows. The introduction of uniform standards and indicators would ensure high-quality health care provision across the country. A commission of experts was looking at innovative technological approaches, which should create jobs and increase self-sufficiency. While governments were responsible for the health of their population, however, global challenges required coordinated efforts.

The Minister of Social Affairs of Estonia said that it would be difficult for his country to reach its former level of resources. Its budget problems were deep because resources came from taxation and had considerably diminished. Unemployment was currently 13.5% according to the International Labour Organization (ILO), or 11.4% according to Estonia's own registries. The labour market was not recovering well, and the country would experience problems for some years. Some changes had been made in the sick leave payments system, so that the employer paid after the first four days and the health insurance fund took over only on the ninth day. Other measures included raising the value added tax (VAT) on medical supplies and excise duties on alcohol and tobacco.

The Minister of Health of Serbia said that his government had implemented major reforms before the economic crisis, but in 2009 it had decided to cut medicine prices by 5% and had also doubled co-payments. The year 2010 would be difficult because that kind of payment would not be easy to introduce, despite the fact that it would be based on the ability to pay. The aim was to do more with less. Consideration was also being given to reducing personnel in hospitals.

In the subsequent discussion, one representative speaking on behalf of the EU, the candidate countries Croatia, the former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilization and Association Process and potential candidate countries Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Armenia, the Republic of Moldova and Ukraine, which aligned themselves with the statement, stressed that a health system was a national asset and contributed to economic development. There was an urgent need to fully understand and assess the direct and indirect effects of economic recession on health and health system performance. The health impacts of the economic downturn could continue for the following two years. They would not be fully felt until the end of 2009, when 2010 budgets would be discussed and resources for health put under severe pressure. That would take place against a backdrop of an ageing population with potentially huge health needs. Concerted action to improve social conditions was very important, as were health promotion, disease prevention and cost-effective strategies, particularly to combat unemployment and poverty. No less than 150 million people were drawn into poverty each year through payments for health services. Addressing those challenges also depended on decisions in other sectors. However, while the crisis was a major socioeconomic challenge for all countries, limited resources could serve as an incentive for agreement among stakeholders on much-needed reforms and cost-effective measures: the crisis could be a window for change and modernization. WHO had a crucial role to play in providing guidance to the Region, and the EU looked forward to continued collaboration.

Several countries reported on their situation and their response to the crisis. One country had seen a sharp reduction in production, a 13% contraction in the first quarter of the year, resulting in a record level of unemployment. Many speakers shared a concern about deepening inequities. It would be more difficult to eliminate poverty and to reach the MDGs. Governments should

look beyond the crisis and act in accordance with their long-term objectives. Core activities should be protected, and universal access should be part of the stimulus packages. WHO had an essential role to play in monitoring the situation and advising countries.

A speaker observed that the outbreak of the flu pandemic, which happened soon after the crisis broke, had changed attitudes. Not only were there suddenly two crises, but the pandemic had changed the perceptions of the public and decision-makers, particularly regarding the importance of universal access to health protection measures and health care. Society's willingness to pay appeared to have increased markedly.

One representative reflected that for countries from the former Soviet Union, the present crisis was much milder than the economic crises they had had to go through. A special fund had been set up in his country for social and health sector benefits, maternal and infant mortality was improving, investment was increasing, new staff were being taken on and the number of medical students was rising. The administrators in oblasts were being asked to make special health services available for rural workers, and things had improved a great deal in the past ten years.

Another speaker described the major crisis his country had experienced in the early 1990s, which had created vicious circles affecting well-being into the next generation. Economic recovery was not enough; it was wise to keep up public expenditure and maintain health systems to mitigate the impact of the crisis. WHO should improve its capacity to deal with the problem of health in times of economic crisis, and it should prepare a regional action plan for effective implementation of World Health Assembly resolution WHA62.14 on the social determinants of health, in order to assist Member States. Another speaker suggested that WHO should make a European strategic review of Member States, which would form the basis of efforts to reduce social inequities in the Region.

Several speakers mentioned that they faced constraints but that primary health care and public health had to be protected, and that the shared values of the Tallinn Charter were even more important than before. Measures that provided returns while protecting health were underlined, such as taxes on alcohol, tobacco and sugar.

It was pointed out that the financial crisis impacted on the entire population, including the middle classes, who had more savings to lose and loans that were becoming a heavy burden. Wise spending was essential. The health industry should be part of government stimulus programmes.

The Lead Health Policy Adviser at the World Bank said that the current grave crisis was not only hitting individuals but also testing the resilience of social protection systems. At the centre of concern were the individuals and households affected by loss of jobs, and all the systems relying on tax revenue. The emerging middle classes who had climbed out of poverty now saw themselves sliding back. Millions of new poor had been created, erasing the progress of 20 years. Many countries were seeing 12% unemployment, some up to 27%. It was worrying that there was little evidence of what such a crisis did to health systems, and there needed to be a global observatory to find it, looking at household expenditures, impact of trade and other factors and how they related to the health sector. There was also a danger that countries would look inward and forget about global infectious diseases. Bilateral aid might shrink, which could be short-sighted, because those infectious diseases could come back. He advised countries not to make health workers redundant, not to increase co-payments and payroll taxes and not to cut public spending. Instead, they should focus on the most vulnerable and provide protection against catastrophic risks. The crisis might make it possible to implement new reforms and make new efficiencies, particularly in regard to expenditure on hospitals and pharmaceuticals. In the long term, such measures could strengthen the financial sustainability of the health care system.

Statements were made by representatives of the International Commission on Occupational Health and the World Federation for Physical Therapy.

The Committee adopted resolution EUR/RC59/R3.

Pandemic (H1N1) 2009

The Acting unit head, Communicable diseases, gave an update on the pandemic (H1N1) 2009 situation, noting the rapidity of development of the pandemic, with only nine weeks between the first report to WHO of an outbreak of an influenza-like illness in Mexico in April 2009 and the declaration of pandemic phase 6 in June, by which time cases had been reported in all regions of the world. The virus had not yet mutated, although there had been cases of resistance to an antiviral, particularly in cases of post-exposure prophylaxis; no confirmed transmission of the resistant strains had been reported.

The virus was very different from known seasonal influenza viruses, notably in that it was highly infectious and that most severe and fatal cases were in younger adult age groups. Although most severe cases also had underlying conditions, those conditions could not be used to predict fatalities, as many deaths had occurred in previously healthy adults and children.

Figures from the United States and Canada showed that demands on the health system would be much higher than normal, with double the numbers of emergency department visits during a normal influenza season, higher numbers of admissions to intensive care units and 10% of hospitalized cases needing mechanical ventilation, placing huge strains on both staff and equipment.

Information was available on the WHO web site, and surveillance was conducted by the Regional Office through the EuroFlu network, which published weekly information, provided it to the global surveillance platform in Geneva, and provided data from Member States in the European Union (EU) and the European Economic Area (EEA) to the European Centre for Disease Prevention and Control (ECDC).

In countries where the novel virus had become established, suspected cases no longer needed to be tested; the recommendation was to presume that any influenza-like illness was pandemic (H1N1) 2009. The current recommendation emphasized that antiviral treatment should be reserved for those persons at risk of or with severe disease.

While much of the population in the European Region lived in countries where vaccines were expected to become available through advance purchase agreements, local production capacity or the possibility of obtaining the vaccines from WHO stockpiles from the GAVI Alliance, solutions were being explored in collaboration with UNICEF, the EU and other partners to help middle-income countries access vaccine.

Those countries that had been affected early by the pandemic had gone some way to dealing with the challenges of communication with the public and the media; a balance needed to be struck between reassuring the people and avoiding complacency.

A panel of representatives of Member States, including the three that accounted for a substantial proportion of the fatalities in the Region, shared their experiences. The Chief Medical Officer of the United Kingdom explained that containment had initially proved useful, with school closures and prophylactic treatment of contacts giving time to prepare for the large numbers who later became infected. With extremely high pressure on the health services in mid-July, telephone triage and Internet self-assessment – part of the pandemic preparedness plan – had

been introduced and proved effective. It was hoped that vaccine supplies would become available in October for priority groups.

The advice from WHO regarding not treating uncomplicated cases was somewhat confusing: since 40% of deaths were in previously healthy young adults, non-treatment would result in more deaths, which, moreover, would be reported negatively by the media. Other unresolved issues were how to ensure enough critical care capacity, what recommendations should be given to pregnant women, and how to ensure that messages were communicated properly to the media, notably regarding mistaken diagnoses and the speed of the vaccine production process. The high numbers of deaths reported in the United Kingdom could have been a result of the special reporting measures that had been used in place of the usual excess death measure, as well as the high number of cases registered.

The Director of the Department of International Relations, Ministry of Health, Israel reported that the number of cases had surged with students returning at the end of the college year from the United States. Containment measures had initially been used, and then the community approach had been adopted. It had been recognized that purely national action would not be adequate; meetings and exercises had been organized with neighbouring countries.

The Director-General for Foreign and Public Health, Ministry of Health and Social Policy, Spain noted that his country had also used containment, which had given time for the health services to organize their response and to collaborate with both WHO and ECDC. There was a need for a common approach and good data on disease progression in asymptomatic cases; the meeting held in Cancun, Mexico in early July 2009 had found that work was being done in that respect. Coordination and consistency were important, particularly in a decentralized country like Spain.

The Deputy Minister of Health and Social Development of the Russian Federation explained that, although all the cases reported had been imported and there had been no deaths, that was a result of the efficiency of the operational response system, which had previously been used for other diseases. The Russian Federation had borders with 16 countries and would certainly see the appearance of new strains. Emphasis was being placed on prevention through education and training. Two reference laboratories were monitoring the situation in the country and in other countries of the Commonwealth of Independent States, where a network had also been set up. Research centres were developing four vaccines and there had been discussions on the possibility of extending their manufacture to other countries. In addition, the effectiveness of medicines such as interferon in comparison to oseltamivir was being studied.

The Minister of Health of Serbia emphasized the usefulness of transparent communication with the public. Weekly press conferences and clear messages had made it possible to proceed with two mass events in the country. Clear information had been given to participants, the responsible medical professionals had been required to report regularly, and good support had been received from WHO and ECDC.

A representative speaking on behalf of the EU, the candidate countries Croatia, the former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilization and Association Process and potential candidates Albania, Bosnia and Herzegovina and Serbia, as well as Armenia, Georgia, Norway, the Republic of Moldova and Ukraine, which aligned themselves with the statement, emphasized the need for flexibility and attentiveness to the development of the pandemic, and to review and adapt pandemic plans. Efforts should continue to implement the IHR fully, and cooperation in the sharing of virus samples was crucial. The EU member countries were better prepared for a pandemic than ever before because of the outbreak of avian influenza a few years previously and the work done on emergency preparedness since then.

Arrangements were requested that would allow EU and EEA member countries to provide the Regional Office with data through the ECDC surveillance system, thus avoiding the burden of double reporting. The EU would explore ways, in cooperation with WHO and national authorities, of helping less developed countries acquire vaccine supplies. Other measures both within and outside the health sector, as well as balanced communication, would all contribute to facing the pandemic.

One representative reported on a centre that had been established to look at the social response to the pandemic and evaluate the possibility of influencing it through analysis and communication.

The representative of the European Commission emphasized that health threats were global and called for a global response involving all international partners. The Commission was about to adopt a communication on pandemic (H1N1) 2009 addressing vaccines and vaccinations, solidarity with third countries, and communication. Recalling Article 57 of the IHR, which provided for flexibility in reporting arrangements, he explained that EC, ECDC and the WHO Regional Office for Europe were working closely to avoid Member States having the burden of double reporting.

In response to points raised in the discussion, the Medical Officer, Global Influenza Programme, WHO headquarters said that, although antivirals were indeed more effective if given early, if all cases were treated there would be an increase in the occurrence of adverse effects, in addition to the possible development of resistance. Moreover, it was possible that the proportion of severe cases with underlying conditions could be higher than reported, as they might be reported as the underlying condition rather than as pandemic (H1N1) 2009. Figures were also unclear for pregnant women; the case definition should be reviewed so that general practitioners understood clearly the early symptoms and treated pregnant women even in the absence of fever.

The Acting Unit Head, Communicable Diseases noted the financial and labour investment in containment, which only slowed the progression of the pandemic for a few weeks. He recognized the efforts being made with ECDC concerning double reporting and was confident that the problem could be resolved through bilateral discussions.

The Director-General noted the importance of conveying the right message to the media, specifically regarding streamlining the regulatory process for vaccines. It had to be made clear that the safety of the vaccines was not being compromised, merely that the bureaucratic procedure was being speeded up. She also encouraged WHO and the European Commission bodies to resolve the issue of double reporting as soon as possible.

Towards improved governance of health in the WHO European Region
(EUR/RC59/8)

A member of the Standing Committee introduced the topic, noting the two aspects of governance of health: national and international. At national level, health systems were evolving, and ways needed to be found to strengthen the role of health ministries. Internationally, the context was also changing and the role of the Regional Office needed to evolve in its relationships with WHO headquarters, other international organizations and partners, and the Member States. Reflection and debate over the coming year could provide guidance and food for thought for the new Regional Director and lead on to discussion and a resolution at the sixtieth session of the Regional Committee in 2010.

The Director, Division of Administration and Finance recalled that, although governance had long been thought of as simply a support function, debates over recent years had shown its impact on health outcomes. There were no clear boundaries between national and international

governance of health and, in defining their own role, Member States would set the international context. There were currently over 100 organizations active in health in Europe, with resulting overlaps in mandates and competition for resources, both human and financial. The Regional Office needed to know how it could best meet the needs of the Member States, how it should work with other international organizations, and how its internal structure could be improved. The survey of Member States had shown a high level of satisfaction with the work of the Office and would be further used for guidance as to where and how improvements should be made.

The Head of Research Policy, European Observatory on Health Systems and Policies gave an overview of the governance of health research in Europe, which he defined as the range of regulations, principles and standards of good practice needed to achieve and improve research quality. Far from being an abstract notion, governance was a practical need in health research.

WHO's strategy on research for health strove to ensure that research responded to priority health needs. Research tended to be concentrated in certain countries and areas of the world, meaning that some of Europe's major health problems received very little attention. Emphasis needed to be placed on facilitating and encouraging ethical research throughout the Region. It was important that clinical trials should be registered in advance, with their protocols, to avoid biased reporting and permit meta-analyses to identify overall effects. Consideration had to be given to data protection; anonymized data were far more extensively available in the United States. The exchange of biological samples was essential, but it required international collaboration and the standardization of protocols. Research capacity needed to be built up to be able to intervene rapidly in emergency situations and ensure that lessons were learned from them. An analysis should be made of research governance in the European Region, the existence of research gaps and ways they could be closed; such information and discussion could contribute to *The world health report 2012*, which was to focus on research for health.

A panel of representatives of other organizations active in the field of health discussed their role compared to that of the Regional Office. The Head of the Health Division, Council of Europe explained that health was one part of his organization's basic role related to human rights and democracy. Some conventions and the European Social Charter contained sections related to health protection; committees considered health in relation to human rights, in the areas of mental health or the protection of vulnerable groups. The Council's approach was similar to that of the Health for All concept, and the potential of its 47 member states could be used to help build health care with a human face.

The Co-Director of the European Observatory on Health Systems and Policies explained that the Observatory acted as a think tank, synthesizing knowledge and providing practical advice on request to governments. The Regional Office should define its role compared to that of other agencies working in the area of health, identifying its unique features, areas in which it complemented their work and areas of overlap, and seeking, for the latter, to establish which agency should take on the full responsibility. Within WHO itself, the Regional Office had a wealth of knowledge that could allow it to become a think tank for the whole Organization.

The Director, Public Health and Risk Assessment, EC Directorate-General for Health and Consumers explained that many bodies and agencies in the EU system worked in areas related to health. The different European treaties had each included a public health agenda, the Commission had a five-year health strategy and there was currently an ongoing process of discussion on global health. Particularly in the current economic crisis, ways needed to be found for international organizations to work together on health. The WHO Regional Office for Europe was a trademark for health professionals. It might usefully reflect on the type of products it wished to produce and who its clients were.

The Lead Health Policy Adviser, World Bank recalled the evolution of his organization: founded after the Second World War to rebuild Europe, its mandate had subsequently been

altered to promote global development. The Bank had been active in health only for the past 25 years, but had seen the clear need for a multisectoral approach; it had expertise in all fields that contributed to health. Moreover, it had dual capacity in financing, with its own income giving it financial stability and meaning it was not dependent on contributions; it was, in fact, one of the largest lenders in health in the world. However, its mandate did not include expertise directly in health, and it needed to collaborate with a strong WHO to help improve health outcomes. The WHO Regional Office for Europe needed to be able to build and adapt in a dynamic environment; to show leadership in research; to ensure that partnerships produced added value; and to speak the truth with openness.

Reflecting on how WHO should best provide the leadership needed in research without overlapping the work of other bodies, the Head of Research Policy, European Observatory on Health Systems and Policies noted that some Member States with stronger capacity could help those with less; governments welcomed advice, and it would be beneficial to establish systems adapted to local circumstances. In adapting to the future, the Regional Office should make sure not to lose what it already had: the Region enjoyed more capacity and closer collaboration than any of the other regions of WHO. By analysing the governance of research over the coming year, it would ensure that Europe was the most dynamic environment for research in the world.

A representative speaking on behalf of the European Union, the candidate countries of Croatia, the former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilization and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Armenia, the Republic of Moldova and Ukraine, which aligned themselves with the statement, welcomed the initiative of the Regional Director to open a discussion on future reforms and the governance of the Regional Office and looked forward to analysing different options in the coming months.

A number of representatives looked forward to discussing the criteria for membership of WHO's governing bodies; the geographical groupings needed to be revisited in the light of political developments. A geographical balance did need to be maintained, not only over time but at any given moment. More weight could be given in the procedure to personal criteria. The method adopted should be equitable without being too complicated.

The role and mandate of the Standing Committee and the possibility of enlarging its competences could usefully be considered; it should continue to play an active role in fostering consensus and smooth elections and nominations, and new ideas for ways of achieving that could be discussed. One speaker thought that the understanding of membership of the Executive Board by the permanent members of the United Nations Security Council also needed to be reconsidered, and a balanced solution found. It was important to ensure a geographical balance, particularly on the Executive Board, where members from the European Region should represent the interests of the Region.

One representative noted that the priorities for the Office in the coming years were consistent with those of WHO as a whole: strengthening health systems; the health workforce; taking forward the work of the Commission on Social Determinants of Health and tackling health inequities, where a clear action plan for the Region was needed; health security and learning the lessons of pandemic (H1N1) 2009; and preparing for the effects of climate change on health systems, where the Office was already working well.

The Regional Office's relations with WHO headquarters were important, with coherence between priorities globally and in the Region reinforcing the "one WHO" approach. In that context too, the Office and the Member States should, in the different WHO fora as well as in external gatherings, present a more consistent message about the Region's priorities.

One speaker noted that the Regional Office should be a model for the other regional offices, attracting the best capacities and responding to the needs of its Member States. The problems and needs of the countries in the Region could be very different, but that was a strength rather than a weakness, and the Office could bring added value to all.

A number of speakers agreed that partnerships were important to the work of the Regional Office and should be beneficial to the Member States. The role, mandate and portfolio of the Regional Office in respect of other organizations in Europe dealing with health should be reviewed, with the aim of avoiding duplication of work and ensuring optimum use of resources.

The analysis of the above mentioned issues to be undertaken by the Standing Committee with the involvement of Member States could form a constructive point of departure for the incoming Regional Director and a solid base for discussions and decisions at the sixtieth session of the Regional Committee.

Responding to the discussions, the Director, Division of Administration and Finance agreed that the time was right to explore and analyse situations and views. The agenda should be led by the Member States, who clearly welcomed the dialogue, focusing on the role and competences of the Standing Committee and the Office's relationship with WHO headquarters. Ways would be explored of ensuring that Member States and the Office spoke with one voice, both in WHO and with other international organizations. The international context needed to be mapped and WHO's role in it reassessed, keeping in mind the fact that the environment was dynamic. There was much material to be worked on in the year ahead.

Statements were made by representatives of Alzheimer's Disease International and the International Diabetes Federation Europe.

Health workforce policies in the WHO European Region (including International recruitment of health personnel: draft global code of practice)

(EUR/RC59/9, EUR/RC59/Conf.Doc./3, EUR/RC59/BD/1)

Introducing the item, a member of the SCRC observed that, while all Member States needed a sufficient health workforce with the proper skills, adequately deployed and working in supportive environments, they had to deal with a wide range of issues in that area. In addition to reviewing health workers' pay and training, European governments needed to cope with a major policy challenge: migration from lower- to higher-income countries. While that could help the latter solve problems with shortages and inadequate skill mixes, it could jeopardize the former's right to health. The development of the draft WHO code of practice on the international recruitment of health personnel raised questions of the level at which Member States were consulted, the values the code would embody and how they would be pursued. Member States could use the Regional Committee discussion to consider such issues.

The Director, Division of Country Health Systems described the work done since the Regional Committee had adopted resolution EUR/RC57/R1 in 2007, particularly by the Regional Office, and the main issues that needed to be tackled. Policy on health workers was being made in a global context of challenges and opportunities that included globalization of labour markets and the financial crisis, and a European context of changes in demographic and epidemiological factors, health technology, the organization and structure of health systems, and the political and economic environment. Member States faced not only an unfinished agenda of issues such as imbalances in health workers' distribution and skills, poor working environments, low salaries and a weak knowledge base, but also new challenges: labour flexibility, patient mobility, growing shortages, uncontrolled migration, poor planning, the increasing role of the private sector and the effects of innovation. The Tallinn Charter called for countries to use long-range planning and investment to secure the right human resources for health, and for both the

minimization of international recruitment and its ethical practice. The Regional Office was committed to helping Member States manage health workforce migration through continuing policy dialogue between source and destination countries, sharing of information and good practices, intersectoral collaboration and work with all relevant partners, including the Statistical Office of the European Communities (Eurostat), OECD and, within WHO, headquarters and the Regional Office for Africa. Because migration resulted from both push factors in source countries and pull factors in destination countries, a balance needed to be struck between the two groups.

The Director, Department of Human Resources for Health at WHO headquarters updated the Regional Committee on the process of developing the draft WHO code of practice on the international recruitment of health personnel and framed the considerations operating on WHO. Milestones since the start of the process in 2004 had included discussion by the Executive Board and the World Health Assembly, with multiple partners in multiple sectors, at the WHO European Ministerial Conference on Health Systems and by the Group of Eight (G8) main industrial countries. Those discussions had had a positive tone, revealed much information and included high-level commentary that encouraged completion of the code. The contributions of European Member States and the role of the Regional Director in fostering interregional dialogue had helped build considerable momentum. The development process had reached the stage of consulting WHO regional committees; a global code should be adopted, even though national and regional codes already existed, because the issue excited global interest, WHO could provide needed leadership, and the code would be the only global framework for international cooperation on the matter as well as a unique platform for global dialogue. Member States still differed regarding some issues in the code; could progress be made towards finalizing it?

A panel of representatives from both source and destination countries shared their views and their countries' policy initiatives. As chair, the Executive Director, Global Health Workforce Alliance noted that many health workers migrated to the European Region, and between and within European countries; stabilizing that migration was essential. Individuals had the right to move but also a responsibility to their home countries, particularly when they were trained at its expense. Understanding both push and pull factors was critical, as was the recognition that countries losing skilled staff were unwilling donors to destination countries in a way that threatened their own health systems.

The Minister of Health of the Republic of Moldova described her country's projects to stop emigration as part of a systematic effort to strengthen its health system, including making policy on migration, introducing health insurance, providing services to rural areas, subsidizing care and improving training. That effort had strengthened basic medical services and increased interest in the training and status of health workers, particularly doctors. The country had also sought funding from WHO to support training. It still needed guidelines on how to retain health workers, and it was working with partners such as the International Organization for Migration (IOM) to gather information on the effects of migration on both countries and migrants. Dialogue and reporting on the issue were needed to identify indicators and resources to enable effective responses. The country supported work to strike a balance between the value of Moldovan health workers to other countries and the country's own needs.

The Under-Secretary of State at the Ministry of Health of Poland focused on the health system's need for doctors, which was an important part of WHO's initiative on migration and the EU green paper on the European workforce for health. The challenges to EU health systems required action at the local, national, regional and Community levels. As health workers accounted directly and indirectly for about 70% of health care expenditure, WHO, the EU, other bodies and health ministries advocated careful planning for their development, including that of medical personnel. Planning to meet the demand for personnel should take account of

migration. The policy framework on organizing and providing health care services needed to include steps to ensure a sufficient number of qualified medical practitioners, by facilitating access to and improving the quality of training and specialist and continuing education, and by adapting health care systems to the needs of ageing societies. To cope with the expected shortage of nurses, procedures should be devised to permit retired nurses to return to work. When giving its position for the green paper, the Government of Poland had welcomed the initiative, expressed support for measures to ensure the availability of doctors and stressed that such measures should not entail negative effects on the health systems of countries outside the EU.

The Director-General of the Ministry of Health and Care Services of Norway commended WHO headquarters and the Regional Office for placing the critical issue of migration high on the global agenda. Enough was known about the issue to conclude that action was needed. As its implications touched every country, all would have to be part of the solution and take account of the likely effects of their health workforce policies on others. WHO needed to continue to take a leading role. The expense of health personnel had prompted Norway to tackle the issue as part of making its health system more sustainable. The Norwegian Government was committed to making good projected shortages without disadvantaging poorer countries. Recognizing that foreign labour could become essential to the health workforce, the Government had identified four principles to guide policy development and considered that they should also underpin international mechanisms such as the draft WHO code. First, all countries should meet their needs with their own resources, as far as possible. That required plans based on projected shortages, which in turn necessitated the collection of data. The Government would focus on domestic measures to increase capacity. Each country needed a sustainable policy to deal with that challenge. The other principles were: stimulating and enhancing discussion on task shifting and other innovative ways to create more cost-effective methods of service delivery; abstaining from active recruitment from poorer countries unless there were equitable bilateral, regional or multilateral agreements; and focusing development aid on educating health personnel and thus helping to strengthen recipients' health systems. The Regional Committee's acceptance of those principles and adoption of the proposed resolution would contribute to the debate at the Executive Board and the World Health Assembly.

The Director, Department of International Relations, Ministry of Health of Israel identified a key question: how many physicians did a country need? Israel used the OECD average figure of 3 per 1000 population. It needed more information – for example, on the number of Israeli medical graduates working abroad – to cope with a projected shortage and the ageing of physicians, and to retain Israeli health workers in the country.

The Head of Section, Directorate of Hospitalization and Organization of Health Care, Ministry of Health and Sports of France expressed her country's support for WHO's initiative to meet health workforce challenges at the global level. The WHO code of practice was needed to protect countries' right to health, but it was not the only tool required to fight excessive migration. International cooperation was needed to reinforce source countries' health systems; France had bilateral agreements with African countries to help them plan their health workforces so that they could care for their populations, to train health workers in France and help countries to provide health workers to serve rural areas. The WHO code should help countries make plans for health personnel that limited the need for foreign recruitment. A new law was intended to help France do that by encouraging better distribution of its numerous health workers; for example, there were 347 doctors per 100 000 population. A planning process enabled local areas to identify personnel shortages and provided incentives to relocate doctors to those areas. Binding "solidarity contracts" could be used to force doctors to move, if an evaluation of progress in three years' time showed that they were needed. Similarly, a Government agreement with nurses forbade them to move to areas with surpluses.

The Assistant Principal, Department of Health and Children of Ireland commended the work done by WHO's and Member States on developing the code of practice and wondered if the code should promote bilateral and multilateral agreements. International policy must be based on country policies. The EU green paper showed the complexity of migration by pointing out that it had advantages and disadvantages for both the countries and the individuals involved. Ireland had developed and used an ethical code for the recruitment of nurses and other health workers. In the current economic climate, it had reduced recruitment and the domestic supply was sufficient. Ireland had also adopted a set of principles for the health workforce. First, workforce policies should be sustainable and include both numbers and skills mix. Medical training and service provision needed reform, particularly in the face of changing roles of service providers. Ireland had reviewed the regulation of health care personnel. Countries should develop workforce planning strategies, and integrate them in overall service and financial planning for health systems. Finally, the country had recently reviewed the grades of health care providers in order to identify supply and demand for the coming years, with the aim of using Ireland's own resources to meet its needs.

Summarizing the discussion, the panel chair noted that countries had a collective responsibility to take action on the critical issue of workforce migration. They needed to take a comprehensive approach, considering both the numbers and distribution of staff, make plans, ensure adequate resources, monitor migration flows and exchange experience. Wealthier countries should assist others. Migration was a constant; the aim was not to stop it, but to manage it to meet domestic and global needs.

In the discussion that followed, almost all speakers expressed support for the WHO code of practice and the draft resolution; several praised the Secretariat's report in document EUR/RC59/9 and some thanked the Regional Office for its work on this issue since 2007. A representative speaking on behalf of the EU, the candidate countries of Croatia, the former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilization and Association Process and potential candidates Albania, Bosnia and Herzegovina and Serbia, as well as Armenia, Georgia and Ukraine, which aligned themselves with the statement, noted that the lack of skilled health professionals was a growing problem in Europe, but migration had created a real crisis for countries in sub-Saharan Africa. The politically delicate task was to strike a sustainable balance between providing good and accessible care for all and honouring individuals' right to leave their countries of origin. The European Region contained both source and destination countries; that showed the complexity of and the need for coordinated approaches to the issue. Countries needed to develop health workforce strategies, but action was also needed at the international level. Such action had included richer European Member States' using development aid to support source countries in strengthening their health systems. In addition, making progress required the collection of timely and accurate data, and the balancing of reporting and monitoring requirements in accordance with the voluntary nature of the code.

As it had at the January 2009 session of the WHO Executive Board, the EU welcomed the proposal for a WHO code of practice, supported the draft resolution and encouraged WHO to continue its work on the topic. A voluntary code opened the way for countries to optimize implementation in accordance with their health systems' varying structures and organizational principles. The presence of many migrants in EU Member States' hospitals gave it a particular responsibility, which it had recognized by trying both to provide high-quality care and to limit the impact on health systems in countries outside the EU. Those efforts were spelt out in the 2005 EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries, the 2006 programme of action to tackle the shortage of health workers in those countries and the 2008 green paper, which referred to the ethical principles mentioned in the WHO report.

WHO's work towards a code on the international recruitment of health personnel offered a framework in which the EU would maintain and strengthen its efforts at the EU, European and global levels. WHO provided an indispensable forum for negotiations. The draft resolution and the process of developing the code were important steps towards finding common solutions to cushion the negative effects of migration in the short run and agreeing on how to strengthen weak health systems in the long run.

Several representatives supported the EU statement and the principles it endorsed. Many speakers described their countries' situations and efforts to build sustainable health workforces. Destination countries were taking measures such as modelling their needs for health workers for a decade or more, passing new laws and making policy on education and recruitment. Source countries were experiencing staff shortages (not all of which resulted from migration) and distribution problems that affected the provision and quality of care. Several countries were taking steps to increase staff retention and reduce shortages and, in some cases, reliance on immigrants. Two speakers suggested that the use of the "blue card" admitting physicians to practise in the EU should be monitored. Representatives described a range of migration problems in their countries, including foreign staff leaving the country and staff moving away from rural areas and from the health sector.

In suggesting next steps, several representatives agreed that the draft code should be finalized as soon as possible, at the 2010 World Health Assembly, and hoped that European Member States could reach consensus or even take a common position at the next session of the Executive Board. Three speakers asked to know the results of the consultations under way in other WHO regions, particularly the African Region. They also asked when and how the consultation for European countries would take place and hoped the format would involve all of them meeting together, as had been done for the WHO Framework Convention on Tobacco Control. Others raised issues in implementing the code once it was adopted. One suggested that Member States should commit themselves to the code's principles and actions, even though it was voluntary. Another called for Member States to consider Directive 2005/36/EC of the European Parliament and of the Council on the recognition of professional qualifications, in selecting the best ways to act on the code.

Further steps that the Regional Committee and WHO might take included harmonizing and standardizing data and indicators on health workforces; minimizing the difference between Member States in health workers' descriptions and qualifications; formulating data collection procedures to obtain information on migration, especially at national level; developing performance criteria within the framework of the Tallinn Charter; building flexible structures to help countries exchange information, and strengthening national human resource capacities. In addition, it would be useful for the Regional Committee to address the issue of the provision of informal care, particularly of elderly people, by immigrants whose education and skills were unknown.

It was suggested that WHO should revise the code to reflect the current economic situation. Migration needed to be monitored, in order to secure better information and ensure that outflows did not endanger care for countries populations. To respond to the crisis, countries needed to take measures such as agreeing regulations with their health workforces; managing their workforce on the basis of conditions in the country and international markets; evaluating the quality and volume of staff in countries and international markets (using information on the latter to be provided by WHO); evaluating the legislative basis; monitoring health professionals in the country, and developing methodological aids.

Another speaker suggested that the Regional Committee should discuss the open questions about a code of practice raised in document EUR/RC59/BD/1, namely, whether it should recommend that Member States limit recruitment from countries with critical workforce shortages; promote the making of bi- and multilateral agreements based on the principle of

mutuality of benefits; recommend that destination countries give source countries financial compensation; and include the concept of national workforce sustainability.

The WHO Regional Director for Africa explained that, although the health workforce migration crisis was hitting African countries hardest, African and European Member States faced similar problems, proposed similar solutions and needed to scale up their efforts to respond. The Regional Committee for Africa had recommended that Member States should develop and implement policies and strategies on human resources for health that emphasized retaining trained staff, improving salaries and working conditions, and using incentive schemes; improve negotiations with bi- and multilateral organizations to reduce migration out of the Region; scale up education and tailor skills to needs in countries; and ensure that the health ministry worked with finance and other sectors to develop and improve the management of human resources for health. The WHO code of practice should discourage active and commercialized recruitment and protect the rights of immigrant health professionals. The code represented a big step forward but could require amendment to meet countries' needs. WHO was asked to keep providing technical support on health personnel issues, to help countries deal with them as part of their efforts to reach the MDGs. Regional Committee proceedings in Africa and Europe indicated that there was common ground for reaching agreement on the code. Nonetheless, some issues needed further consideration. How would the non-binding code be enforced? How could its ethical content be implemented? And how could the focus on strong national capacity be balanced with meeting international health needs?

In reply, the Director, Division of Country Health Systems welcomed Member States' support for the code and resolution. To ensure the consultation with Member States needed to complete the process, the Regional Office would organize meetings up to the Executive Board session in January 2010. A common European position on the code would be a worthy goal. It was important to monitor migration, in order to produce the additional information countries needed. Again, the central issue was to manage migration, not stop it.

The Director, Department of Human Resources for Health recognized that Member States had given a clear message to move forward on the code. WHO headquarters would listen to all regions' messages and incorporate them in its report to the Executive Board. To accelerate the process, the Secretariat would consult as appropriate on the code and attach a revised version to its report.

Statements were made by representatives of the following nongovernmental organizations (NGOs): Medicus Mundi International Network, the World Confederation for Physical Therapy, the International Federation of Medical Students' Associations, the EuroPharm Forum and the WHO European Forum for National Nursing and Midwifery Associations.

Concluding the discussion, the WHO Regional Director for Europe said that several factors had made it particularly interesting. First, everyone had appreciated the participation of the Regional Director for Africa, which bore witness to the complementary approaches adopted by WHO. Second, the subject was an entry point for wider considerations about health systems and the application of human rights to health and to migration. Third, owing to the diversity of the European Region, coping with the international problem of health workforce migration entailed taking account of many aspects, ranging from numbers through human rights to training. Fourth, the issue showed that solidarity was essential for security; problems on one country made problems for others. Finally, he thanked Norway for urging WHO to act on the issue.

The Committee adopted resolution EUR/RC59/R4.

Implementation of the International Health Regulations (2005) in the WHO European Region

(EUR/RC59/10, EUR/RC59/Conf.Doc./8)

A member of the Standing Committee of the Regional Committee noted that the emergence of the pandemic (H1N1) 2009 had underlined the importance of the IHR, which would help to monitor and manage the public health risk it posed. The all-hazards and multisectoral approach of the IHR offered an exceptional opportunity to build on existing capacities in a cost-effective manner; important progress had been made, but there was room for improvement. Political commitment was fundamental to empower national authorities to move forward in the IHR implementation process. Lessons should be learned and applied. June 2009 had been the deadline for assessing core capacity and developing national IHR action plans, but countries had until June 2012 for their implementation. By that time, core capacities should be in place. Political commitment would also be needed to mobilize the resources required.

The Acting Director, Health Programmes, summarizing the activities and achievements to date, recalled that the IHR had come into force in 2007, as a legal instrument setting out procedures and the rights and legal obligations of States Parties and WHO. Unusual health events of potential public health concern could be addressed only through a strong international response system, which involved many partners and levels of collaboration, including globally. Seventy-nine per cent of the States Parties in the Region had participated in bilateral or multilateral groups to prepare for or respond to cross-border health events. The Office had organized training, meetings of national IHR focal points, and the sharing of experience and expertise. One of the challenges had been to maintain the regional coordination of global IHR initiatives while still recognizing the great diversity across the Region. The pandemic (HIN1) 2009 had been the first test case.

All States Parties to the IHR, including those 54 States Parties in the WHO European Region, had been asked to report back annually to the World Health Assembly; however only 31 States Parties were reporting on time as requested, which did not give a comprehensive picture of IHR implementation. In the 2009 States Parties report, countries had reported on progress they had made with building national core capacity for surveillance and response, which were at the core of the IHR, as well as the major strategic focus within the European Region of WHO. Of the 30 countries that had responded, 28 reported that they had assessed their surveillance and early warning functions, and 27 had assessed their response function. Only 17 of 31 responding countries however, reported that they had developed action plans to address the gaps.

The Office had developed generic and hazard-specific assessment tools for countries and had organized or supported workshops backed by evidence and best practice. Country missions provided technical guidance, and several countries had supported others with their expertise.

Travel and transport reflected the truly multisectoral approach promoted by the Regulations. Certain aspects of that area of work were complex and new to public health professionals, so achieving a harmonized approach had been difficult and communication with focal points was vitally important. The Regional Office had taken the lead, holding a dedicated workshop, providing training for focal points and facilitating input from national experts into global guidance documents: their contributions had been invaluable.

Since 2007 more than 200 public health events of potential international concern in over 40 States Parties had been subject to joint risk assessment. Pandemic (H1N1) 2009 had demonstrated the value of the IHR framework in maintaining communication and disseminating information: the lessons learned from the outbreak of severe acute respiratory syndrome (SARS) had paid off. Coordinated action by WHO and national focal points had been invaluable, and the experience should be evaluated.

National legislation had to be compatible with the IHR, and 16 out of 30 responding States Parties had adopted new or revised legislation, which was challenging in view of the limited legal expertise available.

Implementation of the IHR was a continuous learning process requiring unwavering commitment and adequate resources, and substantial work had been done in that area. Monitoring of IHR implementation should go beyond the current quantitative approach that focused on compliance with IHR provisions. WHO should identify possible qualitative mechanisms to also assess the public health benefits resulting from implementation of the IHR.

WHO should further work with other partners operating at regional level in order to define better mechanisms and structures that would enable States Parties to comply with their obligations under the IHR and other independent legally binding frameworks. Such mechanisms should be built on existing structures and networks, which would avoid duplications and create synergies.

In the subsequent discussion, a representative speaking on behalf of the EU, the candidate countries Croatia, the former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilization and Association Process and potential candidate countries Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Armenia, Georgia, Norway, the Republic of Moldova and Ukraine, which aligned themselves with the statement, said that the outbreak of pandemic (H1N1) 2009 had clearly demonstrated the importance of the IHR. They were a crucial global instrument enabling joint and transparent risk management based on evidence, and a rapid response to international threats to human health. The pandemic had also highlighted the challenges that remained. Common interpretation of the scope of the IHR and application of their provisions were important, and further efforts were needed to build capacity for surveillance and effective response in all countries. The exchange of best practice was an effective tool, and the work should involve all relevant sectors, including those responsible for areas such as chemical and radioactive substances, to ensure that the broad scope of the IHR was implemented. WHO had a vital role to play in coordinating global and national efforts, and WHO at global and regional levels had done excellent work in a challenging situation, in close collaboration with the European Centre for Prevention and Disease Control.

Representatives underlined the need to protect their citizens, particularly in the anticipated second wave of the pandemic (H1N1) 2009. International gatherings were useful for raising awareness, exchanging experience and enhancing cooperation. WHO's annual meeting of national focal points had had to be postponed but it was hoped that it could be held soon. An assessment mechanism, such as a checklist to guide countries towards full implementation, would be useful.

One representative observed that the introduction of the IHR was a priority issue, and in his country the surveillance and response system had been strengthened through a series of measures including specialized teams. In the context of the IHR, new laws and new methodological approaches to communicable disease had been used to examine the novel influenza strain and its spread. Earmarked funds were being channelled towards improving laboratories and equipment, and monitoring was being carried out in cooperation with neighbouring countries. It was important that database information was accessible. Finally, there was a need to address the transport of medication and to minimize the bureaucracy involved.

In response, the Acting Director, Health Programmes thanked States Parties in the Region for their ongoing commitment to implementation of the IHR and announced that the work would continue and that the annual meeting of national focal points was now planned for January 2010.

The Committee adopted resolution EUR/RC59/R5.

Follow-up to previous sessions of the Regional Committee

(EUR/RC59/Inf.Doc./1)

Future of the WHO Regional Office for Europe

The Regional Director for Europe gave an overview of developments in the role and position of the Regional Office up to 2020. The strategic directions outlined in document EUR/RC56/11, submitted to the Regional Committee at its fifty-sixth session, were still valid and work on them was evolving in the context of a changing environment, notably the economic crisis. Work with international partners was aimed at ensuring the best use of resources. In line with the aim of strengthening health security, the Office had been playing a leading role in the international response to the pandemic (H1N1) 2009. The new Regional Director would no doubt ensure continuity in areas such at the Country Strategy but it was the Member States who would decide on the path that the Office's work would follow.

Progress made towards attaining the Millennium Development Goals

The Head of the WHO Country Office, Republic of Moldova considered the progress made towards attaining the health-related Millennium Development Goals (MDGs) five years before the target date of 2015. Although there had been challenges in reducing child mortality, there had been a steady decline across the Region. Maternal health was the area in which progress was most lacking, and data modelling indicated higher rates of mortality than were reported by national systems. Tuberculosis was particularly problematic, as 15 of the world's 27 high-burden countries were in the WHO European Region, and there was a worrying increase in the prevalence of drug-resistant forms, especially in the east of the Region. Economic differences gave rise to health inequities throughout the Region, and countries faced a challenge in ensuring that their health systems reached rural and disadvantaged populations.

A representative speaking on behalf of the European Union, the candidate countries, Croatia, the former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilization and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Armenia, Georgia, the Republic of Moldova and Ukraine, which aligned themselves with the statement, highlighted the lack of progress in statistics on maternal and newborn health, reflecting the low status of women, and called for a focus on those, as well as on gender equality and equity. The number of tuberculosis cases in the Region was alarming, with the highest rates in the world of new cases of multidrug-resistant tuberculosis and tuberculosis linked to HIV. A further high-level meeting was to be held in Berlin in October 2009 to focus on ways of dealing with those challenges.

One speaker urged greater coordination between countries and international organizations to speed up attainment of the MDGs and called for attention to be paid to the need for infrastructure and training, in addition to combating specific diseases.

Elections and nominations

(EUR/RC59/5 Rev.1, EUR/RC59/Conf.Doc./5, EUR/RC59/Conf.Doc./6)

The Committee met in private to nominate one candidate for the post of Regional Director for Europe and two candidates for membership of the Executive Board, as well as to elect three members of the SCRC and one member of the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases.

Regional Director

By resolution EUR/RC59/R1, the Committee requested the Director-General to propose to the Executive Board the appointment of Ms Zsuzsanna Jakab as Regional Director for a period of five years from 1 February 2010.

The Committee also adopted resolution EUR/RC59/R2, expressing its gratitude to Dr Marc Danzon for his commitment and invaluable contribution to the work of WHO, especially in advancing the public health agenda in the European Region, and declaring him Regional Director Emeritus.

The Director, European Centre for Disease Prevention and Control thanked Member States for nominating her and pledged that she would do all she could, with the help of the staff at the Regional Office and in close cooperation with the Director-General and WHO headquarters, to ensure that the Regional Office remained a strong public health leader and innovator in Europe and throughout the world. She looked forward to working with every single Member State in the European Region and would maintain a close working relationship with all partner organizations, notably the European Union, for the benefit of the Region and the Organization as whole.

The Deputy Regional Director was grateful for the support she had received from Member States, which she valued as recognition of the successes achieved by the Regional Office in recent years. She congratulated Ms Jakab on her nomination and wished her every success in the future. The Regional Director paid tribute to the work done by his deputy and reiterated his pledge to make the transition to his successor as smooth as possible.

A representative speaking on behalf of the EU, the candidate countries of Croatia and Turkey, the countries of the Stabilization and Association Process and potential candidates Albania, Bosnia and Herzegovina, and Serbia, as well as Armenia, Iceland, Norway, the Republic of Moldova and Ukraine, which aligned themselves with the statement, acknowledged the high competence of the other candidates in the nomination process and also congratulated Ms Jakab on her nomination. The EU reaffirmed its strong commitment to working in partnership with the WHO Regional Office for Europe, in order to achieve the common health goals of the European Region.

The Regional Director was commended on his impeccable leadership of the Regional Office over the previous ten years.

Executive Board

The Committee decided by consensus that Armenia and Norway would put forward their candidatures to the Health Assembly in May 2010 for subsequent election to the Executive Board.

Standing Committee of the Regional Committee

The Committee by consensus selected Azerbaijan, Sweden and Ukraine for membership of the SCRC for a three-year term of office from September 2009 to September 2012.

Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases

In accordance with the provisions of paragraph 2.2.2 of the Memorandum of Understanding on the Special Programme for Research and Training in Tropical Diseases, the Committee by consensus selected Tajikistan for membership of the Joint Coordinating Board of the Special Programme for a four-year period from 1 January 2010.

Dates and places of regular sessions of the Regional Committee in 2010–2013

(EUR/RC59/Conf.Doc./4)

The representative of Malta recalled that his country had, at the Regional Committee session the previous year, offered to host the sixty-second session in 2012, and it had subsequently confirmed that offer in writing. Equally, the representative of Lithuania recalled that his country had offered to host a session in 2012 or 2014 but pointed out that it was flexible with regard to the year.

Notwithstanding the recommendations made by the Sixteenth Standing Committee of the Regional Committee at its fifth session (as recorded in the report of that session, document EUR/RC59/4 Add.1), the Regional Committee agreed that, exceptionally, it would decide on the venues of its sessions for the following five years, given the number of offers that had fortunately been received. However, it also agreed to ask the Standing Committee to prepare for a debate at a subsequent session of the Regional Committee on the principles or criteria that should underlie the choice of sites of future sessions, and it decided that no further offers would be received until that debate had been held.

The Committee therefore adopted resolution EUR/RC59/R6, by which it decided that its sixtieth session would be held in Moscow, Russian Federation from 13 to 16 September 2010; its sixty-first session would be held in Azerbaijan from 12 to 15 September 2011; its sixty-second session would be held in Malta from 10 to 13 September 2012; its sixty-third session would be held in Portugal from 16 to 19 September 2013, and its sixty-fourth session would be held at the WHO Regional Office for Europe in Copenhagen (exact dates to be decided).

The representative of the Russian Federation said that his country was looking forward to welcoming participants in the sixtieth session and would do its utmost to make sure the session was a fruitful one.

Resolutions

EUR/RC59/R1

Nomination of the Regional Director for Europe

The Regional Committee,

Considering Article 52 of the Constitution of WHO; and

In accordance with Rule 47 of the Rules of Procedure of the Regional Committee for Europe;

1. NOMINATES Ms Zsuzsanna Jakab as Regional Director for Europe; and

2. REQUESTS the Director-General to propose to the Executive Board the appointment of Ms Zsuzsanna Jakab from 1 February 2010.

EUR/RC59/R2

Expression of appreciation to Dr Marc Danzon

The Regional Committee,

Expressing its gratitude to Dr Marc Danzon for his commitment and his invaluable contribution to the work of WHO, especially in advancing the public health agenda in the European Region;

1. EXPRESSES its sincere thanks to Dr Danzon for all he has done to advance the work of WHO;

2. DECLARES Dr Marc Danzon Regional Director Emeritus of the World Health Organization.EUR/RC59/R3

EUR/RC59/R3

Health in times of global economic crisis: implications for the WHO European Region

The Regional Committee,

Recalling resolution EUR/RC58/R4 on stewardship/governance of health systems in the WHO European Region, related to the Tallinn Charter adopted at the WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth";

Recalling resolution EUR/RC57/R2 on the Millennium Development Goals in the WHO European Region;

Mindful of the reports of the global high-level consultation on the financial crisis and global health, held in Geneva on 19 January 2009, and of the meeting on health in times of global economic crisis: implications for the WHO European Region, held in Oslo on 1 and 2 April 2009 and whose recommendations are attached as Annex 1;

Having reviewed document EUR/RC59/7 on Health in times of global economic crisis: implications for the WHO European Region;

1. ACKNOWLEDGES the risks for health and health systems, and the main opportunities for action that the ongoing global economic crisis entails, as well as the positive reaction of Member States and different stakeholders in the health sector in responding jointly to it;

2. TAKES NOTE OF the recommendations for action made by the meeting held in Oslo in April 2009;

3. URGES Member States to ensure that their health systems continue to protect those most in need (the poor, the elderly, the sick and frail), to demonstrate effectiveness in delivering personal and population services, while cooperating with other sectors to encourage health equity considerations to be taken into account, and to behave as wise economic actors in terms of investment, expenditure and employment;

4. INVITES Member States to continue collaborating in the context of the work of the WHO Regional Office for Europe by:

(a) stepping up the monitoring and analysis of ongoing changes in living conditions, social norms and values, lifestyles, health status and access to health care, keeping in mind the shared values of solidarity, equity and participation;

(b) assessing health system performance in a systematic way in order to attain equitable health gain, financial protection, responsiveness and efficiency improvement, noting the particular importance of fair financing, universal access to health promotion, disease prevention and health care;

(c) articulating realistic policy options aimed at responding to the negative impacts of the economic crisis on health and health systems, while seizing opportunities to introduce any necessary adjustments into their decision-making mechanisms, entitlements, rules, functioning, organizational architectures, etc.;

5. REQUESTS the Regional Director to:

(a) provide leadership to Member States in their efforts to minimize the negative impact of the crisis on the health of their populations by offering services tailored to specific country needs;

(b) produce health intelligence as well as conduct innovative, value-adding policy dialogue with countries by means of voluntary benchmarking, networking among interested countries on specific topics, sharing of information by all, and the production of a minimum set of relevant common indicators for follow-up;

(c) report back to the Regional Committee at its sixty-first session in 2011 on the lessons learned at regional level in the handling of the economic crisis.

Annex 1

The recommendations presented below are the outcome of the high-level Conference that took place in Oslo on 1–2 April 2009.

1. Distribute wealth based on solidarity and equity.
2. Increase official development assistance (ODA) in order to protect the most vulnerable.
3. Invest in health to improve wealth; protect health budgets.
4. "Every minister is a health minister".
5. Protect cost-effective public health and primary health care services.
6. Ensure "more money for health and more health for the money".
7. Strengthen universal access to social protection programmes.
8. Ensure universal access to health services.
9. Promote universal, compulsory and redistributive forms of revenue collection.
10. Consider introducing or raising taxes on tobacco, alcohol, sugar and salt.
11. Step up the education of health professionals and ensure ethical recruitment.
12. Encourage active public participation in the development of measures to mitigate the effects of the economic crisis on health.

EUR/RC59/R4

Health workforce policies in the WHO European Region

The Regional Committee,

Recalling World Health Assembly resolutions WHA57.19 and WHA58.17 on the international migration of health personnel: a challenge for health systems in developing countries, and resolutions WHA59.23 on the rapid scaling up of health workforce production, and WHA59.27 on the strengthening of nursing and midwifery;

Recalling also resolutions EUR/RC50/R5 and EUR/RC55/R8 on cooperation with countries and strengthening European health systems as a continuation of the WHO Regional Office for Europe's Country Strategy "Matching services to new needs", and EUR/RC57/R1 and its accompanying background document EUR/RC57/9 on Health workforce policies in the European Region;

Recalling the recommendation made by the WHO Executive Board at its 124th session concerning wider global consultations with the Member States on the World Health Organization code of practice on the international recruitment of health personnel and the subsequent request by the Director-General that the regional committee sessions be used to enhance regional consultations with the Member States, with a view to providing feedback to the Executive Board at its 126th session and a recommendation on the adoption of the WHO code of practice by the Sixty-third World Health Assembly in 2010;

Taking stock of the recent efforts made at both global and regional levels to increase awareness of the negative consequences of the increasing migration of health workers, with a view to the adoption of a code of practice on the international recruitment of health personnel;[1]

Acknowledging once again that educated and well-trained health workers save lives, and that the functioning of health systems depends on the availability, efforts and skill mix of the workforce and relies on their knowledge, skills and motivation;

Reasserting the undeniable importance of adequate numbers, distribution and skills mix of human resources in strengthening health systems and ensuring equitable access to health care, regardless of ability to pay or location, as affirmed in the Tallinn Charter on Health Systems, Health and Wealth;

Calling attention once again, with great concern, to the geographical and skill-mix imbalances in the health workforce that result from the increasing migration of health workers within, into and from the Region, and their consequences on health systems and access to health care in the countries of origin;

Recognizing that, while the international migration of health workers can bring mutual benefits to both source and destination countries, migration from those countries that are already experiencing a crisis in their health workforce is further weakening already fragile health systems and represents a serious impediment to achieving the health-related Millennium Development Goals;

Having considered document EUR/RC59/9 on health workforce policies in the WHO European Region;

1. WELCOMES the report;

2. URGES Member States:

   (a) to increase their efforts to develop and implement sustainable health workforce policies, strategies and plans as a critical component of health systems strengthening, particularly in view of the changing demographics and health care needs in the Region, and the need to ensure equitable access to health care services while minimizing the need to rely on the immigration of health personnel from other countries;

   (b) to increase their efforts to monitor the trends in, and patterns of, health workforce migration and to assess its impact in order to identify and initiate effective migration-related policy options, including the enactment of a new, and/or harmonization of their existing, code of practice on the international recruitment of health personnel, and establishing agreements with other countries to address the movement of health workers;

[1] Including, but not limited to, in chronological order: (i) *The world health report 2006* on human resources for health; (ii) the Kampala Declaration made at the end of the Global Forum on Human Resources for Health, (Kampala, Uganda, 2–7 March 2008); (iii) the WHO Ministerial Conference on Health Systems: "Health Systems, Health and Wealth" (Tallinn, 25–27 June 2008), and the pursuant Tallinn Charter, adopted by the WHO Regional Committee for Europe at its fifty-eighth session, (Tbilisi, Georgia, 15–18 September 2008); (iv) the reference to the need to train a sufficient number of health workers in the G8 communiqué issued in July 2008; (v) the progress report and draft code of practice submitted to the WHO Executive Board at its 124th session in January 2009 (EB124/13); and (vi) the issue paper entitled *International recruitment of health personnel: a draft global code of practice*, prepared by the WHO Secretariat and presented as a technical brief at the Sixty-second World Health Assembly, on 20 May 2009.

(c) to advocate the adoption of a global code of practice on the international recruitment of health personnel in line with the European values of solidarity, equity and participation, both within the WHO European Region and globally;

(d) to advocate, in line with the principles of transparency, ethics, fairness and mutuality of benefits, that the code should include protecting the right to leave his or her own country, and balance the relation between the individual rights of the migrant workers and the right to health of the populations of the source countries, helping, to mitigate the effects of migration on the health systems of source countries; and

(e) to promote positive development effects of migration within the health care sector;

3. REQUESTS the Regional Director:

(a) to continue to promote the harmonization of health workforce data and the use of standard indicators and tools to improve quality and comparability for assessing performance in human resources for health;

(b) to continue to develop the core set of indicators for assessing performance in health workforce development in Member States, and to monitor and evaluate the current patterns and trends in migration of health workers, and the implementation and impact of policy interventions at national and WHO European regional levels through the analysis of country reports and the publication of annual regional syntheses of those reports;

(c) to complete the consultation process with Members States, civil society organizations, professional associations and other regional and international entities, and the compilation and review of the various national and regional codes of practice in the WHO European Region and of the literature and data on migration of health workforce, as an input to the global code of practice for the international recruitment of health workers; and

(d) to report back to the Regional Committee at its sixty-second session in 2012 on the progress made.

EUR/RC59/R5

Implementation of the International Health Regulations (2005) in the WHO European Region

The Regional Committee,

Recalling World Health Assembly resolutions WHA48.7 on revision and updating of the International Health Regulations, WHA48.13 on communicable diseases prevention and control: new, emerging, and re-emerging infectious diseases, WHA54.14 on global health security: epidemic alert and response, WHA55.16 on global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health, WHA56.19 on prevention and control of influenza pandemics and annual epidemics, WHA56.28 and WHA58.3 on revision of the International Health Regulations, WHA56.29 on severe acute respiratory syndrome, WHA58.5 on strengthening pandemic influenza preparedness and response, WHA59.2 and WHA61.2 on the application and implementation of the International Health Regulations (2005) (IHR), and WHA62.10 on pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits, as well as World Health Assembly report A62/6 on implementation of the IHR and Regional Committee document EUR/RC56/9 Rev.1 on enhancing health

security: the challenges in the WHO European Region and the health sector response, all of which respond to the need to ensure global public health security;

Concerned by the challenges posed by pandemic (H1N1) 2009 and calling for individual, collective and adapted responses at a time when health systems and the livelihood of populations are under pressure as a result of the global economic crisis;

Mindful that the IHR are a key instrument in protection against the international spread of diseases and play an important role in management of the current influenza pandemic (H1N1) 2009 in particular;

Acknowledging the role of WHO in regional and global alert and response activities and that the control of international public health risks requires close collaboration, effective strategies and dedicated resources in partnership at subnational, national and international levels;

Aware of the diversity in the Region with respect to Member States' capacities for timely detection and mounting of adapted responses to public health risks;

Recognizing that the development of capacities and the implementation of the IHR are continuous processes for Member States and WHO, requiring unrelenting commitment and resources;

Having considered the background paper presented by the WHO Regional Office for Europe (document EUR/RC59/10);

1. URGES Member States in the European Region of WHO to:

   (a) support the development and/or maintenance by 2012 of the core capacities required under the IHR for early warning and response functions at subnational, national and international levels;

   (b) build capacities on existing resources, initiatives and structures and maximize synergies in order to detect emerging and re-emerging diseases, as well as evolving characteristics of public health risks;

   (c) empower national IHR focal points to stimulate collaboration and dialogue between the relevant sectors and disciplines, in order to ensure that the early warning and response functions are carried out and that the risk assessment process determines the required public health actions;

   (d) empower health care workers in their capacity as a key resource of the health system, ensuring their adequate personal protection by means of infection control and fostering interaction between health care workers and public health professionals;

   (e) engage in partnership characterized by solidarity among Member States, in order to foster mutual exchanges of experience and lessons learned and thereby support capacity-building and response activities beyond national borders;

   (f) utilize the unique opportunity presented by the implementation of the IHR, including the development of a national IHR action plan, as a tool to strengthen national partnerships;

   (g) mobilize, in partnership, the resources required to develop and maintain the necessary core capacity at subnational and national levels as specified in Annex 1 of the IHR;

(h) extract and take advantage of lessons learned from past and present health risks, including pandemic (H1N1) 2009, in order to adjust responses to future public risks and to develop and/or maintain capacities in an evidence-based manner;

2. REQUESTS the Regional Director to:

(a) support Member States in their IHR implementation and pandemic preparedness and response in a need-driven manner and continue to monitor activities and capacities, in order to formulate regional strategies for response and long-term capacity-building;

(b) continue to provide leadership in coordinating and prioritizing activities and provide tools and technical support for Member States, particularly those in need;

(c) facilitate exchanges of information and experience among Member States and make regularly available to national IHR focal points information on the detection, assessment and management of events, including lessons learned in the implementation and application of the IHR;

(d) engage in global and regional partnerships to foster coordination with other relevant intergovernmental bodies while maintaining direct communication between Member States and WHO in detection, assessment and response with regard to international public health risks;

(e) extract lessons learned from pandemic (H1N1) 2009 in order to translate these into evidence-based recommendations for Member States and WHO in the European Region, and for strengthening capacities for detection, assessment and response in the short, medium and long terms;

(f) collaborate with Member States and engage in global and regional partnerships, fostering coordination with other relevant intergovernmental bodies in efforts to mobilize human and financial resources for detection, assessment and response with regard to international public health risks, notably pandemic (H1N1) 2009;

(g) provide expertise and technical guidance documentation for monitoring the implementation of national IHR action plans;

(h) at the request of the State Party concerned, facilitate the certification by WHO of airports and ports as per Article 20 paragraph 4 of the Regulations.

EUR/RC59/R6

Date and place of regular sessions of the Regional Committee in 2010–2014

The Regional Committee,

Recalling its resolution EUR/RC58/R6 adopted at its fifty-eighth session;

1. RECONFIRMS that the sixtieth session shall be held in Moscow, Russian Federation from 13 to 16 September 2010;

2. DECIDES that the sixty-first session shall be held in Azerbaijan from 12 to 15 September 2011;

3. DECIDES that the sixty-second session shall be held in Malta from 10 to 13 September 2012;

4. DECIDES that the sixty-third session shall be held in Portugal from 16 to 19 September 2013.

5. FURTHER DECIDES that the sixty-fourth session shall be held in Copenhagen in 2014, on dates to be confirmed.

EUR/RC59/R7

Report of the Sixteenth Standing Committee of the Regional Committee

The Regional Committee,

Having reviewed the report of the Sixteenth Standing Committee of the Regional Committee (documents EUR/RC59/4 and EUR/RC59/4 Add.1);

1. THANKS the Chairperson and the members of the Standing Committee for their work on behalf of the Regional Committee;

2. INVITES the Standing Committee to pursue its work on the basis of the discussions held and resolutions adopted by the Regional Committee at its fifty-ninth session;

3. REQUESTS the Regional Director to take action, as appropriate, on the conclusions and proposals contained in the report of the Standing Committee, taking fully into account the proposals and suggestions made by the Regional Committee at its fifty-ninth session, as recorded in the report of the session.

Annex 1

Agenda

1. Opening of the session

Election of the President, the Executive President, the Deputy Executive President and the Rapporteur

Adoption of the provisional agenda and programme

2. Address by the Director-General

3. Address by the Regional Director on the work of the Regional Office

4. General debate

5. Matters arising out of resolutions and decisions of the World Health Assembly and the Executive Board

6. Report of the Sixteenth Standing Committee of the Regional Committee (SCRC)

7. Policy and technical topics

(a) Health in times of global economic crisis: implications for the WHO European Region

(b) Towards improved governance of health in the WHO European Region

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(d) Implementation of the International Health Regulations (2005) in the WHO European Region

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(a) Nomination of a candidate for the post of Regional Director for Europe

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Annex 3

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Annex 4

Report of the Regional Director

Mr President, Your Royal Highness, Distinguished ministers and representatives of Member States and other organizations, Madam Director-General, Ladies and Gentlemen,

For my last report, I have tried to present the work done by the Regional Office in the past 12 months from two points of view: first of all, in the light of the 10 years since I took office in 2000 (and a document has been submitted to you, outlining the main events, activities and priorities during that period); and second, from a perspective that I have always defended, reflecting a set of specific regional characteristics within the overall framework of WHO's general programme of work.

Salient features of the past year

It will certainly come as no surprise to you when I say that the year since our last meeting in Tbilisi has been an eventful one. I will begin (not in chronological order) with a topic that concerns us all: H1N1 influenza. As you have already decided this morning, we will devote part of our meeting this afternoon to this subject, and we will take it up again during a technical briefing tomorrow.

Pandemic (H1N1) 2009

Rarely in history has a disease aroused so much emotion among the public and been the subject of so much media coverage, especially in developed countries. It is also the first time since the new International Health Regulations came into force in 2007 that an event has been classified as a public health emergency of international concern.

People often ask whether the situation has been over-dramatized, but that is not the real question. The pandemic exists, and there is no doubt that it will develop rapidly and last for a long time. Of course, there is still some uncertainty about how it will evolve: at present, it is impossible to say what will happen in terms of the mutation and virulence of this virus. What we do know is that it is unpredictable, and that it affects younger population groups than seasonal influenza.

The history of pandemics teaches us that we must be particularly vigilant and not be caught up by the idea that this virus is not very aggressive. Faced with an event as extensive as this, it is right and proper that WHO, like national authorities, has chosen transparency and truth over an approach based on secrecy that would be held against them even more. As a natural consequence of this choice, however, people have been concerned and the media have focused on the issue. On the other hand, the response to the current pandemic benefits from the national preparedness plans drawn up following the recent epidemics of avian influenza and SARS. Our mission is to maintain close surveillance, to provide accurate information and reassure people while encouraging them to follow the health guidance given, and to prepare very carefully the essential phase of vaccination that we are currently entering.

In the months ahead, we are going to face a large number of problems that we must anticipate if we are to take the right decisions. These have to do with the priority groups for receiving the first doses of the vaccine: health personnel, pregnant women, people with chronic diseases, especially respiratory ones, and the obese. And we will have to think about the messages to give

to the "worried well", people who are not in priority groups but who will want to be vaccinated while there are not enough doses available. The same problem will be faced at global level, between those countries that can purchase large amounts of vaccine and those who will be excluded from this market. Questions of solidarity and inequity become even more acute in times of crisis.

Another uncertainty concerns the ability of health systems to carry out mass vaccination programmes. Once again, this underlines the importance of having efficient and well-managed health systems.

The meeting this afternoon and the technical discussion tomorrow will give us the opportunity to take up all these issues and perhaps to harmonize, to some extent, our views of this crisis, looking in particular at the repercussions of health measures on the ways in which our societies operate.

More than an individual risk, H1N1 influenza now poses a collective threat, owing to the economic and social repercussions it will have. Their effects can further endanger populations that are already in an extremely precarious position. We must break this vicious cycle by both individual and collective measures.

The financial crisis

As soon as the first tremors of the crisis were felt, WHO sized up the event and created a working group which I have had the honour, on a proposal from Dr Chan (whom I thank), to co-chair with Dr Asamoah-Baah.

We have kept Member States regularly informed about the risks to health systems posed by the crisis and about the responses that could be considered, especially for countries facing economic difficulties and their well-known repercussions on people's health. A document on this subject was drafted in preparation for the consultation held before the opening of the Executive Board session in January this year, and the report of the consultation was also widely disseminated.

In the European Region, a high-level meeting took place in Oslo in April. Apart from exchanges of information and experience, the meeting saw the emergence of a fighting spirit. The health sector can no longer agree to be held accountable just for exorbitant levels of expenditure; on the contrary, it must assert its contribution, including its economic input, to the development of society. Another point forcefully made at the Oslo meeting was that the policies drawn up by ministries of health in recent years, often in conjunction with WHO, are good responses to the crisis. This is true in particular of the primary health care approach. Of course the crisis, with its attendant social and health problems, cannot in any way constitute an opportunity, but it can be an exceptional moment for taking decisions and drawing on experience to deepen our knowledge.

The Gaza crisis

I should to mention briefly here the modest but positive role that the Regional Office played last winter when, thanks to its contacts in Israel, it facilitated the shipment of drugs supplied by Turkey to the population of the Gaza strip.

Follow-up to the Tallinn Conference on Health Systems

The Tallinn Conference in June 2008 launched a new dynamic for health systems and raised people's hopes of making progress in health, so it was essential that the closing ceremony was followed up by action on the ground.

In the measures taken at national and regional level, special attention has been paid to performance assessment and strengthening of "stewardship". We have initiated activities in these two areas at regional level, thanks to support from the United Kingdom's Department of Health.

At the same time, we have joined several Member States in the Region (notably Estonia, Georgia, Kyrgyzstan, Latvia, Portugal and Tajikistan) in carrying out evaluations of the performance of their health systems and analysing the effects of certain reforms.

With a similar aim in mind, we have encouraged training by organizing sessions that brought together several countries, such as the Baltic states and Poland.

A first formal follow-up meeting was held in February 2009, at which the Member States from the Region exchanged views on how to give effect to the Tallinn Charter in the new economic climate.

The topic of health systems is sufficiently extensive and all-encompassing to give unity and perspective to a large number of actions in the health field. Here I would like to mention **World Health Day** on making hospitals safe in emergencies. This event gave rise to a large number of activities in many countries in the Region. Personally, I took part in a real-life test on this subject in the Republic of Moldova. I must say I was impressed by the serious and motivated involvement of participants from a range of sectors. My conclusion from this was that health systems should learn to cope better with the crises now threatening the world and adopt the training, testing and simulation methods that are extensively used in other sectors.

I would also like to link the Tallinn Conference to our ongoing work in the area of **health workforce migration**, stimulated by our Member States and especially Norway. As in the other regions of WHO, one item on the agenda of this session of the Regional Committee is devoted to this subject. The European Region has contributed and will contribute to adoption of the Code that is currently being drawn up. As a member of the Global Council on this subject, I have contacted my fellow regional directors in order to stimulate and harmonize the involvement of the regions in this process.

Celebration of the **thirtieth anniversary of the Declaration of Alma-Ata** last October brought together participants from all over the world in this famous city of Kazakhstan. For WHO and its Director-General, this was an opportunity to reaffirm the continuing vital importance of primary health care for health systems. The report distributed on that occasion defines the modern approaches and policies concerning this level of service, which is the closest to individuals and communities.

Lastly, I should like to mention the essential role and the universally acknowledged very high quality work of the **European Observatory on Health Systems and Policies**. This institution, led by Dr Josep Figueras, is a fine example of a cooperative structure and was instrumental in the Tallinn Conference itself. Its publications ("policy briefs"), its summer school and its support to reform programmes in numerous countries (such as Belgium, Latvia, Poland, the Republic of Moldova and the United Kingdom) make this programme an essential tool for ensuring continuity and making sustained progress after Tallinn. The work it does in partnership with other bodies enjoys extensive coverage, even beyond the European Region.

Activities in various fields of public health

Communicable diseases

While much energy has been channelled towards influenza, especially in recent months, other activities in this field have continued, notably organization of the **third European immunization week**. Thirty-six countries in the Region took part in this event between 20 and 26 April. Modern methods of communication such as YouTube, Facebook, VKontakte and StudiVZ were used to disseminate our messages. Anti-vaccination propaganda continues to be put out, especially via the Internet, and it was essential to respond using the same media channels.

Unfortunately, the goal of eliminating **measles** and **rubella** from the European Region by 2010 will not be reached. The remaining pockets of these diseases correspond to areas where vaccination is rejected by some population groups.

The strong commitment to tackling **tuberculosis** made in Berlin two years ago has been maintained and strengthened. Particular attention has been paid to the problem of multidrug-resistant tuberculosis in the most severely affected countries, especially the 18 countries in the Region that are classified as high priority. Eligible countries have been given specific assistance with obtaining resources from the Global Fund, the Green Light Committee, the Global Drug Facility and UNITAID.

Real progress is being made towards eliminating **malaria** from the Region. However, six of the 53 countries (Azerbaijan, Georgia, Kyrgyzstan, Tajikistan, Turkey and Uzbekistan) are still reporting locally contracted cases. Turkmenistan is in the process of certifying the elimination of malaria and Armenia will do so very shortly. Thanks to support from the Global Fund, malaria elimination will contribute to the development of industry, tourism and trade in the countries still affected by the disease.

Noncommunicable diseases

These diseases continue to be priorities for the work of the Regional Office, especially with regard to controlling risk factors, notably tobacco, alcohol and obesity. The Office is also investing considerable efforts in the area of maternal and child health.

Selection of the head of the new **Athens Centre** and of its principal staff members is under way, in full conformity with WHO's rules. The Centre will be operational at the end of 2009, which will strengthen the Office's capacity in this area and stimulate implementation of the European strategy for control of noncommunicable diseases and their risk factors.

In the area of **mental health**, the year was marked by the launch of a European report in London on 10 October 2008. This report, produced jointly with the European Commission and supported by the Department of Health in London, presents new data on mental health policies and practices throughout the European Region. It opens the way for new possibilities of making comparisons between countries on the basis of specific indicators.

Preparation of the **Fifth Ministerial Conference on Environment and Health** is continuing. This conference will be held in Parma from 10 to 12 March 2010, with the support of the Italian government, as decided by the Regional Committee at its fifty-fourth session. Preparatory meetings have been held thanks to support from Andorra, Austria, Germany, Kyrgyzstan, Luxembourg, Serbia, Spain and Tajikistan. I would remind you that a technical briefing on this subject will be held at lunchtime on Wednesday.

Society and the determinants of health

The report of the WHO Commission on Social Determinants of Health, previewed at the Regional Committee session in Tbilisi, gave rise to a resolution of the World Health Assembly which sets out the approaches to be followed to give effect to the Commission's recommendations. The report was presented and discussed on numerous occasions this year, at meetings bringing together academics, policy-makers and representatives of international organizations. The meeting in London in November, attended by Prime Minister Gordon Brown, is a good example of the practical and lively debate that this report is generating.

On 13 November 2008, the Regional Office organized a conference on **women and prison** in Kiev, Ukraine. This is in line with WHO's commitment to equality between the sexes, as defined in the strategy adopted by the World Health Assembly in 2007. The conference concluded with a declaration that was also adopted at the 18th session of the Commission on Crime Prevention and Criminal Justice. An international conference is to be held in Madrid in October on the main communicable diseases in prisons.

I have pleasure in announcing that Dr Alex Gatherer has received a very prestigious award from the American Public Health Association in recognition of his leadership in promoting prisoners' health within the context of the WHO Health in Prisons Project.

Partnerships

As an essential strand of the country strategy adopted in 2000, partnerships with other organizations (whether or not they are part of the United Nations family, or governmental or nongovernmental bodies) have also been of importance this year.

Relations between the Regional Office and the institutions of the European Union continue to develop in a spirit of seeking to derive mutual benefit. The most recent review of this cooperation – made, as each year, on the occasion of the high-level meeting between officials from WHO and the European Commission – clearly shows that our collaboration has been strengthened and deepened, both at strategic and technical levels and on the ground.

The Commission's Directorate-General for Health and Consumers (SANCO) is our main partner but links are also being developed with other directorates, such as those for employment and social affairs, agriculture, environment and the regions. We are also working with six technical agencies involved with health. This is true in particular of the European Centre for Disease Prevention and Control (ECDC), with whom we have collaborated intensively this year, on other areas as well as the H1N1 pandemic.

During the year, we have also continued to collaborate with **successive presidencies of the European Union** (France, the Czech Republic and Sweden). This joint work has been taken forward in a number of areas, especially the control of microbiological hazards, health system financing, human resources for health, prevention of accidents and violence, alcohol and, of course, the H1N1 pandemic.

Our office in Brussels has been strengthened and an initiative was taken to train all staff at the Regional Office, in order to improve our knowledge of the institutions and actors involved in the European Union.

Collaboration with our **other international partners** has continued, especially in the field, notably with the World Bank on strengthening of health systems, with the United Nations Children's Fund (UNICEF) on immunization, nutrition, accidents and violence, and with the United Nations Population Fund (UNFPA) on reproductive health. We are working with the

Organization for Economic Co-operation and Development (OECD) on the harmonization and dissemination of health data and analyses. Our Office now has the necessary internal structures to help Member States obtain funds from the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Of course, we also take part in brainstorming and efforts aimed at improving coordination of the strategies and actions of the **United Nations (One UN)**, both generally and on the ground (especially in Albania, which is one of the pilot countries for this process).

The internal life of the Office

We have taken the findings from the survey of Member States' satisfaction with the work of the Regional Office, carried out this year, as encouragement to continue our commitment to and engagement with countries. The results are also an interesting guide for developing our services in the future. A document summarizing these findings has been distributed to you.

Without going into detail, I would simply say that we have continued our efforts to strengthen the **delegation of authority** to staff closest to the activity in question, especially in our country offices. This trend towards more delegation of authority has been accompanied by continued extension of training of staff at all levels. I have personally attached considerable importance to the development of a spirit of enterprise and initiative in the Office. Once again, I should like to express my gratitude to all the staff and my admiration for their competence and devotion to duty. I know that you share my opinion of them.

As you certainly know, we are introducing WHO's **Global Management System**. This represents a very significant change in the way we do our work, a change that does not happen without some difficulties and "gnashing of teeth". But, thanks to everyone's good will and with the help of extra training and information, we should get through the transition period of several months without too many problems.

Here I should again like to bear witness to the very considerable progress made in recent years within our Organization thanks to the political determination and diplomatic skills of Dr Margaret Chan. My dream of an organization that is both unified and decentralized, working smoothly at the service of its Member States, is coming true under her leadership.

The regular meetings between the **Director-General and the regional directors** have continued throughout the year. Major issues related to the Organization's policies have been tackled openly and frankly, with the sole aim of improving the management and efficiency of our Organization. The most recent of these meetings was held in Tirana, Albania. I had the great pleasure and, I must say, a certain amount of pride in presenting to my colleagues the achievements of the Regional Office at country level and demonstrating the respect and credibility earned by our presence in the field.

In conclusion

On 31 January next year I will hand over to my successor the responsibilities that you entrusted to me ten years ago. Whoever you select, I consider it my duty to make the transition phase as smooth as possible.

I should like to conclude this last report by once again thanking the Member States for their trust, their support and the opportunity they have given me to carry out a thoroughly exciting function. Again, I would like to thank the staff of WHO for their unshakeable attachment to their organization and for the support that they have always given me over the past ten years. Lastly, I thank the Standing Committee for the support it gives to the work of the Office and to me personally as Regional Director.

My final words are to its current Chair, Dr Bjørn-Inge Larsen, for his courage and scrupulous honesty in discharging his duties. I am very happy that our working relationship has been transformed into one of friendship. After all, that remains the most important thing, once the work is done.

Thank you for your attention.

Annex 5

Address by the Director-General

Mr Chairman, honourable ministers, distinguished delegates, Dr Danzon, ladies and gentlemen,

Let me begin with an expression of appreciation to Dr Danzon and to this region for the many achievements during his leadership.

These achievements moved on from a time when European countries were envied as a largely privileged group, with high standards of living, excellent population health, long life expectancies, and well-functioning health systems.

From this vantage point, the region expanded the health agenda to cover new frontiers. You pioneered work on health and the environment, the impact of urbanization on health, including mental health, the health needs of the elderly, and the role of healthy lifestyles as preventive medicine.

You sounded the alarm about the rise of chronic diseases, and again, the need for prevention. You laid the foundation for understanding the social determinants of health and tackling them through policies that valued social cohesion and protection as worthy political goals.

This turned out to be forward-looking work for the entire world. As we know, these issues are now among the top concerns for public health in every region of the world.

The health agenda for the region changed dramatically in the 1990s, as countries in Central and Eastern Europe underwent rapid political and economic transition. Old health problems resurged or became more apparent, especially when government health spending dropped.

What had previously been pockets of poverty, or pockets of problems, spanned entire countries. The close links between wealth and health came into even sharper focus.

Specific events, such as the resurgence of tuberculosis and the return of vaccine-preventable diseases, pointed to an alarming deterioration in basic health system capacity. The consequences of unhealthy behaviours became more acutely visible, again forcing a look at the social determinants of health.

The region responded to these disparities in a true spirit of solidarity. Privilege was interpreted as responsibility. Resources were made available for direct support to countries.

The agenda turned to weak health systems as a fundamental barrier to more equitable health outcomes, and tackled the need for reform. In so doing, health officials in this region took on what must be one of the most critically important and difficult challenges in public health today: health care reform. You did so with discipline and rigour.

In 1998, the European Observatory on Health Systems and Policies was established, with this regional office as a founding partner. The Observatory approached a sometimes elusive area of research and policy, extracted context-specific lessons and best practices, and made a long-standing problem look much more manageable. Standardized studies of health systems in transition brought the power of scientific evidence and analysis to bear on a fundamental cause of health disparities in Europe.

This was just one of the broad measures for improving health that Dr Danzon promoted as he moved the agenda forward, again to the benefit of international public health.

The WHO European Ministerial Conference on Health Systems and the resulting Tallinn Charter made the case that well-functioning health systems contribute to national wealth as well as health. The Charter pulled together many lines of thinking and debate into a coherent and sensible framework, with well-defined options for action

Phrases such as "health in all policies", "every minister is a health minister", and "health is wealth" have entered the vocabulary of international health development. This has happened at a time when world leaders and ministers in other sectors have been primed, by crises, to listen very closely. This is quite a legacy.

Marc, it has been a great personal and professional pleasure to work with you. Under your leadership, the achievements of this region have again expanded the health agenda. This will hold the world in good stead as we seek to reach international health commitments, like the Millennium Development Goals, at a time of multiple global crises on multiple fronts.

As you in this region have noted, strong health systems are essential for weathering current and coming storms, like the economic downturn, climate change, the influenza pandemic, and the many other global crises that our imperfect world is certain to deliver.

Ladies and gentlemen,

Let me quote from one of your documents. "Health authorities across Europe are concerned that the present economic system does not distribute wealth on the basis of values of solidarity and equity, thus hindering improvement in health outcomes."

Precisely. This is the heart of the problem. The report of the Commission on Social Determinants of Health, issued last August, includes one particularly striking statement. "Implementation of the Commission's recommendations depends on changes in the functioning of the global economy."

At the time, that statement raised some eyebrows. A review, published in The Economist magazine, praised the report's ambitions but suggested that its attempt to correct global imbalances in the distribution of power and money was basically "howling at the moon".

A month later, the financial crisis hit the world like a sudden jolt, and hit the world where it hurts the most: money. Greed seeded the financial crisis, which sprang out of control as corporate governance and risk management failed at every level of the system.

In a world characterized by radically increased interdependence among nations, mistakes made in one country or one sector are highly contagious. And the consequences are profoundly unfair. Developing countries have the greatest vulnerability and the least resilience. They are hit the hardest and take the longest to recover.

In a sense, the Millennium Development Goals are a corrective strategy. They aim to compensate for international policies and systems that create benefits, but have no rules that guarantee the fair distribution of these benefits.

The Goals and the many new initiatives and instruments for improving health are badly needed and doing great good. But they do not address the root causes of the great gaps in health outcomes. The root causes lie in flawed policies. This conclusion, I believe, is one of the most important outcomes of the Commission on Social Determinants of Health.

Some political analysts and academics are now predicting an end to the capitalist market model and point to signs that globalization is in retreat. We hear some sweeping conclusions: blind faith in the power of market forces to solve all problems has been misplaced.

World leaders struggling to re-position the management of their economies have been advised to look to Europe for guidance. A well-managed welfare state is not the enemy of globalization. Instead, some say it is the saviour.

As we know, the international policies and systems that govern financial markets, economies, commerce, trade, and foreign affairs have not operated with fairness as an explicit policy objective.

Too many models for development assumed that living conditions and health status of the poor would somehow automatically improve as countries modernized, liberalized their trade, and improved their economies. This did not happen.

Too many international systems have worked in ways that favour those who are already well off. In reality, gaps in health outcomes will be reduced, and health systems will strive for fairness only when equity is an explicit policy objective, also in sectors well beyond health.

Money makes the world go round. This will never change. But, as we have seen, market forces, all by themselves, will not solve social problems. The world needs to turn with a value system at its axis. We need this symmetry. If not, an already dangerous situation of vast imbalances, in income levels, in opportunities, and in health status, will only grow worse.

Leaders in sectors with far more clout than health are making a similar point. At the April G20 summit in London, world leaders called for a fundamental re-engineering of the international systems to incorporate a moral dimension and make them responsive to genuine social values and concerns. They voiced a need to invest these systems with values like community, solidarity, equity, and social justice.

While this is welcome new thinking for world leaders, this is a familiar vocabulary for public health, dating as far back as the Declaration of Alma-Ata.

For once, the ironic twists of history may turn in the favour of public health. The potential of the Declaration of Alma-Ata to revolutionize the delivery of health care was cut short by an oil crisis, an economic recession, and the introduction of structural adjustment programmes that reduced budgets for social services, including health care.

Today, a financial crisis and severe economic recession have encouraged world leaders to seek the kind of value system that primary health care has always represented. Perhaps this time around, in a world jarred awake by crises, some long-standing arguments will finally be heard.

Ladies and gentlemen,

Public health had no say in the policies that seeded the financial crisis or set the stage for climate change. But public health has much to say about the influenza pandemic, how it is managed, and how its impact can be reduced.

This is one occasion when heads of state and ministers of finance, tourism, and trade will listen closely to ministers of health. This is one occasion where the need for “health in all policies” becomes readily apparent. This is one occasion when standard arguments about the need to build up fundamental health capacities in an inclusive way will ring true.

To date, we have been fortunate in the way the pandemic has evolved. The overwhelming majority of cases continue to experience mild symptoms and recover fully within a week, even without any medical treatment.

But clinically, this is a virus of extremes. It does not seem to have a middle ground. At one extreme are the mild cases. At the other extreme is a small subset of patients who quickly develop very severe disease.

Though the numbers are small, the demands on health services are disproportionately high. Saving these lives depends on highly specialized intensive care, with highly specialized equipment and highly skilled staff. In countries that lack such capacities, these lives will be at great danger.

Of course, this is true for a multitude of other diseases and health problems. Weak capacities cost lives. But this pandemic, I believe, will make the same old point in an especially visible and tragic manner.

I believe that this pandemic will be a watershed event. It is taking place at a time when differences, within and between countries, in income levels, in health status, and in levels of care, are greater than at any time in recent history. The pandemic will test the world on the issue of fairness in a substantial way.

The same virus that causes manageable disruption in affluent countries will almost certainly have a devastating impact in countries with too few health facilities and staff, no regular supplies of essential medicines, little diagnostic and laboratory capacity, and vast populations with no access to safe water and sanitation. For these populations, advice such as wash your hands, call your doctor, or rush to the emergency ward will mean very little.

Let me give just one precise example. We know, from all outbreak sites, that pregnant women are at increased risk of severe or fatal infections. Increased deaths of these women, because of the pandemic, will be tragic everywhere, but most especially so in the developing world, as the numbers will be so much greater.

Already, more than 99% of maternal mortality occurs in the developing world, where it is one of the strongest indicators of poorly functioning and inequitable health systems.

Since taking office, the health of women has been one of my priority concerns. A renewed commitment to primary health care underpins efforts to improve the health of women. This relationship is starkly evident in a report on Women and Health that I have commissioned. The report, which will be issued in November, explores the many health risks that women face throughout the life course, and sets out an agenda for change.

As this region has done with health systems, we need to make the agenda for women's health look manageable, with clear policy options, and compelling arguments for more attention and greater investment based on solid evidence.

Ladies and gentlemen,

Let me conclude with another brief expression of appreciation.

Many of the countries represented in this room have played a leading role in the creation of new health initiatives for the developing world and in finding innovative ways to secure additional funds. You are also addressing the pressing need for more effective aid.

When privilege is interpreted as responsibility, we again see those values, like equity, solidarity, social cohesion and protection, that are at the heart of your contribution to better health, not only regionally but also internationally.

Thank you.