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Report of the fifty-eighth session of the Regional Committee for Europe

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Contents

Opening of the session

The fifty-eighth session of the WHO Regional Committee for Europe was held at the Sheraton Metechi Palace Hotel in Tbilisi, Georgia from 15 to 18 September 2008. Representatives of 47 countries in the WHO European Region took part. Also present were observers from one Member State of the Economic Commission for Europe and one non-Member State, and representatives of the Food and Agriculture Organization of the United Nations, the Office of the United Nations High Commissioner for Refugees, the United Nations Children's Fund, the United Nations Office in Georgia, the United Nations Population Fund, the World Bank, the Council of Europe, the European Centre for Disease Prevention and Control, the European Commission, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the International Committee of the Red Cross and of nongovernmental organizations (see Annex 3).

The first working meeting was opened by Professor Tomica Milosavljević, outgoing President. Participants were welcomed by Mr Vladimer Gurgenidze, Prime Minister of Georgia.

In connection with provisional agenda item 9, "Elections and nominations" and pursuant to Rule 48 of its Rules of Procedure, the Committee decided, in the light of difficulties faced by certain delegations as a result of the circumstances surrounding the session, to suspend with immediate effect and for the duration of its fifty-eighth session the requirement of Rule 14.2.2(d), namely that "Member States having submitted nominations must be represented at the Regional Committee during the relevant agenda item, otherwise their nominations will not be considered." It was understood that the suspension would be temporary and would not affect the rule in question beyond the present session of the Regional Committee, and that care must be taken with regard to resort to suspension of the Rules of Procedure.

Election of officers

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

Mr Alexander Kvitashvili (Georgia)	President
Ms Annemiek van Bolhuis (Netherlands)	Executive President
Dr Bjørn-Inge Larsen (Norway)	Deputy Executive President
Mr Wojciech Kutyła (Poland)	Rapporteur

Adoption of the agenda and programme of work

(EUR/RC58/2 Rev.1 and EUR/RC58/3)

Having agreed that the topic of "Director-General of the World Health Organization" (a matter referred to regional committees by the Executive Board and due to be taken up under provisional agenda item 9) would be considered in an open meeting, the Committee adopted the agenda (Annex 1) and programme of work.

Report of the Regional Director on the work of the Regional Office and general debate

(EUR/RC58/4 and EUR/RC58/Conf.Doc./1)

The Regional Director began his address (Annex 4) by expressing his sympathy for those recently killed, wounded or displaced in the part of the WHO European Region where the Regional Committee was meeting, and by thanking the representatives for their presence and the Government of Georgia for fulfilling its commitment to host the session. Events in the year since the Regional Committee's previous session illustrated the issues in the Region since the turn of the century, and the Regional Office's response to them.

The WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth", in Tallinn, Estonia, had been a major turning point in the evolution of health vision in the Region. The Conference had reaffirmed the needs to strengthen and modernize health systems, to use assessment to improve health systems' performance and to include in the concept of performance and accountability both the human dimension and all activities to improve health, within and beyond the health sector.

Other significant events in the year had been the severe disruption of the health system in Tajikistan by the harsh winter, and the suspension of the mass immunization campaign against measles and rubella in Ukraine following the death of a young man 15 hours after vaccination. The former had caused both great suffering and a brave response in the country and called forth a positive response from the international community, including essential support from Norway. The latter highlighted the complexity of work for health and the need to base action on solid evidence. Convinced by the evidence that the young man's death had not resulted from vaccination, the Regional Office had called for the resumption of immunization, guaranteeing that all measures had been taken to ensure the safety of the vaccine. The situation compromised the effort to eliminate measles and rubella from the Region by 2010 and showed the good will needed from all parties involved in such work.

As well as the challenges that WHO and Member States had taken up, the past year had been one of continuity in the Regional Office's activities. For example, the Region and the Regional Office had made an important contribution to the report of the WHO Commission on Social Determinants of Health, while the WHO Ministerial Forum: All against Tuberculosis had resulted in Member States committing themselves to stop the rise of the epidemic and particularly drug-resistant cases. World Health Day had focused on protecting health from climate change. On nutrition, the Regional Office was working with the food industry to reduce sodium intake and improve information to consumers. The Regional Director's published report gave more information on those and other subjects, particularly HIV/AIDS, tobacco and alcohol consumption, and noncommunicable diseases (NCDs). In that area, it was important to maintain and strengthen the Regional Office's work on mental health, which would include publishing a study on countries' mental health policies. Upcoming activities also included cosponsoring a conference on injury prevention and safety promotion in October 2008.

The Regional Office was working with a large number of countries on a wide range of issues. Examples included assistance (with other United Nations agencies) in drafting a reproductive health strategy for 2008–2015 for Azerbaijan; a mission with the European Centre for Disease Prevention and Control (ECDC) to assess the risk of Chikungunya virus in Italy; the follow-up study (conducted with the European Commission (EC) Directorate-General for Research) on toxic oil syndrome in Spain; the drafting (with the Ministry of Health and Medical Industry) of a plan for 2008–2010 to eliminate malaria from Turkmenistan; and follow-up to assessment of the programme of clinical guidelines of the National Institute for Clinical Excellence (NICE) in England (United Kingdom).

The Regional Office was maintaining and further developing its partnerships, particularly with the EC. Its Directorate-General for Health and Consumers had actively supported the Tallinn Conference, while the Regional Office had contributed to the Directorate-General's consultative process to draft the European Union (EU) health strategy. The Regional Office was cooperating with the EC in a number of technical areas and had stepped up its participation in the initiatives of successive EU presidencies: health in all policies (Finland), cancer (Slovenia) and health security and Alzheimer's disease (France). The Regional Office was working closely with ECDC on number of issues such as avian influenza, TB and HIV/AIDS surveillance, and the two had adopted a work plan for expanded cooperation in 2008–2009. Further, the Regional Office's continued partnerships with the World Bank, the Council of Europe and the Organisation for Economic Co-operation and Development (OECD) had benefitted from the impetus raised in Tallinn.

As to developments within WHO, the strong, positive and stimulating relationship between the Regional Office and WHO headquarters had benefitted services to Member States. Discussions were continuing on the modernization of WHO, the new Global Management System, delegation of authority, human resources policy and the reform of the United Nations system. Within the Regional Office, plans to open a

new office on NCDs in Athens, Greece were coming to fruition. The contract signed with Greece specified that the new office would be entirely under the Regional Office's programmatic and policy guidance and would be fully integrated in the WHO hierarchy. Finally, the Regional Director paid tribute to the adaptability and desire to excel of staff all over the European Region, and to the contribution of the Standing Committee of the Regional Committee (SCRC) to determining the content of the Regional Committee programme and ensuring that the session was held in Tbilisi as planned.

In the discussion and general debate that followed, several speakers expressed appreciation of the Regional Director's report and the work of the Regional Office. 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, Montenegro and Serbia, as well as Armenia, Georgia, the Republic of Moldova, and Ukraine (which aligned themselves with her statement), emphasized the importance those countries attached to holding the present session of the Regional Committee, despite the political circumstances of the previous few weeks. It was important that the Member States of the Region came together with common value given to the health of citizens. Their shared beliefs in health promotion, exchanging experience and providing mutual assistance should continue to guide WHO's work.

Three factors negatively affected health in the Region and needed coordinated action. The first was the heavy disease burden of NCDs, where the EU was looking forward to the coming debate on strategies to modify behaviour affecting health, which would also contribute to the reduction of injuries and violence, and to WHO's draft global strategy to reduce the harmful use of alcohol. It was important that the Office had the capacity for such work, and the establishment by the Office of the European Alcohol Information and Monitoring System was an important tool.

The second important factor comprised the environment and the health impact of climate change. Striking statistics in the Regional Director's report illustrated the direct links between the environment and health, and the implementation of environment and health plans was urgent, addressing areas such as access to safe water and the risks posed by chemicals and industrial products. WHO's European ministerial conference in 2009 would give impetus to attack those risks, as well as climate change.

Third, communicable diseases remained an important problem. HIV/AIDS had increased in one part of the Region and still not stabilized in others, and efforts needed to be stepped up in treatment, care and surveillance. The collaboration between WHO and ECDC was essential, especially on the International Health Regulations (IHR) (2005), and the representative thanked WHO for its participation in the informal meeting of health ministers on the IHR held in September 2007.

Too many inequalities in health remained in the countries of the European Region, and health systems should contribute to reducing them. That would also facilitate progress towards the Millennium Development Goals. The Tallinn Conference had helped to prioritize the strengthening of health systems in the Region. The report of the WHO Commission on Social Determinants of Health, to be presented at the session, would assist countries in their fight against those inequalities. The responsibility for addressing social determinants could not lie solely with health ministries, but they should be the "engine" and influence other sectors, as well as mobilizing political and public support. The opportunity to discuss the Commission's conclusions at the Executive Board and the World Health Assembly was awaited with impatience.

Other speakers highlighted key issues such as NCDs, which constituted 80% of the total disease burden of the Region. Some good progress was being made in tobacco control, with 157 out of 193 countries parties to the WHO Framework Convention on Tobacco. Nevertheless, 55 million adults were reported to be drinking at levels that harmed health, and 23 million were considered to be alcohol-dependent. Alcohol was the fifth leading risk factor for death and disability; the global alcohol strategy expected in 2010 would be widely welcomed.

On communicable diseases, several speakers stressed the major threat posed by tuberculosis (TB), but the Berlin Declaration led the way and WHO would assess progress, making biennial reports starting in 2009. WHO's support of the IHR and assistance in developing capacity for surveillance and response was appreciated. A representative noted that stockpiling oseltamivir for 25% of the population, as recommended by WHO in 2006, was very expensive and the stocks were approaching their expiry date; he suggested that a task force be set up to consider what should happen next.

Climate change was also a matter of great concern. Germany had provided US$ 10 million to work on that issue and would host a preparatory meeting for the 2009 ministerial conference on environment and health. Climate change was also linked to access to safe drinking water and sanitation, and the Protocol on Water and Health played an important role in that regard.

Another key area was the international recruitment of health personnel. One country had decided to focus on domestic measures instead of recruiting internationally. Portugal, when holding the EU presidency, had worked closely with WHO on the health of migrants. Demographic changes had not been mentioned in the Regional Director's report, but every country had to deal with the negative consequences of an ageing population. It was important to promote active and healthy ageing, to reduce the pressure on the next generation. Two representatives welcomed WHO's ambitions to enhance country support and the valuable work of its country offices.

Commenting on the case study mentioned by the Regional Director, the representative of the country concerned informed the Committee that its national parliament would most likely decide in the coming week to halt the national immunization campaign against rubella and measles. To strengthen WHO's ability to offer countries long-term support in crisis situations, she recommended that the Regional Office should consider creating a mechanism to mobilize the necessary human and financial resources, as well as to ensure consultation with ministries of health on the specialist personnel needed to deal with such crises. Only through a strategic partnership with WHO would the national health system be in a position to react to the challenges it was facing.

In reply, the Regional Director thanked Member States for their appreciation and support of the efforts of WHO in the European Region and globally. In the area of TB, the Regional Office hoped to make an agreement for joint work with the WHO Lyon Office for National Epidemic Preparedness and Response. Applying the lessons learned from fighting tobacco to alcohol control would be useful, but some other regions needed to be convinced of the problem's importance in order to enable the global response required. As to avian influenza, consultation with partners such as the EU and ECDC was required before setting up a task force on oseltamivir stockpiling; in the mean time, the Regional Office would continue to circulate information. Further efforts were needed to maintain the impetus of work for mental health. Health worker migration was an acute problem; rich countries should help poor ones strengthen their health systems, not raid them for staff. The Regional Office would take part in a meeting of the global Policy Advisory Council on the subject.

In response to the suggestion that the Regional Office establish a mechanism to mobilize resources and ensure consultation with health ministries in crisis situations, the Regional Director drew a clear distinction between the roles of the Regional Office and of Member States. For its part, WHO would continue to provide all possible scientific, evidence-based technical and policy support to countries in health crises.

Speaking at the invitation of the Regional Director, the First Lady of Georgia, Ms Sandra Elisabeth Roelofs, welcomed representatives to Georgia. Referring to recent events in her country and the response to it, she emphasized that in times of crisis, health systems found out if they were "waterproof". The ministry of health had coped well. In the four years since she had been First Lady, her priorities had been inspired by the Millennium Development Goals, and Georgia was committed to fighting poverty and creating more employment, having reduced poverty from 50% to 30% of the population in the previous four years. She described her work in countries with a high burden of TB through the Stop TB Campaign

and emphasized that it was important to ask for assistance rather than deny the existence or legitimacy of a problem, try to cope alone and fail.

Self-respecting governments should not let politics meddle with public health issues. Popular health solutions for quick political advantage were short-sighted: long-term investment might be less visible and less popular, but it guaranteed a healthier generation and brought political benefit in an indirect way. She had worked in palliative care and believed, as mentioned in the Tallinn Charter, that the self-esteem and dignity of the patient were of the utmost importance. Despite offering harm reduction programmes, prenatal diagnostics and early detection of cancer, including breast cancer screening, Georgia could perform much better in some areas, and it was facing numerous challenges. She thanked the many donors, agencies and partners active in Georgia and acknowledged that WHO was up to the task of leading the Region in helping people to make healthy choices.

The Committee adopted resolution EUR/RC58/R1.

Report of the Fifteenth Standing Committee of the Regional Committee

(EUR/RC58/5, EUR/RC58/5 Add.1, EUR/RC58/Conf.Doc./2 and EUR/RC58/Conf.Doc./9)

The Chairperson of the Standing Committee noted that the Fifteenth SCRC had held a number of teleconferences with the Regional Director and the Minister of Health of Georgia and his staff prior to deciding whether the Regional Committee session could be held in Tbilisi as planned. Having received an assurance from the Georgian government that the current situation was safe and could be dealt with in a way that would ensure the full participation of European Member States of WHO, the SCRC had been glad to confirm that the session should go ahead.

Since September 2007, the SCRC had held six regular meetings, the major part of which had been devoted to preparing for the current session of the Regional Committee. One innovation had been to introduce an agenda item allowing for a general debate on topics not covered elsewhere in the programme. Another change was to schedule the private meeting on nominations and elections earlier in the session, to facilitate high-level political participation.

One key lesson learned had been the need to limit the number of subjects discussed by the Regional Committee. The SCRC had accordingly selected only four technical and policy items for inclusion in the agenda. In addition, it had decided to limit the number of topics followed up from previous sessions to two and it had chosen only two subjects for technical briefings outside the session.

Another major issue debated during the year had been how to enhance the strategic function of the Standing Committee. To that end, an information note had been prepared and posted on the Regional Office web site describing the SCRC's legal status, role and way of working. Member States were encouraged to convey their main concerns to the SCRC, so that its work could be further prioritized and given sharper focus and to enable it to serve more as a bridge between the Regional Committee and the Regional Office.

The SCRC also considered that it was equally important to link the Regional Committee even more closely with the business conducted at WHO headquarters and was pleased that the Director-General had indicated, from the start of her term of office, that she attached great importance to the view and roles of the six regional offices of WHO. During the year, the Standing Committee had provided opportunities for Member States to be thoroughly briefed before sessions of the Executive Board and the World Health Assembly, and for European members of the Board to be engaged more fully with issues of importance to the Regional Office. Such cross-fertilization of issues would ensure more effective interaction of the various entities in the future.

Another task of the Standing Committee was to prepare proposals concerning candidatures for nomination or election to various WHO bodies and committees. In doing so, it had looked closely at the

geographical groupings used in the European Region but was not satisfied with the overall distribution of seats. It had therefore started to discuss the sensitive issue of "semi-permanency", a question that it recommended for follow-up by its successor.

During the year, the SCRC had been kept informed by the Regional Director of progress towards opening a "geographically dispersed office" (GDO) of WHO on NCDs in Athens, requesting and receiving from him a complete assurance that it would not engage in independent priority-setting and that it would be an integral part of the Division of Health Programmes at the Regional Office who would set policies and the direction of work.

Lastly, the Vice-Chairperson of the Standing Committee had attended the First Global Forum on Human Resources for Health, held in Kampala, Uganda in March 2008. One measure advocated there had been the promulgation of a code of practice on the international recruitment of health personnel; web-based public hearings were being organized by WHO, and Member States were urged to submit contributions by the end of September 2008.

A representative speaking on behalf of the five Nordic countries noted that NCDs constituted approximately 80% of the disease burden in the WHO European Region, as compared with 50% globally; they therefore believed that fighting NCDs should be a top priority for the Regional Office. The Athens GDO should focus on building technical capacity, while policy development and follow-up should remain at the core of the Regional Office. The Regional Director reiterated that the GDO would work under the policy guidance of the responsible divisional director based in Copenhagen. The Director-General thanked Member States for their support in filling gaps in WHO's capacity and pledged that she would continue to manage the Organization's various centres so that they delivered the best output in terms of priorities set by WHO.

The Committee adopted resolution EUR/RC58/R7, on the report of the Fifteenth SCRC, and decided to refer the question of distribution of the WHO European Region's seats on the Executive Board back to the Standing Committee for more thorough consideration.

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

(EUR/RC58/6)

Dr Božidar Voljč, a European member of the Executive Board, said that he had been the link between the Board and the Standing Committee in the previous year, taking part in the activities of both governing bodies. Almost two thirds of the Member States of WHO in the European Region were members of the EU or were in the process of acceding to membership of it. The EU prepared joint statements on almost all items on the Board's agenda, yet he believed that there was a need for a heightened spirit of pan-regional affinity and responsibility, in order to reduce the striking health inequities found in the European Region and thereby lead to more genuine realization of public health values.

Among the resolutions adopted by the Sixty-first World Health Assembly in May 2008, European countries had supported all WHO activities in the remaining four countries that were endemic for poliomyelitis, some of which bordered on the Region, with the aim of achieving final eradication of the disease (resolution WHA61.1). They had also supported further implementation of procedures under the IHR (resolution WHA61.2). For effective realization of the global immunization strategy (resolution WHA61.15), European countries had endorsed the need for routine immunization and sufficient resources as well as vaccine manufacturing capacities.

The dramatic increase of chronic NCDs called for the strengthening of health systems, with a particular focus on primary health care. Regional Office staff had prepared good documentation on the prevention of chronic NCDs, and European countries had been of the opinion that progress in combating such diseases required strong health systems, supported by political action, broad participation and sustained

advocacy (resolution WHA61.14). The harmful use of alcohol was an important issue for the Region, where consumption was the highest in the world, and European members of the Board had accordingly proposed a draft resolution requesting the Director-General to develop a global strategy for submission to the Sixty-third World Health Assembly in 2010 (resolution WHA61.4).

With regard to the health of migrants (resolution WHA61.17), national legislatures needed to give more consideration to non-discriminatory, comprehensive, culture- and gender-sensitive policies. Cultural sensitivity had its limits, however, and European members of the Executive Board had agreed that female genital mutilation was a needless, harmful practice leading to serious health problems and raising human rights issues (resolution WHA61.16).

Climate change was an ominous global challenge to public health in the twenty-first century. Many European countries had accordingly sponsored a resolution (WHA61.19) urging Member States to develop health measures and integrate them into plans for adaptation to climate change. Another important European initiative had been with regard to monitoring and speeding up progress towards attainment of the Millennium Development Goals, especially those related to infant and maternal mortality and HIV/AIDS (resolution WHA61.18). In the opinion of European members of the Executive Board, the subject needed to be on the agenda of the World Health Assembly each year, and closer coordination with other specialized agencies of the United Nations was needed.

The Regional Director thanked Dr Voljč for his work as a member of the SCRC and the Executive Board.

Address by the Director-General

In her address (Annex 5), the Director-General congratulated the Ministry of Labour, Health and Social Affairs of Georgia on its plans to reform the country's health sector and improve public health by guaranteeing universal access to services and basic health care, with primary health care as a priority for investment. She assured Georgia of WHO's continuing support.

The Committee would be tackling two of the most complex and elusive issues in public health: improving the performance of health systems and changing human health behaviour. Efforts to improve the performance of health systems had been marked by decades of experiment, shifting policy advice, huge and costly errors and an almost incomprehensible failure to learn from successes and mistakes. The WHO European Ministerial Conference on Health Systems had clearly emphasized the importance of organizing, financing and managing health systems. Improved performance was critical, even in countries with the best health systems in the world.

Stalled progress towards the health-related Millennium Development Goals, especially those related to sexual and reproductive health, was the consequence of decades of failure to invest in basic health infrastructure, services and staff. Nevertheless, powerful interventions and the money to purchase them would not result in better health in the absence of efficient delivery systems. For example, the drive to reach 3 million people with antiretroviral therapy had revealed the barriers set up by weak drug procurement and delivery systems, weak laboratory support and inadequate human resources.

The Global Leaders' Forum held in New York in June 2008 had discussed integrating the responses to the closely related epidemics of AIDS and tuberculosis, to ensure more efficient service delivery. She recalled the alarming rise of multidrug-resistant tuberculosis in Europe, where one in every five new cases was resistant to multiple drugs. The implications for health systems and budgets were huge, as that form of tuberculosis was much more difficult and about 100 times more expensive to treat. Estonia and Latvia had shown, however, that when basic health system capacity was improved, the high rates could be contained and even reversed.

Thirty years previously, the Declaration of Alma-Ata had defined primary health care (PHC) as a set of guiding values for health development, a set of principles for the organization of health services and a

range of approaches for addressing the fundamental determinants of health. Equity in access to care and efficiency in service delivery were considered the overarching goals. Above all, PHC offered a way to organize the full range of health care, from household to hospital, with prevention as important as cure, and with rational investment of resources at the different levels of care. The importance of using the common values of equity, social justice and universal coverage in health decision-making had been reiterated in the Tallinn Charter, which also promoted a holistic approach to health, including community participation, with women as important agents of change, multisectoral action and appropriate use of technology.

The PHC approach articulated in 1978 had been misunderstood almost immediately as a radical attack on the medical establishment and an exclusive focus on first-level care. Some proponents of development had considered it cheap: poor care for poor people, a second-rate solution for developing countries. After 30 years, PHC had found its original meaning as a rational approach to fair, efficient, good-quality care, with values, principles and approaches that were relevant in rich and poor countries alike.

The Tallinn Charter drew on work initiated by the Commission on Macroeconomics and Health showing that health was not a drain on resources but was a producer of economic gain. A health system was not a burdensome, money-guzzling duty of governments: it was a strategic opportunity to manage health with foresight and to foster the two-way relation between a nation's health and its wealth. For instance, the WHO European Ministerial Conference on Health Systems had pointed out that demographic ageing resulting from increased life expectancy throughout the world was driving the rise in chronic diseases and the costs of caring for them. The Conference had shown that health systems could use the strategic opportunity to make prevention and health promotion priorities and thus cut disabilities in the elderly, reduce the costs of care and improve the quality of life.

The report of the Commission on Social Determinants of Health challenged the assumption that economic growth alone would reduce poverty and improve health. Increased economic prosperity tended rather to benefit populations that were already well-off, leaving others further and further behind, as was apparent in parts of Europe. The most important determinants of health were the social conditions in which people were born, lived, worked and aged, and those conditions were shaped by government policies. Inequities in health outcomes were not a matter of fate: they were markers of policy failure. The report called for a 'whole-of-government' approach in which health was part of all government policies, in all sectors.

Although health had moved up the international development agenda, in most governments the health ministry usually had less negotiating power than other ministries. The European Region had elaborated a range of policy tools, incentive schemes and legal and regulatory instruments for improving the performance of health systems, which were based on solid evidence and powerful, persuasive economic arguments. PHC was quality health care, which required resources. That approach must be supported by powerful arguments, persuasive evidence and enormous political courage.

It was not easy to make a value such as fair access to medicines count at the international policy level; however, the recent World Health Assembly resolution on public health, innovation and intellectual property had shown that the rules governing international trade could be shaped in ways that favoured greater equity in health. Nor was it easy to make health equity a guiding principle for health systems, especially when market forces made health care a commodity and encouraged inefficient consumption; however, the forthcoming *World Health Report*, on the theme of PHC to commemorate the thirtieth anniversary of the Declaration of Alma-Ata, offered practical technical guidance for reforms that could help health systems respond to complex challenges. The report asked political leaders to pay close attention to rising social expectations for health care, as people wanted care that was fair as well as efficient, incorporating many of the values, principles and approaches articulated at Alma-Ata. That argument could be added to others for making health a 'whole-of-government' concern, with health in all policies.

One representative thanked the Director-General for her determined leadership in so many of the areas important for global health and the health of the peoples of the European Region. He welcomed her

emphasis on PHC and strong health systems and the work of the Commission on Social Determinants of Health. Another representative said that in her country improved health had indeed led to economic gains, and health development had been based on multisectoral collaboration. She recommended uptake by WHO of a cost-effective model whereby midwives were trained to train trainers in maternal health and the prevention of violence towards women and children.

The Director-General reiterated that a PHC model, revitalized for the 21st century, was needed to respond to the requests of Member States. When PHC had first been introduced, HIV/AIDS had been unknown, the prevalence of noncommunicable diseases and health care costs had been lower, and fewer resources had been available from governments and international development agencies. Member States should now seize the opportunity to make a real change to the health of the peoples of the world.

The Regional Director said that, in his experience of Regional Committee meetings, no other Director-General had made such a significant contribution to the work of the Committee.

Address by His Excellency Mikheil Saakashvili, President of Georgia

The President of Georgia welcomed the Regional Committee to the capital, regretting that circumstances prevented the representatives from seeing all the positive changes made all over the country, and thanking the Regional Director and the Regional Office for their help in improving health in Georgia. The country had suffered from problems similar to those of others in the Region and had had to reform its health sector in a very short time. In the 1990s, the Georgian health system had been in ruins; for example, there had been too many hospitals and doctors of too low quality, and out-of-pocket payments had accounted for 80% of health expenditure. Work to rebuild the health system had begun with important measures taken with the International Monetary Fund and the World Bank. The reforms had entered a new stage in 2006, focusing on restructuring the hospital sector, reforming health care financing and PHC, and human resources development.

The country had achieved much in those areas, increasing investment in the health system, improving the equipment and staffing of PHC centres, training doctors and nurses, creating centres of clinical excellence in Tbilisi and five other cities, building a well-functioning private insurance system and ensuring that necessary care was available to all citizens, regardless of ability to pay. The payoffs in health outcomes included reductions in young people's smoking and drinking, TB, and infant and maternal mortality; in addition, levels of poverty in the country were substantially reduced. Georgia was working to do more: to ensure a healthy economy and health equality, and to exchange experience and information at the international level. Its experience showed, for example, the need for a strong PHC network, regulation of the private sector and health leadership by the state, and cooperation between countries on action to improve health.

Policy and technical topics

Proposed programme budget 2010–2011

(EUR/RC58/8, EUR/RC58/8 Add.1, EUR/RC58/Conf.Doc./3 and EUR/RC58/Inf.Doc./1 (PBPA/2006-2007))

A member of the Standing Committee of the Regional Committee, introducing the item, described the sequence of events leading up to approval of the programme budget by the Health Assembly. In programme budget preparation, the Regional Office continued to focus on combating the challenges posed by the burden of communicable diseases as well as NCDs in the Region, while ensuring the continued strengthening of health systems and the country strategy as the backbones and essential means to achieve the desired outcomes and attain the Millennium Development Goals. The decision by WHO's Global Policy Group and the regional directors that the overall proposed programme budget for 2010–2011 would be in the same range as the programme budget for 2008–2009 created challenges for the

European Region. The weak United States dollar made planning and delivery of commitments difficult, as Regional Office expenditures were based on euros while the 2008–2009 budget had been planned in United States dollars. Even if that fact seemed to have been given due consideration for the 2010–2011 budget, it had not been taken into account when planning for 2008–2009. Consequently, using the 2008–2009 budget envelope for the Regional Office's 2010–2011 budget might not be adequate and raised concerns about actually decreasing, rather than maintaining the value of the programme budget for the Regional Office. If no remedial action were taken, it could mean a significant real decrease in activities, and that would compromise achievement of the results defined by the Medium-Term Strategic Plan (MTSP). Also, the high proportion of closely earmarked voluntary contributions, which made up about 65% of WHO's revenues, meant that the Organization ran the risk of having to follow the preferences of donors rather than the priorities that had been decided upon by its governing bodies. Another problem was that, although the assessed contributions of Member States of the European Region had increased from US$ 49 million in 2000–2001 to US$ 63 million in 2008–2009, the contributions expressed in euros had actually decreased in the same period, from €54.6 million to €39.8 million, owing to the weak United States dollar.

The Deputy Regional Director, presenting document EUR/RC58/8 Add.1 containing the WHO European Region's perspective on the draft proposed programme budget for 2010–2011, said that the budget was based on an effort to consolidate the growth of WHO while strengthening its capacity to implement programmes, on an unchanged segment of the budget for WHO programmes and on an effort to separate growth from the impact of the exchange rate. Although the number and substance of strategic objectives in the MTSP would remain unchanged, the emphasis placed on each had been shifted to reflect global health priorities, and two new Organization-wide expected results related to climate change and patient safety had been introduced. Furthermore, the quality of the indicators had been improved by a number of revisions.

Up to about 2002, WHO's budget had remained relatively stable, with about 50% financed from voluntary contributions; that proportion was projected, however, to be 81% in 2010–2011. The presentation of the proposed budget in three segments, and the separation of partnerships and collaborative arrangements from WHO programmes, would lead to greater accountability and transparency. Funds for outbreak and crisis response would also be considered separately for reasons of accountability, as the funding required was by nature unpredictable. The actual amount was not included in the proposed budget and would be determined later. The Regional Office for Europe's proposed total programme budget for 2010–2011 was US$ 278 million, of which US$10 million was a segment for partnerships and collaborative arrangements, and US$ 268 million for WHO programmes, which also included the budget of the European Observatory on Health Policy and Systems. The proportion of the WHO total budget that was proposed to be allocated to the Regional Office for Europe in 2008–2009 was 6.5%, while that proposed for 2010–2011 was 5.6%.

The Deputy Regional Director then illustrated the programme budget trends for communicable diseases, NCDs and the environment, health systems and the social determinants of health, and leadership and governance (including WHO's country presence) during the previous three bienniums and those projected for 2010–2011 based on the Regional Office's work in previous bienniums, including financial performance data. There had been a steady increase in the budgets of Communicable diseases, as well as Noncommunicable disease and environment (NCE) in absolute figures in the past several bienniums. Currently, the Regional Office was strengthening and consolidating its implementation capacity in order to respond properly to that increase and to develop an adequate resource base. It should also be noted that strengthening the Regional Office's work in health systems, which also included addressing the social determinants of health, contributed to addressing challenges in both communicable diseases and NCE through a more comprehensive, system-wide approach. Since the 2004–2005 biennium, the Regional Office had substantially increased the collective financial envelope to the traditionally underfunded area of health systems. It was proposed to maintain the priority that had been given to health systems in 2010–2011 and to consolidate the Regional Office's work. Notwithstanding substantial efficiency savings, the need to allocate resources in the area of Leadership and governance, including country presence, and the increased demands for accountability had meant that expenditures had been exceeding programme

budgets over several bienniums. That had been the result of strengthening WHO's country presence, increases in fixed costs and running costs for WHO offices in all 35 locations, and increased investment in the transparency and accountability of the Regional Office, as well as intensified work with the governing bodies. The Regional Office for Europe's country component in strategic objectives 12 and 13 was the largest (13.8%) among WHO regional offices, when compared to the total revised budget for each office and represented more than 50% of the Regional Office's total budget allocated to the area of leadership and governance, including country presence. The Regional Office's expenditure for administration was comparable to that of the other regional offices (7.3%).

The Director, Administration and Finance described in more detail the impact of currency fluctuations and exchange rate variations on the WHO budget. While WHO's budget was accounted for in United States dollars, only 41% of its income was received in that currency, and it incurred expenditures in many other currencies. That made for uncertainty and posed a challenge for financial management. Since 2006, the United States dollar had devalued against the euro by 31%. The estimated impact of that devaluation on the budget of the Regional Office for Europe in 2008–2009 was US$ 25 million. Although the Regional Office's budget had grown dynamically during the previous decade when expressed in United States dollars, the growth had been limited in terms of euros. Furthermore, local currency inflation had meant an average increase in running costs for WHO offices in 35 locations of 40%. None of those factors had been foreseen when planning the 2008–2009 programme budget in 2006. Moreover, there was no established mechanism for global adjustment of the current programme budget. However, during the programme budget revision in January 2008, several major WHO offices had obtained an increase in the 2008–2009 programme budget, while the European Region's programme budget had remained almost unchanged, despite the request for budget adjustment due to the weakening United States dollar.

A further challenge was related to diminishing levels of assessed contributions. Owing to the weak United States dollar, that presented an even bigger challenge for the Regional Office than for WHO globally. While the assessed contributions had increased from US$ 49 million in 2000–2001 to US$ 63 million in 2008–2009, they had decreased by 27% when expressed in euros. That decrease meant that Member States who paid their contributions in United States dollars had realized significant 'savings' over that period. The increasingly difficult financial situation of the Regional Office could be eased if Member States were to use part of those savings to make non-earmarked, flexible voluntary contributions to the Organization. Adding to the Regional Office's difficulties was the fact that it received the lowest relative share of the assessed contributions of all the regional offices. That problem remained unresolved despite various rectifying actions in the past. Implementation of strategic objectives 1–11 would be difficult if the budget for SOs 12 and 13 (so called "enabling functions") for 2010–2011 were maintained at the level of 2008–2009.

The member of the SCRC presented a list of points that might guide the discussions of the Committee on the agenda item. Was the proposed programme budget for 2010–2011 acceptable? Would the Regional Office be able to implement resolutions when the earmarked part of the budget had increased to about 65%? Should Member States consider making more flexible voluntary contributions to WHO? Should Member States consider using part of their reduced financial burden due to the weak United States dollar to increase their assessed contributions? Should the budget ceilings for 2008–2009 be raised in order to reduce the impact of the weak United States dollar, by allowing the Regional Director to seek more voluntary contributions? Should the Regional Office's share of assessed contributions be discussed further? Should the Secretariat provide more timely and more detailed financial analyses?

The Assistant Director-General, General Management, WHO headquarters, said that the programme budget reflected the aspirations of the Member States. She reminded representatives that the only part of the budget that was assured was the assessed contributions. As about 65% of the budget consisted of closely earmarked voluntary contributions, it was difficult to meet expectations and to conduct needed activities.

In the debate that followed, one representative, speaking on behalf of the European Union, candidate countries Turkey, Croatia and the former Yugoslav Republic of Macedonia, potential candidate countries

Albania, Montenegro and Serbia, as well as Armenia, Georgia, the Republic of Moldova, and Ukraine (which aligned themselves with the statement) said that the proposed programme budget for 2010–2011 was an indication of the relevance of the MTSP as a framework for the activities of the Organization, although it might be necessary to adjust it in the light of the current international health situation. However, the document failed to mention creation of an international health partnership to strengthen collaboration in meeting strategic objective 12; adoption of a world strategy on innovation, public health and intellectual property to orient the activities of the Organization in 2008–2015 for attaining strategic objective 11; and the world food crisis, which should be taken into account in meeting strategic objective 9. Mention of the MPOWER programme in relation to the global tobacco epidemic was problematic for Member States that had signed the WHO Framework Convention on Tobacco Control, which for them was binding. Only essential revisions should be made to the established indicators, so that they would remain comparable over time.

She asked for further justification of the proposal to increase the global budget from US$ 4.2 billion to US$ 4.9 billion, in view of the fact that expenditure in certain programmes and regions had been low and that an excess of US$ 1.6 billion had been accumulated over the previous bienniums. She welcomed the separation of the budget into three segments and, in particular, the effort to increase the transparency of partnerships. With regard to epidemic and crisis management, a distinction should be made between preparatory and capacity-building activities, which could be predicted, and unpredictable crisis interventions. The Secretariat should be able to provide a preliminary estimate of the funds needed for the first group of activities, while a contingency fund could be set up for the second. While commending the attribution of resources for most of the strategic objectives, she asked for clarification of the implications of introduction of the global management system (GSM) and moving part of the financial administration of the Organization to Malaysia, an explanation of the proposed decrease in the allocation for strategic objective 4, and a list of the programmes that were to be phased out in the coming few years.

Several speakers thanked the Secretariat for the quality, clarity and detail of the presentations and expressed support for the documents and for the proposed ways of addressing challenges. One speaker expressed concern that the imbalance between assessed and voluntary contributions meant that donors, rather than the governing bodies were in fact deciding the Organization's priorities. Another proposed that, in view of the negative effect of the unfavourable exchange rate on the activities of the Regional Office, that rate should be factored into the budget for each biennium, and in particular that the programme budget 2008–2009 needed to be adjusted to reflect the impact of the weakened United States dollar since 2006, prior to being taken as a base for 2010–2011. One representative said that the proposed decrease in funding for sexual and reproductive health was not in line with efforts to reach the Millennium Development Goals nor with the ambition expressed by the Director-General that WHO be judged by progress made in the health of women. It was proposed that the budget of the European Observatory on Health Policy and Systems be included in the partnerships segment of the Regional Office's programme budget. One representative commented that the full performance assessment report for the biennium 2006–2007 should have been made available earlier, in order to guide the Committee's deliberations on future activities and priorities for the 2010–2011 budget.

A number of representatives urged Member States to provide fully flexible voluntary contributions to WHO. One representative commented that the imbalance between assessed and voluntary contributions meant that the Organization expended energy on raising funds which would more usefully be spent on conducting normative work and providing technical support to Member States. His country would be willing to consider an increase in assessed contributions in the next biennium. Nevertheless, if more voluntary contributions were fully flexible, the Secretariat should keep Member States fully informed about the programmes for which the funds were used.

The Director-General, responding to comments, agreed that the Secretariat should be independent and capable of fulfilling the expectations of Member States, as expressed in governing body decisions. She asked how the Organization had arrived at a situation in which 65% of its budget came from earmarked voluntary contributions. Did Member States consider that WHO was not performing satisfactorily? Did they not trust the Secretariat? Or did Member States not wish to set priorities through the governing

bodies and therefore bypassed those organisms by providing earmarked voluntary contributions? She affirmed her intention to ensure that WHO performed well and called for the Member States' support and understanding with regard to the challenges faced. In her opinion, it was important that her 193 bosses – the Member States of WHO – decided on priorities, with full consideration of whether the work was duplicating that of another organization.

The Deputy Regional Director said that in addition to financial performance data, a new set of performance measures and indicators had been included for the first time in the Regional Director's report for 2006–2007 in relation to each area of work; 85% of the desired results had been attained. Although some crises and outbreaks could be addressed only by raising money through appeals, a certain level of resources was planned for disaster preparedness work and for ensuring a timely, relevant response to crises. With regard to the impact of economic recession, various calculations had been made, which were reflected in the proposed programme budget through the currency adjustment mechanism to be introduced for the first time in 2010–2011. Maintaining the same budget level from one biennium to the next for the Regional Office would mean a de facto decrease in the budget, with corresponding decreases in programmes, deliverables and staffing, and she therefore welcomed the Member States' proposal to introduce an adjustment in the 2010–2011 proposed programme budget. The apparent decreases in funding for sexual and reproductive health, maternal health and noncommunicable diseases were in fact offset by increases in the proposed allocations for other strategic objectives, since strengthened health systems, including actions to address social determinants of health, as well as governance and country presence, would result in improved outcomes for those areas. The comments and suggestions of Member States would be reflected in the next version of the Proposed Programme Budget 2010–2011, to be presented to the Executive Board in January 2009.

The Assistant Director-General, General Management, WHO headquarters reiterated that the governing bodies should decide on priorities, not the donors of voluntary contributions. Part of the proposed increase in the overall budget was outside the control of the Secretariat because increases were decided upon by WHO's partners in various collaborative programmes. Nearer the time of the next Executive Board session, the precise impact of the exchange rate on the different WHO regions would be assessed. The impact appeared to be greatest in the European Region, at headquarters and in the African Region. GSM had been introduced at WHO headquarters and in the Regional Office for the Western Pacific and would be implemented in the other regions by the end of the biennium. The benefits of consolidation would then become apparent; savings of about US$ 5 million were anticipated. She welcomed the expression of Member States' intention to provide more fully flexible voluntary contributions. She considered that the confidence that showed in the Secretariat stemmed from the efforts that had been made to improve transparency and accountability.

The Committee adopted resolution EUR/RC58/R2.

Stewardship/governance of health systems in the European Region: meeting the commitments made at the WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth"

(EUR/RC58/9, EUR/RC58/Conf.Doc./4 Rev.1 and EUR/RC58/Inf.Doc./4)

The Health Systems Adviser for the Regional Office, introducing the item, said that, as the Ministerial Conference had made clear, stewardship was central to equitable health systems in all countries.

A member of the Standing Committee of the Regional Committee noted that, although health status had improved in the previous 15 years, there were still some major challenges and many pressures on governments to improve performance and financial fairness. The stewardship function was critical. The goal was to achieve better health system performance and secure the highest possible levels of health, while taking stakeholders' views and expectations into account and maintaining flexibility.

A short video was shown about the Ministerial Conference in Tallinn and a greeting was played from the Minister of Social Affairs in Estonia.

The Deputy Regional Director outlined major developments and challenges. Stewardship was the role of government, both in health and in those activities that impacted on health. There were many forms of stewardship in the Region and there was no one model, but it involved setting strategic direction and making policies, creating effective regulations and exercising accountability.

Stewardship also involved influencing other sectors to promote good health and healthy behaviour. It was relevant not only to specific health system functions such as resource generation or financing, but also to wider factors such as corruption: it went far beyond the health system. There was strong evidence that health systems improved health, but they had to be shaped in such a way as to improve outcomes and make them more equitable. Economic development by itself would not achieve improvements in health, if not accompanied by investments in technology, human capital and enterprise capital. Tools were available to help countries as they faced scarcity of information, pressure for quick results, and high turnover of personnel, and several interesting case studies had been made of exercising a stronger stewardship role, both within and between countries.

There was a need to revisit PHC development and work out how best to act on the evidence about the impact of social determinants. Proper measures should be taken to manage human resources; indeed, the movement towards consultation on a code of practice on international recruitment was itself a form of stewardship.

Good intentions were not enough in health systems. Performance and stewardship should be measured, and some useful initiatives had been taken in benchmarking and assessment of system performance. The measurement of performance was not an easy concept and carried some political risk: WHO's framework did not necessarily intend the ranking of countries, but it could help to see what others were doing. WHO would continue to develop tools, examine governance, support countries and strive for consensus.

A panel of experts then shared their views. The Chair of the Commission on Social Determinants of Health, whose report had just been launched, observed that health was not the same as health care, and PHC needed to be redeveloped within the context of social determinants: the two needed each other. There was no clash with the Commission on Macroeconomics and Health, either: the point was that health was to be improved not because of the economy but as a matter of social justice. Politicians cared about the findings of the Commission he chaired because everyone cared about their health; it represented the outcome of all social policies. As Sir Liam Donaldson had once said, health should be a corporate issue for the whole of government. Ministries were not only the advocates but should also be the "social accountants" who ensured that health was measured. At the beginning of the Commission's work, he had had no view on whether a health system should be private or public but now the evidence was clear: the higher the proportion of health care costs in the private sector, the worse the population's health status. One hundred million people a year were driven into poverty by the cost of health care. Bad policies and unfair economic arrangements were responsible for some of the inequities in health. How countries organized their health care made a statement about what kind of society they wanted.

The Director of the European Observatory on Health Systems and Policies talked about measuring performance. The main problem was how to link performance assessment to policy. A lot of assessment was done "downstream" on evaluating drugs, for example, but upstream evaluation of say, investing in welfare or housing, was needed. It was more complex, but it could take into account future benefits that were typically overlooked. Life expectancy was influenced not only by social determinants but also by improvements in services. However, in spite of all the years of the Health for All philosophy, there was as yet no evaluation of how well intersectoral structures and approaches worked. There was some way to go.

The First Lady of Georgia considered the role of the public, which had been summarized as voice, choice and representation. Citizens were all potential patients or ex-patients and could play a role both in governance and as volunteers: people learned by doing. WHO could be active in providing information to the public about their rights and about health issues.

The Director-General for Health of France noted that it was important to worry about the things that were not under control. Vulnerable patients, such as the very young, the very old, minority groups, the mentally ill or migrants, might therefore need specific programmes and policies to ensure access. Health policy-makers were like goalkeepers, they were very aware of their failures – the goals that had been let in – but their concerns needed to be shared with those dealing with social affairs, using crises to drive home the message of the importance of health. That would mean raising awareness and making political arguments. He referred to earlier remarks that the tasks were like those of Sisyphus and noted that Camus had remarked that one had to imagine Sisyphus as happy!

The Minister of Health of Serbia returned to the need for a balance between macroeconomics and social determinants. It was important to have the data, to be frank in any communication with stakeholders, including the public, and to provide a consultative framework but then to be strong in implementation, while being also ready to learn and adapt. He described successes in his country in tackling smoking and tobacco control and advocated being not only a health professional but a serious policy-maker who could also learn from other ministries.

The Head of the WHO Office in Barcelona addressed the question of how health ministries could exercise stewardship when their budget was decentralized or in the hands of insurance companies. Controlling policy without funding was linked to a concept in the Tallinn Charter whereby actions should be driven by well-defined health policy objectives, not just expediency or stand-alone new developments. Action was usually needed on associated training and service delivery, and criteria should be set for and questions asked of insurance funds to ensure accountability. Accountability was historically exercised by the control of inputs, but it was better if the system was made accountable in terms of its outputs, its results. Collecting and using intelligence was also important: data were power. There were tools available to exercise stewardship and governance of key agencies implementing the finance system, including giving information to the public or service providers. Regulation of the system helped to steer the intermediaries towards defined social objectives. Public policy could also put risk adjustment mechanisms in place to ensure equable distribution of funds, in order to facilitate access by the most vulnerable. A number of countries had, with the support of WHO, successfully improved their stewardship to support overall reforms. WHO focused on giving the best advice based on evidence: that was its stewardship role in the Region.

In the subsequent discussion, one representative described the move his ministry had made in the previous eight years from “rowing” to “steering”. The best ideas came from local imagination and action; traditionally, the centre had been over-bureaucratic, telling people what to do and stifling creativity. The Ministry had concentrated on setting clear standards with not too many targets, creating a fair and effective way of allocating resources in different areas with different needs, and facilitating change. It had also tried hard to make health a responsibility of all government departments.

Following the panel discussion, the Deputy Regional Director briefly reviewed the content of the draft resolution and the content, key messages and commitments of the Tallinn Charter, which should be the starting point for a wide range of activities by WHO, Member States and partners to strengthen health systems.

In the subsequent discussion, many speakers praised the document on stewardship/governance in the Region and the innovative presentation of the topic. They welcomed the proposed resolution as a means of implementing the Tallinn Charter and strengthening health systems in the European Region.

A representative speaking on behalf of the EU, candidate countries Croatia, the former Yugoslav Republic of Macedonia and Turkey, and potential candidate countries Albania, Montenegro and Serbia, as well as Armenia, Georgia, the Republic of Moldova and Ukraine (which aligned themselves with his statement) further emphasized three requirements for good governance: the need for health ministries that were strong leaders and cooperated with civil society and partners in the private sector, and cooperation and coordination at the regional and international levels. First, owing to the importance of health systems to health and wealth and the impact of health ministries’ activities on development as a whole, the

ministries needed to be able to lead, coordinate and evaluate public health policies, convince other ministries to integrate health into their policies and ensure both good cooperation between central and local government and the prioritization of health in national governments. Second, health ministries' cooperation with civil society and private-sector partners should include consultations with patients' associations and nongovernmental organizations (NGOs), and consideration of ethical issues, transparency and responsibility for taking account of service users' needs. In addition, dialogue with medical research bodies was important for coping with innovation and ensuring cost–efficiency; health ministries' capacity for dialogue with all stakeholders was crucial to effective PHC. Third, national and international cooperation and coordination were necessary to deal with such issues as patients' and professionals' mobility and health worker migration; WHO's public consultations on the draft code of practice on the latter were very welcome. Finally, the exchange of experience and good practices would contribute to the good governance of national health systems.

The Regional Office played an indispensable role in that work by helping Member States to develop their policies, strategies and legislation in accordance with their diverse circumstances. WHO at the regional and global levels could help to develop the dialogues required. Further, while the working paper rightly emphasized some tools needed to ensure an efficient health ministry – the development of regulations, evaluation of health system performance, sharing of good practice and establishment of an epidemiological surveillance system – it could have placed more emphasis on the need for health system financing that was sustainable and ensured universal coverage. The speaker supported the proposed resolution as a means to implement the Tallinn Charter and achieve the Millennium Development Goals (MDGs) in the European Region.

A representative speaking on behalf of the five Nordic countries fully endorsed those views and welcomed WHO's continuing support for strengthening health systems and its emphasis on PHC. Several others speakers echoed those views, especially as 2008 marked the thirtieth anniversary of the Declaration of Alma-Ata and the Region had been the home of the father of the PHC centre, Andrija Stampar. A new approach to PHC was needed, as it was key to addressing the causes of ill health, particularly in light of the report of the WHO Commission on Social Determinants of Health. Other significant aspects of stewardship included the importance of equity, leadership by health ministries and improvement of health system effectiveness. The working paper, however, could have broadened the definition of equity to include health outcomes and could have reflected more on the generation of human resources for health as an important field for exercising steawardship. WHO already provided a technical framework on human resources for health and technical advice to Member States. All countries were debating immigration and international recruitment; the proposed WHO code of practice was urgently needed. In addition, national and intersectoral interventions were needed to integrate immigrants and their families into their destination countries.

Many other speakers stressed particular aspects of governance and/or health system strengthening, including: the need for policies on social justice, in order to tackle the macroeconomic determinants of health and increase equity; the essential contribution of strong health systems to economic and social development; the need for better access to services and financial protection; the importance of strengthening the promotion of public health, and the need for optimum solutions for countries in diverse circumstances.

As to the Tallinn Charter, representatives proudly recalled their roles in developing it, strongly endorsed its values, methods and commitments, and described in detail how they had implemented it or were using it to strengthen the health systems or tackle current challenges in their countries. One speaker described the preparation process for the Tallinn Conference and Charter as exemplary and a model for other regional and global initiatives. Representatives called for further action on implementation, citing the Charter's usefulness as a basis for further work and calling on all Member States to transform their words into actions and move forward at the national and international levels on the basis of solidarity.

Some speakers welcomed the report of the Commission on Social Determinants of Health as a useful tool, although one asserted that higher private-sector payments would not lead to lower health outcomes if the government ensured universal coverage and focused on the socioeconomic determinants of health.

As to the role of WHO, several speakers thanked the Regional Office for supporting their work on health systems, praising the incorporation of the health system approach in country work, and pledged to work with WHO to implement the Tallinn Charter. Others pointed to the usefulness of WHO's linking health systems to health and wealth. The focus on health systems at the Regional Office and WHO headquarters would help countries at all levels of development. Many representatives stressed the importance of intelligence and the evaluation of successes and failures, and expressed their willingness to share their experience and information both in their own countries and internationally. Several called on the Regional Office to collect and analyse such information, as that would help countries develop common mechanisms and tools.

The Regional Director welcomed the satisfaction expressed by Member States with regard to the Tallinn Conference and said that the challenge was to follow up the spirit of the Conference over the long term. He had noted the areas in which the Regional Office should strengthen its support and the new topics that it should address. The panel discussion had highlighted the diversity and complexity of health systems and shown that innovative solutions would have to be found for strengthening them; the capacity of ministers of health must be increased to allow them to address their diverse responsibilities; and new ways would have to be found to ensure community participation in health issues. The discussion had also emphasized the importance of research and information as tools for measuring progress. PHC represented the basic values of health systems, although new techniques would have to be introduced to modernize the concept.

The Director-General also stressed the importance of evidence and information for measuring, monitoring and evaluating health systems. Less than one third of the Member States of WHO had robust health information systems for collecting, registering and using the fundamental data that were essential for convincing other government ministers of the importance of health issues.

The Sector Manager for Health, Nutrition and Population (Europe and Central Asia) at the World Bank said that the exemplary partnership between the Regional Office and the World Bank had contributed to the success of the Tallinn Conference. He identified six approaches to funding health services for the poor: (i) disassociate the use of health services by the poor and how much they pay for them; (ii) ensure that funds are directed towards the poor and not towards programmes; (iii) link reimbursement of service providers to use of the services; (iv) close the gap between the poor and health services, both geographically and culturally; (v) ensure a stronger voice for the poor by enacting regulations; and (vi) use behaviour change to close the gap between what the poor demand and what they need.

A representative of the United Nations Children's Fund (UNICEF) congratulated the Regional Office on addressing the issue of strengthening health systems. Health was not a privilege but a right; all people had the right to equal access to good-quality health care. Programming should also be based on human rights, with the responsible participation of all family members. He agreed with the Director-General that national information was essential, as it had a greater impact on national decisions than data from other countries.

The Head, Health Division, Social Cohesion, Council of Europe, said that human rights were an issue that united the Council's aims with those of WHO. The Council was in effect already implementing the provisions of the Tallinn Charter through an expert committee on good governance in health care, with emphasis on transparency, accountability and participation. Another committee was preparing a recommendation on mobility, migration and access to health care. The Council and WHO had a long history of fruitful cooperation, including the South-Eastern Europe Health Network within the Stability Pact, which had shown that health could be a bridge to peace and that peace could engender better health.

Statements were received from the following nongovernmental organizations: Alzheimer's Disease International, the International Planned Parenthood Federation (European Network) and the International Association of Medical Regulatory Authorities.

A number of representatives and the Regional Director, commenting on an amendment to the draft resolution proposing that an international working group be set up to facilitate development of an optimal health system model, said that the financial implications of any such proposal should first be considered by the SCRC and subsequently by the Regional Office. Others considered that it would be impossible to define an optimal health system. The Committee decided to include instead a reference to 'minimum standards' for health systems.

The Committee adopted resolution EUR/RC58/R4.

Behaviour change strategies and health: the role of health systems

(EUR/RC58/10 and EUR/RC58/Conf.Doc./5 Rev.1)

A member of the Standing Committee introduced the topic, which presented what he described as a crucial but immensely complex challenge. Within the WHO European Region, behavioural risk factors were the leading causes of morbidity and mortality due to chronic health conditions and injuries, and there was convincing evidence that healthy behaviours (including smoking abstinence, healthy diet and regular exercise) were associated with enhanced life span and improved quality of life. However, health promotion activities did not always have the desired effect. The working paper aimed to consolidate the evidence documenting effective interventions, outline critical factors for success and explore their implications for health systems and for a wider government response. Influencing individuals' behaviour while respecting personal freedom of choice was key to promoting health across the Region.

The Director, Division of Country Health Systems said that one might ask what was new, given that people had known about the subject for over 30 years. However, NCDs had become the main killers in the Region, and they were mostly the result of unhealthy lifestyles and behaviours, especially among disadvantaged groups. Evidence indicated that interventions could reverse that trend, and human behaviour as a cluster of risk factors warranted a second look: what was also new was the need to make explicit the role of health systems in behaviour change. It was time to examine the determinants related to health systems, to assess how effective interventions had been, and to see what lessons had been learned.

There was little disagreement that upstream interventions such as legislation on tobacco control made a lot of sense, particularly economic sense, but the jury was still out on whether a proper understanding had been gained of the relationship between health, ill health and other factors in the causal chain. Increased awareness did not necessarily mean behaviour change, indeed often the louder the message, the greater the resistance. People's ability to change was affected by many external and contextual factors. To that end, it was crucial to underline the importance of structural measures. Positive results would not be achieved if they were not taken fully into account. The health system could ensure that happened: it could conduct research on fatalities and risk groups or advocate legislation (for example on seat belts, the minimum age for driving licence penalties, or ambulance system response). Health authorities had a key role to play in the implementation of effective interventions.

Effective implementation meant paying attention to four considerations: whether the target population had been carefully defined; whether the coverage level was adequate; whether the targeted population was responding (and if not, whether that was due to shortcomings in programme design and tools for ensuring compliance); and whether the staff needed better or different skills, training or motivation. All those could be addressed by involving the health system and its functions of service delivery, resource generation, financing, and stewardship.

Interventions were context-specific: it was not a case of "one size fits all". However, there were common features to successful interventions such as commitment, knowledge, multisectoralism, good timing and adequate financing. The health system could steward behaviour change using a minimum set of

principles, ranging from wide ownership to continuous evaluation and comprehensiveness. The approach had to be upstream and multisectoral.

A panel of experts shared their views. The Head of the WHO European Office for Investment for Health and Development, Venice said that a first attempt was being made to place behaviour change in the overall framework of health systems, which would require a strong performance by all health system functions as it would be linked to elements of health system performance assessment. It was often said that individuals should take responsibility for their health, but the Commission on Social Determinants had shown that health was not distributed equally in society and that the opportunity for people to adopt healthy behaviours also had a social gradient. Making a healthy choice the easy choice required government action.

The acting Head, Noncommunicable Diseases unit said that the days when health education involved simply sending messages and blaming the victims were long gone: now it was more about individual responsibility in a supportive environment, for there was strong evidence on what encouraged and discouraged people from adopting healthy lifestyles. Health was becoming a core value in many sectors such as urban planning, housing regeneration or economic development. Better documentation and evaluation were needed, but a lot was happening: family doctors were prescribing physical exercise, cycle paths were being extended, ministries of agriculture were promoting cheap vegetable markets in neighbourhoods. Partnership was important at different levels, and social marketing was a useful tool to make those initiatives sustainable.

The acting Head, Communicable Diseases unit said that for many communicable diseases, behaviour change was the main objective of interventions, such as those targeted at harm reduction among injecting drug users or promotion of universal access to antiretroviral therapy among people living with HIV. It was again a case of creating enabling environments in challenging situations, for example by persuading an injecting drug user that there could be important short-term gains as well as the promise of a better life in the future. It was not enough to promote harm reduction approaches, however; health systems also needed to provide services. Once interventions aimed at behaviour change were embarked upon, health systems could be faced with continuing them over people's lifetimes, even spanning generations, to achieve public health gains. Political and legal factors came into play, along with gender questions, as well as the issue of balancing public health and individual human rights when it came to criminalization.

The Director-General of Health Improvement and Protection in the United Kingdom said that his department was focusing on social marketing. The retail sector had elaborate ways of assessing consumer behaviour and implementing subtle measures to modify it, but the public sector was some way behind. It was a question not only of defining messages but also of gaining critical insight into what triggered behaviour change, the right environment, and winning the trust of the consumer. His department had run television campaigns on issues such as smoking, alcohol, road safety and back-seat safety belts. Its obesity strategy used a cross-sectoral approach that involved the transport, culture, media, sport and health sectors. The "Change4life" products had been developed with schools, parents, the food industry and local activists. The idea was to sensitize the population to healthy lifestyle ideas by extending the concept to walking, dancing, cycling, shopping, cooking, etc.

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, Montenegro and Serbia as well as Armenia, Georgia, the Republic of Moldova and Ukraine (which aligned themselves with her statement) said that action on targeting environmental and structural factors of healthy behaviour, using legislative and regulatory instruments and financial or other incentives, deserved considerably higher priority. The EU had begun to implement its strategy to support countries in reducing alcohol-related harm; that strategy advocated restrictions on the sale of alcohol and enforcement measures to control alcohol use by drivers. The intersectoral dimension was very important, but health ministers played a central role in mobilizing all those responsible for public policies. The speaker supported the recommendation to analyse problematic forms of behaviour and their influence on heath, and to mobilize existing knowledge. That would include

identifying the population groups at risk, taking into account social and environmental impacts on health, organizing multisectoral action and highlighting the role of the health ministry, with the involvement of other sectors including those that would benefit from the measures.

Other speakers described initiatives they had taken such as incorporating the health promotion concept into official policies and national health strategies; launching intersectoral government programmes; running campaigns on heart health; conducting television campaigns to reduce risk factors; making health an obligatory school subject, or making progress with tobacco control. It was stressed that for activities to be successful they had to be right in the specific country context, but healthy choices had to be made easy, accessible, attractive and affordable. It was important to address structural measures, including measures through taxes, subsidies, or educational initiatives. Poor health behaviours led to great economic losses.

Over the years, countries had tried to make people change their behaviour through information only, so far with limited success: it was more than 20 years since WHO had expressed the aim to "Make the healthy choice the easy choice". One country noted the limited attention paid to alcohol in the report. The responsibility for and stewardship of health promotion programmes lay squarely within the health system, and there was also a need for strong stewardship at the Regional Office.

One speaker pointed out that the decisions taken by local government also had a great impact, since people's physical and social environments greatly affected behavioural factors. The education of health professionals, their financial incentives and the ways in which health services were organized could all contribute coherently to effective health promotion and disease prevention efforts.

Children and young people were often the main target groups in the promotion of healthy choices, because investment in their health was one of the most efficient ways of ensuring good health in future adults. However it was pointed out that for risk factors such as alcohol or tobacco, narrowly targeted approaches might not be as effective as broader, population-level approaches (often referred to as "the prevention paradox"), since most people were exposed to the risks.

In response, the Director, Division of Country Health Systems reiterated that the subject being discussed was not new but that the approach being advocated was innovative, in that it tried to define the role of health systems in a systematic and sustainable manner and to link the four functions of a health system with behaviour change. The devil was in the detail. The role of the state was very important. Governments could counteract the peer, community and neighbourhood effects that were often seen in disadvantaged populations. That was government acting as an enabling rather than a constraining force.

A statement was made by the representative of the International Pharmaceutical Federation.

The Committee adopted resolution EUR/RC58/R8.

Process of reporting back to the Regional Committee on resolutions adopted at previous sessions

(EUR/RC58/11 and EUR/RC58/Conf.Doc./6)

Introducing the item, a member of the Standing Committee said that the SCRC had, during the previous year, reviewed the process of reporting back to the Regional Committee on resolutions it had adopted. An increasing number of those resolutions required reporting back periodically, and often with no end date. That limited the time allotted for technical and policy issues and the space for new agenda items. To overcome that problem, the SCRC was proposing that an end date for reporting back be applied to a number of resolutions already adopted by the Regional Committee. In addition, it was recommending that resolutions adopted in the future should not contain any open-ended commitment to report back and that there should preferably, and where practicable, be a minimum of five years between such reports.

In answer to a question raised, the Deputy Regional Director explained that the working paper and draft resolution dealt only with the periodicity of reporting. Decisions about the form of the reports submitted

(oral or written) and their formal inclusion in the agenda of a Regional Committee session were taken by the SCRC. If such reports were submitted in written form only and were not included in the agenda of the session (as was the case with the report of the European Environment and Health Committee at the present session), representatives could comment on them during the general debate.

The Committee adopted resolution EUR/RC58/R5.

Follow-up to issues discussed at previous sessions of the Regional Committee

Child and adolescent health strategies, including immunization

The Director, Division of Country Health Systems reported on the progress made in implementing the European strategies on child and adolescent health and on immunization. Resolution EUR/RC55/R6 had called on Member States to try to reduce inequalities in children's health and access to health systems by drawing up and carrying out national strategies in line with the European strategy on child and adolescent health and development. The Regional Office had held regional and national workshops on strategy development for 18 countries (including 13 with biennial cooperation agreements) and conducted a situation analysis to establish the baseline. As of 2008, such analyses had been carried out for 12 countries, while 5 had advanced draft strategies and action plans and 4 had strategies and action plans approved by the government cabinet or the health ministry.

The Regional Office had evaluated progress by conducting a cross-Region survey and case studies in Albania, Armenia, Hungary, Scotland (United Kingdom) and Uzbekistan. The survey showed progress on four criteria between 2006 and 2008. Increases were found in the share of countries whose strategies on child and adolescent health addressed different age groups (from 25% to 35%) and focused on inequities among population groups (from 50% to 80%) and of countries that had established a multisectoral task force as a result of the European strategy (from 10% to 30%) and involved young people in strategy development/implementation (from 30% to 45%). The case studies had shown that, to implement national strategies, countries needed to strengthen the reliability of data and mechanisms for their collection, fill gaps in professionals' training to build their implementation capacity, improve the geographical distribution of health professionals and facilities and the monitoring and evaluation of health services, and secure adequate financing. Future challenges for countries included integrating their child and adolescent health strategies into their health systems, making action plans for implementation and developing indicators, adopting a unified approach to data collection and analysis, and obtaining reliable disaggregated data. Challenges for the Regional Office included continuing to support strategy development and implementation in countries and focusing more on specific parts of the life-course.

The WHO strategy to eliminate measles and rubella from the European Region by 2010 had a three-pronged approach: strengthening national immunization systems, providing strategic direction and technical guidance, and facilitating communication and a common approach. Satisfactory progress was being made. Overall immunization coverage was very high and sustained. The incidence of measles and rubella had fallen across the Region; while some western countries still suffered measles outbreaks, the number of countries with an incidence below 1 case per million population had risen from 19 in 2006 to 29 in 2007. Those results were secured through high-level government commitment to and resource mobilization for immunization programmes, national policy development, advocacy work (such as that of the annual European Immunization Week), stronger surveillance structures and supplemental immunization activities for hard-to-reach groups.

While the Region was on track to reach its goal, countries needed continued political commitment and advocacy, sustained financing, more aggressive efforts in western Europe to increase routine immunization coverage to 95%, and services to reach susceptible populations. Continued commitment to the poliomyelitis eradication initiative and to measles and rubella elimination would strengthen routine

immunization systems. Finally, the Regional Committee could consider fostering the development and implementation of a certification process for measles and rubella.

Speakers praised the response to the Regional Committee's requests in resolutions EUR/RC55/R6 and EUR/RC55/R7; the Regional Office had done very well in both taking action and reporting on it.

In reply to a query, the Director, Division of Country Health Systems said that the outcomes showing progress on child and adolescent health currently focused on the development of national strategies and action plans; more time would be needed to determine their effects on young people's health.

Prevention and control of noncommunicable diseases, including prevention of injuries, and alcohol-related problems and policies

The acting Director, Division of Health Programmes recalled that the Regional Committee had adopted resolutions on noncommunicable diseases (EUR/RC56/R2), prevention of injuries (EUR/RC55/R9) and the framework for a policy on alcohol (EUR/RC55/R1), which requested that the Regional Office report back to the Committee in 2008. Cardiovascular diseases were the main cause of mortality in the Region, followed by cancer; injuries were the third most common cause of death overall but the commonest cause among people aged 5–44 years. Large inequalities in risks and deaths from injuries were seen, with people in low- and middle-income countries four times as likely to die from that cause as those in high-income countries. The average alcohol consumption in Europe was twice the world average, and it was the most important risk factor for disease, after hypertension and tobacco use.

The Regional Office's strategy consisted of keeping the prevention and control of NCDs, harmful alcohol consumption and injuries high on the political and social agendas. In order to do so, it was forming multisectoral partnerships and integrated approaches. It was generating scientific evidence to support the setting and implementation of priorities and was strengthening the capacity of Member States' health systems in order to improve prevention and control.

Preliminary results showed that 32 Member States had strong national policies for NCD prevention and control, 47 had policies with respect to nutrition and 44 had ratified the WHO Framework Convention on Tobacco Control. About one half of Member States had integrated policies for preventing unintentional injury, and about one fourth had policies for preventing violence. She was pleased to note heightened interest from Member States in working with WHO in those areas. In order to respond to that interest, the Regional Office was increasing its capacity, promoting and reviewing integrated policies, materials and methods for implementation, increasing human resource capacity and setting up 'integrated risk factors' surveillance systems.

The progress made included strengthening NCD prevention within PHC and establishing comprehensive programmes for the prevention of specific diseases, in partnership with other organizations. With regard to the prevention of violence and injuries, a number of advocacy events had been held and partnerships formed. A majority of Member States had reported that the resolution had catalysed national action. Progress in prevention of alcohol abuse had been made by strengthening collaboration with other relevant international organizations and setting up a European information system on alcohol. The strategy was supported by strong commitment from international and national bodies and by strong evidence.

The challenges that remained were to develop comprehensive, integrated approaches, identify the social determinants of the high risks of certain groups, strengthen health system capacity, ensure effective multisectoral collaboration and strengthen partnerships for prevention and control.

Several representatives described progress that had been made in their countries in implementing the various Regional Committee resolutions. Nevertheless, in view of the alarming rise in NCDs in the European Region, it was important that the issues be given even higher priority in both Member States and at the Regional Office. All risk factors should be taken into account in the strategy, while at the same time maintaining the horizontal approach to the entire complex of NCDs. Not only individual but also

structural measures were needed to face the multiple challenges, and Member States should consider introducing regulatory measures such as marketing restrictions, codes of conduct and subsidies conducive to health and taxes.

A statement was made by the representative of Consumers International.

The acting Director, Division of Health Programmes, replying to comments, said that she was encouraged to hear that WHO technical support was helping countries to achieve results. The comprehensive action plan on NCDs that had been adopted at the recent World Health Assembly would raise the priority of those diseases and therefore attract more funding. Integrated surveillance of risk factors would present a challenge, and she recommended that ministries of health hold wide consultations with other sectors to ensure that all relevant behavioural factors were included.

The Regional Director agreed that behavioural factors were difficult to address. It was essential to avoid the perception that all pleasurable activities were to be banned, and strategies for behaviour change should be addressed by better stewardship of health systems.

Elections and nominations

(EUR/RC58/7, EUR/RC58/7 Add.1, EUR/RC58/Conf.Doc./8 and EUR/RC58/Inf.Doc./2)

Private Meeting

The Committee met in private to consider the nomination of members of the Executive Board and to elect members of the SCRC, the Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction and the Regional Search Group for candidates for the post of Regional Director.

Executive Board

The Committee decided that Estonia, France, Germany and Serbia would put forward their candidatures to the Health Assembly in May 2009 for subsequent election to the Executive Board.

Standing Committee of the Regional Committee

The Committee selected Andorra, Lithuania, and Montenegro for membership of the SCRC for a three-year term of office from September 2008 to September 2011.

Policy and Coordination Committee of the Special Programme of Research, Development and Research Training in Human Reproduction

In accordance with the provisions of the Memorandum on the Administrative Structure of the Special Programme of Research, Development and Research Training in Human Reproduction, the Committee selected Ukraine for membership of the Policy and Coordination Committee for a three-year period from 1 January 2009.

Regional Search Group

The Committee selected Portugal, the Russian Federation and Turkey as members and Sweden, Armenia and Latvia (in that order) as alternate members of the Regional Search Group.

It consequently adopted resolution EUR/RC58/R3.

Public Meeting

The representative of Andorra said that the issues being discussed by the Regional Committee would result in strengthened health systems throughout the Region. He thanked all those delegations that had

supported his country's candidacy for membership of the SCRC, which represented the first time his country had been a member of a United Nations committee.

The representative of Armenia said that her country had for the second time been obliged to withdraw its candidate for membership on the Executive Board, despite the fact that he was a well-known scientist and policy-maker and a former member of the SCRC. The candidacy had been withdrawn only so that the Regional Committee could reach consensus and to respect existing subregional groupings. Those groupings, however, when combined with the limited number of seats on the Executive Board and the practice of semi-permanent membership, ran counter to the principle of equal opportunity for membership. New democratic principles were needed for election of members of the Executive Board and she asked for follow-up action to be taken.

The Executive President, speaking in her capacity as retiring Chairperson of the SCRC, replied that the Standing Committee was discussing the current methods for electing Board members in the light of the expanded membership from the European Region. She understood the difficulty referred to by the representative of Armenia and assured her that the SCRC was doing its best to find an equitable solution. She also reiterated that the next SCRC would have to revisit and follow-up those issues.

Director-General of the World Health Organization

(EUR/RC58/BD/1)

The Deputy Executive President recalled that the Executive Board at its 122nd session had decided to refer the matter of which principles should be followed in selecting the Director-General of WHO to the six regional committees. The document before the Committee, prepared by the WHO Secretariat, contained a number of options for procedures to be followed. The views of the Committee on those options would be reported back to the Board at its next session.

One representative spoke on behalf of the European Union; candidate countries Turkey, Croatia and the former Yugoslav Republic of Macedonia; potential candidate countries Albania, Montenegro and Serbia; Norway, which was a member of the European Free Trade Association and the European Economic Area; and Armenia, Georgia, the Republic of Moldova and Ukraine (which aligned themselves with the statement). She said that personal and professional qualifications should be the primary consideration in choosing candidates for the post of Director-General of WHO and therefore expressed her preference for the first option listed in the document, namely maintaining the status quo. Furthermore, she stressed the need for a detailed analysis of the possible political and legal implications of introducing the principle of geographical rotation, to give the Executive Board a clear understanding of the implications of such a decision (which would constitute a precedent) in the wider United Nations context.

Another representative acknowledged that reverse discrimination in the selection of candidates for the position of Director-General was not appropriate but nonetheless expressed a preference for option 2, giving special consideration to candidates from certain regions.

Date and place of regular sessions of the Regional Committee in 2009–2012

(EUR/RC58/Conf.Doc./7)

The Committee adopted resolution EUR/RC58/R6, by which it decided that its fifty-ninth session would be held at the Regional Office in Copenhagen, Denmark, from 14 to 17 September 2009; its sixtieth session would be held in Moscow, Russian Federation from 13 to 16 September 2010; its sixty-first session would be held in Copenhagen from 12 to 15 September 2011; and its sixty-second session would be held from 10 to 13 September 2012 (exact location to be decided).

The representative of Malta said that his country offered to host the sixty-second session, while the representative of Lithuania extended his country's offer to host the sixty-second or sixty-fourth session. Both offers were gratefully received.

Resolutions

EUR/RC58/R1

Report of the Regional Director on the work of WHO in the European Region 2006–2007

The Regional Committee,

Having reviewed the Regional Director's report on the work of WHO in the European Region in 2006–2007 (document EUR/RC58/4) and the related information document on implementation of the 2006–2007 programme budget (document EUR/RC58/Inf.Doc./1 (PBPA/2006-2007));

1. THANKS the Regional Director for the report;

2. EXPRESSES its appreciation of the work done by the Regional Office in the biennium 2006–2007;

3. REQUESTS the Regional Director to take into account and reflect the suggestions made during the discussion at the fifty-eighth session when developing the Organization's programmes and carrying out the work of the Regional Office.

EUR/RC58/R2

Proposed Programme Budget for 2010–2011

The Regional Committee,

Having reviewed the proposed programme budget for the biennium 2010–2011 (document EUR/RC58/8) and the regional perspective thereon (EUR/RC58/8 Add.1), and having taken note of the comments made in this respect by the Standing Committee of the Regional Committee and the Regional Committee;

Welcoming the continuing efforts made throughout the Organization to present a more focused budget now aligned to a longer-term strategic vision covering three biennia, as articulated in the medium-term strategic plan through its objectives;

Noting that the budget proposals are in accordance with resolution EUR/RC47/R9, which requested the Regional Director to prepare the regional perspective of the programme budget in accordance with the principles used for presentation of the global programme budget, while at the same time reflecting the regional priorities and specificities;

Noting further that the present budget proposal is to be regarded as a draft, in view of the fact that Article 34 of the Constitution of WHO stipulates that the Director-General shall submit the budget proposal of the Organization to the Executive Board prior to final approval by the World Health Assembly;

1. REQUESTS the Regional Director to convey to the Director-General the views, comments and suggestions expressed by the Regional Committee on the proposed programme budget document, for these to be taken into consideration during its finalization;

2. NOTES the global proposed programme budget 2010–2011 contained in document EUR/RC58/8, which is to be financed by assessed contributions and voluntary contributions, to the extent that the latter become available;

3. ENDORSES the strategic directions contained in the document "Proposed programme budget 2010–2011: The European Region's perspective" (EUR/RC58/8 Add.1).

EUR/RC58/R3

Appointment of a Regional Search Group

The Regional Committee,

Pursuant to Rule 47 of its Rules of Procedure:

1. APPOINTS a Regional Search Group composed of the following members and alternates:

Members:

Portugal

Russian Federation

Turkey

Alternates:

Sweden

Armenia

Latvia

2. REQUESTS the Regional Search Group to carry out its work according to the Rules of Procedure of the Regional Committee and other criteria laid down in document EUR/RC58/Inf.Doc./2, and to report on its work to the Regional Committee at its fifty-ninth session.

EUR/RC58/R4

Stewardship/governance of health systems in the WHO European Region

The Regional Committee,

Recalling resolution EUR/RC55/R8 on Strengthening European health systems as a continuation of the WHO Regional Office for Europe's Country Strategy "Matching services to new needs" that called on Member States to elaborate their policy objectives guided by the WHO values and principles endorsed by the Member States, supported by transparent processes of monitoring and evaluation;

Recalling its resolutions EUR/RC57/R2 on the Millennium Development Goals in the WHO European Region: Health systems and health of mothers and children – lessons learned and EUR/RC57/R1 on health workforce policies in the European Region;

Recalling World Health Assembly resolutions WHA56.25 on the role of contractual arrangements in improving health systems' performance, WHA58.17 on international migration of health personnel: a challenge for health systems in developing countries and WHA 61.18 on monitoring of the achievement of the health-related Millennium Development Goals;

Acknowledging the challenges faced by governments in steering health systems towards better performance and the importance of the health system stewardship function exercised by health ministries within governments;

Mindful of the discussions and comments at the fifty-eighth session of the Regional Committee on lessons learned and practical ways to improve the stewardship function of health ministries and governments;

Having reviewed document EUR/RC58/9 on the stewardship/governance of health systems in the WHO European Region;

Having considered the Tallinn Charter adopted at the WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth";

1. COMMENDS the WHO Regional Office for Europe on organizing the WHO European Ministerial Conference on Health Systems in Tallinn from 25 to 27 June 2008, in collaboration with partners and stakeholders;

2. THANKS the government of Estonia for hosting the Ministerial Conference and providing excellent arrangements for it;

3. ENDORSES the Tallinn Charter: Health Systems for Health and Wealth adopted at the Ministerial Conference as political guidance and strategic direction for Region-wide action in this area;

4. ACKNOWLEDGES the positive trends that have been initiated by the efforts made to strengthen health systems in the WHO European Region since 2005;

5. URGES Member States to:

(a) continue collaborating in the context of the WHO Regional Office for Europe's Country Strategy;

(b) strengthen the health system stewardship roles of health ministries and governments along the lines set forth in document EUR/RC58/9 on the stewardship/governance of health systems in the WHO European Region and in the Tallinn Charter;

(c) ensure the systematic production and use of health system performance and other relevant (epidemiological, economic, etc.) information and evidence in decision-making, including that available from the WHO European Ministerial Conference on Health Systems held in Tallinn, in order to better meet the needs of the people and attain health system goals;

(d) ensure that robust health system strategies, consistent with WHO and national values and linked to clear performance expectations, are in place;

(e) make health care systems more responsive to people's needs, preferences and expectations, while recognizing their rights and responsibilities with regard to their own health and engage stakeholders in policy development and implementation;

(f) use the diversity of policy instruments (such as framework laws and incentives) at their disposal to support the attainment of health system goals, as necessary;

(g) ensure that the international recruitment of health workers is guided by ethical considerations and cross-country solidarity, and by a code of practice;

(h) promote intersectoral collaboration in order to address the broader social determinants of health and to ensure a holistic approach to services, including health promotion and disease prevention;

(i) ensure universal access to health promotion, disease prevention and health services as a fundamental means to achieve equity in health;

(j) generate further evidence on the effectiveness of health system stewardship through a more systematic evaluation of the way they carry out their stewardship function;

(k) ensure aid coordination in accordance with the principles set out in the Paris Declaration on Aid Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability, whenever applicable;

6. REQUESTS the Regional Director to:

(a) take steps to support ministries of health in developing their competences to carry out their health system stewardship function, including their skills in leading intersectoral efforts across government to address the broader determinants of health;

(b) facilitate the further development of relevant evaluation tools, performance indicators and minimum standards to assess the effectiveness of the health system stewardship function in a context of accountability, pluralism and transparency;

(c) facilitate the collaboration of Member States on successful health systems stewardship practices and promote the sharing among Member States of case studies from the WHO European Region and beyond;

(d) reinforce collaboration on health systems strengthening with other international organizations concerned by and active in the health field, such as the World Bank, the United Nations Children's Fund, the International Organization for Migration, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the Council of Europe, the Organisation for Economic Co-operation and Development, the European Commission and related institutions, the European Investment Bank and others;

(e) report to the Regional Committee in 2011 and again, with a final report, in 2015 on the support provided by the WHO Regional Office for Europe and the progress accomplished by Member States in the framework of the follow-up to the WHO European Ministerial Conference on Health Systems held in Tallinn.

EUR/RC58/R5

Review of process of reporting back to the Regional Committee on resolutions adopted at previous sessions

The Regional Committee,

Having reviewed document EUR/RC58/11 on the process of reporting back to the Regional Committee on resolutions adopted at previous sessions;

Noting that a number of resolutions have an open-ended requirement for reporting back to the Regional Committee;

Acknowledging that, with the increasing number of resolutions where reporting is required, there are repercussions for the agenda and programme of future sessions of the Regional Committee, and desiring to make optimal use of time during sessions of the Regional Committee;

1. ENDORSES the recommendations made in document EUR/RC58/11;

2. REQUESTS the Regional Director:

(a) to ensure that requirements for reporting on the implementation of resolutions should be clearly defined and, for resolutions that specify more than one report back, the intervals in reporting should be not less than three years and not more than five years;

(b) to propose, for each resolution, a specified end date for reporting back to the Regional Committee;

(c) to discontinue the practice of open-ended reporting.

EUR/RC58/R6

Date and place of regular sessions of the Regional Committee in 2009–2012

The Regional Committee,

Recalling its resolution EUR/RC57/R3 adopted at its fifty-seventh session;

1. RECONFIRMS that the fifty-ninth session shall be held in Copenhagen from 14 to 17 September 2009;

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

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

4. FURTHER DECIDES that the sixty-second session shall be held from 10 to 13 September 2012, exact location to be decided.

EUR/RC58/R7

Report of the Fifteenth Standing Committee of the Regional Committee

The Regional Committee,

Having reviewed the report of the Fifteenth Standing Committee of the Regional Committee (documents EUR/RC58/5 and EUR/RC58/5 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-eighth 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-eighth session, as recorded in the report of the session.

EUR/RC58/R8

Behaviour change strategies and health: the role of health systems

The Regional Committee,

Recalling resolution EUR/RC55/R8 on Strengthening European health systems as a continuation of the WHO Regional Office for Europe's Country Strategy "Matching services to new needs", which called on Member States to elaborate their policy objectives guided by the WHO values and principles endorsed by the Member States, supported by transparent processes of monitoring and evaluation;

Recalling resolution EUR/RC56/R2 on Prevention and control of noncommunicable diseases in the WHO European Region;

Acknowledging Member States' existing commitments and ongoing work under the European Strategy for Tobacco Control (EUR/RC52/R12), the Framework for Alcohol Policy in the WHO European Region (EUR/RC55/R1), the Second European Action Plan for Food and Nutrition Policy (EUR/RC57/R4), the Children's Environment and Health Action Plan for Europe (EUR/RC54/R3), and the European Strategy for Child and Adolescent Health and Development (EUR/RC55/R6);

Recalling World Health Assembly resolution WHA53.17 on the Global strategy for the prevention and control of noncommunicable diseases, together with resolutions WHA56.1 on the WHO Framework Convention on Tobacco Control and WHA58.26 on Public health problems caused by harmful use of alcohol, as well as Executive Board resolution EB117.R9 on Health promotion in a globalized world and WHA61.4 on Strategies to reduce the harmful use of alcohol;

Acknowledging that epidemiological studies point to the fact that behaviour-related risk factors have become the leading causes of morbidity and mortality in the WHO European Region and acknowledging the evidence that individual health behaviours cannot be seen in isolation, as they mostly are inextricably connected to the social determinants of health;

Mindful of the discussions and comments at the fifty-eighth session of the Regional Committee on the lessons learned and practical ways of strengthening health systems and the roles of health ministries and governments;

Having considered the documentation prepared for the WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth";

Having reviewed document EUR/RC58/10 on Behaviour change strategies: the role of health systems in the WHO European Region:

1. COMMENDS the WHO Regional Office for Europe for raising awareness in recent years of a number of intersectoral health issues such as the Framework Convention on Tobacco Control, the International Health Regulations, environment and health, and counteracting obesity, and of public health in general;

2. ACKNOWLEDGES the efforts made by the WHO Regional Office for Europe in recent years to provide policy guidance and strategic direction in those areas, while linking them to health systems development in Member States in the WHO European Region;

3. URGES Member States to continue collaborating in the context of the WHO Regional Office for Europe's Country Strategy by:

(a) identifying those areas of high public health relevance (such as smoking cessation, increased physical activity, balanced diet and minimization of the harmful use of alcohol)

that would be amenable to (even limited) initiatives along the lines set forth in document EUR/RC58/10;

(b) using the necessary policy instruments and strategies such as regulation, education, motivational techniques, individual or group counselling and community capacity-building, as necessary, to work in synergistic ways in support of attainment of the health system goals set;

(c) ensuring the creation of one or more specific teams with clear mandates to explore both population health and personal health care policies and strategies on behaviour change linked to the health system, and to define the respective roles and responsibilities of ministries of health and all relevant stakeholders in governance, financing and service delivery, including other sectors, as appropriate, in the interests of intersectoral collaboration;

(d) facilitating access at national level to existing information related to behaviour change in the WHO European Region, in order to promote comparability and to facilitate the replicability of successful interventions in other settings;

(e) ensuring that such experiences are properly evaluated in terms of value for money, accountability and transparency, in order to generate evidence on the cost and effectiveness of behaviour change while working towards a more systematic linkage with health systems and the stewardship function;

4. REQUESTS the Regional Director to:

(a) facilitate the exchange and sharing of experiences among Member States with regard to case studies and demonstration projects in the field of behaviour change in the WHO European Region and beyond, in order to document the critical health system-related factors that are at play, and to enable lessons to be learned and achievements to be replicated;

(b) take steps when so requested to support ministries of health in developing their competences to address behaviour change, including integrated multisectoral policies and strategies within their health systems;

(c) position the WHO European Region for the upcoming debates at the Sixty-second World Health Assembly on the report of the Commission on Social Determinants of Health and the action plan for the global strategy for the prevention and control of noncommunicable diseases (World Health Assembly resolution WHA61.14 on Prevention and control of noncommunicable diseases: implementation of the global strategy) and for the upcoming debate at the Sixty-third World Health Assembly on the Global strategy to reduce the harmful use of alcohol (World Health Assembly resolution WHA61.4 on Strategies to reduce the harmful use of alcohol);

(d) support robust and methodologically sound evaluation of the progress made at national and European level in this area (individual and population health, disease burden, health care costs and the critical factors for success in linking theory and practice);

(e) explore, with those Member States that have specific interests in the area, the main implications for health systems and the wider government response;

(f) report to the Regional Committee in 2015 on the support provided to Member States by the WHO Regional Office for Europe and the progress made by Member States in the framework of follow-up to the WHO European Ministerial Conference on Health Systems, held in Tallinn in 2008.

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

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(b) Stewardship/governance of health systems in the European Region: meeting the commitments made at the WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth"

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(b) Election of three members of the Standing Committee of the Regional Committee

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Annex 3

List of representatives and other participants

I. Member States

Albania

Representative

Dr Arben Ivanaj
Deputy Minister of Health

Andorra

Representatives

Ms Eva Descarrega Garcia
Director, Bilateral and Consular Affairs and European Union, Ministry of Foreign Affairs

Mr Josep M. Casals Alís
Head, Food and Nutrition Service, Ministry of Health, Social Welfare, Family and Housing

Armenia

Representatives

Professor Harutyun Kushkyan
Minister of Health

His Excellency Mr Hrach Sylvanyan
Ambassador of Armenia to Georgia

Alternates

Dr Narine Beglaryan
Director, Department of International Relations, Ministry of Health

Dr Gayane Sahakyan
Chief Specialist, Department of Epidemiology of Communicable and Noncommunicable Diseases, State Hygiene Anti-epidemic Inspectorate, Ministry of Health

Austria

Representatives

Dr Andrea Kdolsky
Federal Minister of Health, Family and Youth

Professor Hubert Hrabcik
Director-General, Public Health, Federal Ministry of Health, Family and Youth

Alternate

Dr Helmut Friza
Health attaché, Permanent Mission of Austria to the United Nations Office in Geneva

Advisers

Dr Reinhild Strauss
Head, Department of Infectious Diseases, Epidemic Control and Disaster Management, Federal Ministry of Health, Family and Youth

Ms Daniela Klinser
Press Officer to the Federal Ministry of Health, Family and Youth

Azerbaijan

Representatives

Dr Abbas Valibayov
First Deputy Minister of Health

Dr Jeyhun Mammadov
Director, Public Health and Reforms Center, Ministry of Health

Belarus

Representative

Dr Vasiliy I. Zharko
Minister of Health

Belgium

Representative

Ms Leen Meulenbergs
Head, International Relations Department, Federal Public Service for Public Health, Food Chain Safety and Environment

Bosnia and Herzegovina

Representatives

Dr Drazenka Malicbegovic
Assistant Minister, Health Care Sector, Ministry of Civil Affairs

Dr Amela Lolić
Assistant Minister of Health and Social Welfare of Republika Srpska

Alternate

Dr Goran Cerkez
Assistant Minister, Department for International Cooperation, Federal Ministry of Health

Bulgaria

Representatives

Professor Lyubomir Ivanov
Director, National Centre for Public Health Protection, Ministry of Health

Dr Dora Mircheva
Chief Expert, National Centre for Public Health Protection, Ministry of Health

Alternate

Ms Desislava Parusheva
Second Secretary, Directorate of Human Rights and International Humanitarian Organizations, Ministry of Foreign Affairs

Croatia

Representatives

Dr Ante-Zvonimir Golem
State Secretary, Ministry of Health and Social Welfare

Ms Sibila Žabica
Adviser for European Integration, Cabinet of the Minister, Ministry of Health and Social Welfare

Cyprus

Representatives

Dr Christos Patsalides
Minister of Health

Dr Andreas Polynikis
Chief Medical Officer, Ministry of Health

Alternate

Dr Christodoulos Kaisis
Chief Medical Officer, Medical and Public Health Services, Ministry of Health

Czech Republic

Representative

Mr Ivo Hartmann
Director-General, Economic and International Affairs, Ministry of Health

Alternates

Dr Jaroslav Volf
Permanent mission of the Czech Republic to the United Nations Office in Geneva

Ms Lucie Wondřichová
Department for International Affairs, Ministry of Health

Denmark

Representatives

Mr Jesper Fisker
Director-General, National Board of Health

Mr Mogens Jørgensen
Head of Division, Ministry of Health and Prevention

Alternate

Ms Marianne Kristensen
Senior Adviser, National Board of Health

Adviser

Ms Helle Engslund Krarup
Head of Section, Ministry of Health and Prevention

Estonia

Representatives

Ms Maris Jesse
Director, National Institute for Health Development

Dr Ülla-Karin Nurm
Head, Public Health Department, Ministry of Social Affairs

Alternate

Ms Heli Laarmann
Head, Chemical Safety, Public Health Department, Ministry of Social Affairs

Finland

Representatives

Professor Pekka Puska
Director-General, National Public Health Institute

Dr Tapani Melkas
Director, Ministry of Social Affairs and Health

Alternates

Dr Taru Koivisto
Ministerial Adviser, Ministry of Social Affairs and Health

Dr Marjukka Vallimies-Patomäki
Ministerial Adviser, Ministry of Social Affairs and Health

Advisers

Ms Salla Sammalkivi
Second Secretary, Ministry of Foreign Affairs

Ms Maire Kolimaa
Senior Officer, Ministry of Social Affairs and Health

Ms Maria Waltari
Senior Officer, Ministry of Social Affairs and Health

Ms Jutta Immanen-Pöyry
Director, National Research and Development Centre for Welfare and Health

France

Representatives

His Excellency Mr Eric Fournier
Ambassador of France to Georgia

Professor Didier Houssin
Director-General of Health, Ministry of Health, Youth, Sport and Associations

Alternate

Mr Michel Baran
Principal Counsellor, Embassy of France in Georgia

Advisers

Ms Brigitte Arthur
Head, International Office for Health and Social Welfare, Delegation for European and International Affairs, Ministry of Health, Youth, Sport and Associations

Ms Isabelle Virem
Head, Mission for European and International Affairs, Directorate-General for Health, Ministry of Health, Youth, Sport and Associations

Ms Géraldine Bonnin
Head of mission, Delegation for European and International Affairs, Ministry of Health, Youth, Sport and Associations

Ms Natacha Tolstoi
Editor, Ministry of Foreign and European Affairs

Ms Anne-Cécile Bard
Intern, Permanent Mission of France to the United Nations Office in Geneva

Georgia

Representatives

Mr Alexander Kvitashvili
Minister of Labour, Health and Social Affairs

Professor Nikoloz Pruidze
Deputy Minister of Labour, Health and Social Affairs

Alternates

Dr Irakli Giorgobiani
First Deputy Minister of Labour, Health and Social Affairs

Ms Manana Jebashvili
Deputy Minister of Labour, Health and Social Affairs

Dr Otar Toidze
Chairman, Parliamentary Committee on Health Care and Social Issues

Advisers

Mr Giorgi Menabde
Rector, Tbilisi State Medical University

Professor Alexander Tsiskaridze
Dean of the Medical Faculty, Tbilisi State University

Ms Nino Esakia
Executive Director, Centre for Implementation of Health and Social Care Projects

Professor Paata Imnadze
Director-General, National Centre for Disease Control and Public Health

Dr Sophio Lebanidze
Head, Healthcare Department, Ministry of Labour, Health and Social Affairs

Ms Nino Mirzikashvili
Head, International Relations Department, Ministry of Labour, Health and Social Affairs

Secretaries

Dr Devi Tabidze
Head, Office of the Minister of Labour, Health and Social Affairs

Mr David Chkhatarashvili
Head, Administrative Department, Ministry of Labour, Health and Social Affairs

Dr Zaza Bokhua
Adviser, Ministry of Labour, Health and Social Affairs

Ms Irma Mjavanadze
Head, Policy Division, Healthcare Department, Ministry of Labour, Health and Social Affairs

Germany

Representatives

Dr Ewold Seeba
Director-General, Personnel, Budget, Organization and European and International Health Policy, Federal Ministry of Health

Mr Udo Scholten
Deputy Directory-General, European and International Health Policy, Federal Ministry of Health

Alternates

Mrs Dagmar Reitenbach
Head, Division of Multilateral Cooperation in the Field of Health, Federal Ministry of Health

Mr Gunnar Berkemeier
Attaché, Permanent Mission of Germany to the United Nations Office in Geneva

Adviser

Mrs Chariklia Tzimas
Adviser, Division of Multilateral Cooperation in the Field of Health, Federal Ministry of Health

Greece

Representative

Professor Jenny Kremastinou
National School of Public Health

Adviser

Dr Dimitrios Efthimiadis
Cardiologist, National Center for Emergency Health Care

Secretary

Ms Maria Liodaki
International Relations Directorate, Ministry of Health and Social Solidarity

Hungary

Representatives

Dr Mihály Kökény
Chairman, Parliamentary Health Committee

Dr Ferenc Falus
Chief Medical Officer

Alternate

Dr Árpád Mészáros
Deputy Head of Department, Ministry of Health

Iceland

Representatives

Mr David Á. Gunnarsson
Special Envoy for Global Health, Ministry for Foreign Affairs

Mrs Sigridur Berglind Ásgeirsdóttir
Permanent Secretary, Ministry of Health

Israel

Representatives

Mr Y. Ben-Yizri
Minister of Health

Professor Avi Israeli
Director-General, Ministry of Health

Alternates

Dr Alex Leventhal
Director, Department of International Relations, Ministry of Health

Mr Yair Amikam
Deputy Director-General, Information and International Relations, Ministry of Health

Advisers

Mrs Galit Levy
Adviser to the Minister of Health

Mr Tal Harel
Communication Adviser, Ministry of Health

Italy

Representative

Dr Francesco Cicogna
Senior Medical Officer, Directorate-General for EU and International Relations, Ministry of Labour, Health and Social Policies

Kazakhstan

Representatives

Mr Igor Musalimov
Chargé d'affaires, Embassy of Kazakhstan in Georgia

Mr Marat Askarov
Second Secretary, Embassy of Kazakhstan in Georgia

Kyrgyzstan

Representative

Dr Marat Mambetov
Minister of Health

Latvia

Representatives

Mr Rinalds Muciņš
Under-Secretary of State for Policy Planning, Ministry of Health

Ms Līga Šerna
Deputy Director, Department of European Affairs and International Relations, Ministry of Health

Alternate

Dr Viktors Jaksons
Adviser to the State Secretary for International Cooperation, Ministry of Health

Lithuania

Representative

Mr Gediminas Černiauskas
Minister of Health

Alternate

Mr Viktoras Meižis
Head, Division of Foreign Affairs, Ministry of Health

Advisers

Professor Zita Ausrele Kučinskienė
Dean, Medical Faculty, Vilnius University

Ms Rita Pazdrazdyte
Head, Public Health Strategy Division, Ministry of Health

Malta

Representative

Mr Joseph M. Stafrace
Assistant Director, Office of the Director-General, Public Health Regulation Division, Ministry of Social Policy

Monaco

Representatives

Dr Anne Nègre
Director, Health and Social Work

Mr Gilles Realini
Third Secretary, Permanent Mission of Monaco to the United Nations Office in Geneva

Montenegro

Representative

Professor Miodrag Radunović
Minister of Health, Labour and Social Welfare

Advisers

Ms Mina Brajović
Adviser, Ministry of Health, Labour and Social Welfare

Ms Nina Milović
Adviser, Ministry of Health, Labour and Social Welfare

Netherlands

Representatives

Mr Marc J.W. Sprenger
Director-General, National Institute for Public Health and the Environment

Ms Annemiek van Bolhuis
Director, Nutrition, Health Protection and Prevention, Ministry of Health

Alternates

Ms Frieda M. Nicolai
Senior Policy Adviser, Ministry of Health

Ms Regine Aalders
Co-ordinator, Global Health, Ministry of Health

Adviser

Ms Radha Gobind
Policy Adviser, United Nations Department, Ministry of Foreign Affairs

Norway

Representatives

Dr Bjørn-Inge Larsen
Director-General, Directorate for Health and Social Affairs

Mr Ole T. Andersen
Deputy Director-General, Division for International Cooperation and Preparedness, Ministry of Health and Care Services

Alternates

Mr Bernt Bull
Senior Adviser, Ministry of Health and Care Services

Ms Tone Wroldsen
Adviser, Ministry of Health and Care Services

Advisers

Mr Arne-Petter Sanne
Director, Multilateral Affairs, Secretariat for International Cooperation, Directorate for Health and Social Affairs

Dr Thor Erik Lindgren
Counsellor, Permanent Mission of Norway to the United Nations Office in Geneva

Poland

Representatives

Dr Adam Fronczak
Under-Secretary of State, Ministry of Health

Mr Wojciech Kutyła
Director-General, Ministry of Health

Alternates

Ms Sylwia Lis
Director, Department of Health Insurance, Ministry of Health

Mr Piotr Warczynski
Director, Department of Health Care System Organization, Ministry of Health

Ms Ineza Dagmara Królik
Director, Department of International Cooperation, Ministry of Health

Portugal

Representatives

Professor Maria do Céu Machado
High Commissioner of Health

Dr Francisco Henrique Moura George
Director-General of Health

Alternates

Ms Filipa Pedrosa
Adviser to the High Commissioner of Health

Dr Paulo Jorge de Morais Zamith Nicola
Adviser to the High Commissioner of Health

Republic of Moldova

Representatives

Dr Mircea Buga
Deputy Minister of Health

Dr Eugenia Berzan
Head, International Relations and External Assistance Division, Ministry of Health

Alternate

Mr Oleg Lozan
Director, Management School of Public Health, State Medical and Pharmaceutical University

Romania

Representatives

Dr Laurentiu T. Mihai
Director-General, Ministry of Public Health

Dr Cristina Vladu
Deputy Director-General, Ministry of Public Health

San Marino

Representative

Mr Marino Guidi
Minister Plenipotentiary, Permanent Mission of San Marino to the United Nations Office in Geneva

Serbia

Representatives

Professor Tomica Milosavljević
Minister of Health

Dr Elizabet Paunović
Assistant Minister for International Cooperation, Ministry of Health

Alternate

Professor Snežana Simić
Special Adviser to the Minister of Health

Adviser

Ms Ana Vuksanović
Chief of Cabinet to the Minister of Health

Slovakia

Representative

Mr Daniel Klačko
Deputy Minister of Health

Alternate

Mr Ivan Rovný
Director, Public Health Authority

Advisers

Professor Danka Farkašová
Vice-Rector, Slovak Medical University

Dr Jaroslava Hurná
Director, Department of Foreign Relations, Ministry of Health

Slovenia

Representatives

Dr Vesna-Kerstin Petrič
Head, Sector for Health Promotion and Healthy Lifestyles, Ministry of Health

Ms Nina Krtelj
Adviser, Ministry of Health

Spain

Representative

Dr José Martínez Olmos
Secretary-General for Health, Ministry of Health and Consumer Affairs

Alternates

Dr Alberto Infante Campos
Director-General, Professional Regulations, Cohesion of the National Health System and High Inspection, Ministry of Health and Consumer Affairs

Ms María Teresa de Martín Martínez
Programmes Coordinator, Cabinet of the Secretary-General for Health, Ministry of Health and Consumer Affairs

Adviser

Ms Carmen Castañón Jiménez
Deputy Director-General, International Relations, Ministry of Health and Consumer Affairs

Sweden

Representatives

Mr Lars-Erik Holm
Director-General, National Board of Health and Welfare

Mr Fredrik Lennartsson
Deputy Director-General, Ministry of Health and Social Affairs

Alternates

Ms Anna Halén
Deputy Director, Ministry of Health and Social Affairs

Ms Maria Möllergren
Legal Adviser, National Board of Health and Welfare

Mr Bosse Pettersson
Senior Adviser, National Institute for Public Health

Switzerland

Representatives

Dr Gaudenz Silberschmidt
Deputy Director and Head, International Affairs Division, Federal Office of Public Health

Mr Jean-Daniel Biéler
Deputy Head, International Affairs Division, Federal Office of Public Health

Alternate

Dr Ewa Mariéthoz
Project Manager, Swiss Conference of Cantonal Directors of Public Health

Adviser

Mr Nicolas Plattner
Third Secretary, Permanent Mission of Switzerland to the United Nations Office in Geneva

The former Yugoslav Republic of Macedonia

Representative

Dr Vladimir Lazarevik
Deputy Under-Secretary, Ministry of Health

Turkey

Representative

Professor Sabahattin Aydın
Deputy Under-Secretary, Ministry of Health

Alternates

Mr Kamuran Özden
Head, Department of Foreign Affairs, Ministry of Health

Dr Bekir Keskinkilıç
Deputy Director-General, Ministry of Health

Ms Sevim Tezel Aydın
Deputy Head, Department of Foreign Affairs, Ministry of Health

Ms Elif Çalışkan
Second Secretary, Embassy of Turkey in Georgia

Advisers

Dr Ahmet Refik İmamecioğlu
Ministry of Health

Dr Kemal Özgür Demiralp
Ministry of Health

Ukraine

Representatives

Ms Zhanna Tsenilova
Head, Department of European Integration and International Relations, Ministry of Health

Professor Vitaliy F. Moskalenko
Rector, National Medical University

Alternate

Professor Olesya Hulchiy
Vice-Rector for International Relations, National Medical University

United Kingdom of Great Britain and Northern Ireland

Representative

Sir Liam Donaldson
Chief Medical Officer, Department of Health

Alternates

Dr David R. Harper
Director-General, Health Improvement and Protection, Department of Health

Ms Sarah Hendry
Director of International Health, Department of Health

Adviser

Ms Adetola Akinfolajimi
Deputy International Business Manager, Department of Health

II. Observers from Member States of the Economic Commission for Europe

Canada

Dr Garry Aslanyan
Principal Adviser, International Public Health Division, Public Health Agency of Canada

III. Observers from Non-Member States

Holy See

Mgr Jean-Marie Mpendawatu
Pontifical Council for Pastoral Assistance to Health Services

IV. Representatives of the United Nations and related organizations

Food and Agricultural Organization of the United Nations (FAO)

Mr Mamuka Meskhi
Assistant Representative in Georgia

Office of the United Nations High Commissioner for Refugees (UNHCR)

Ms Edina Dziho
Associate Protection Officer, Georgia

Ms Tamar Magradze
Protection Clerk, Georgia

United Nations Children's Fund (UNICEF)

Mr Reza Hossaini
Representative in Turkey

United Nations Population Fund (UNFPA)

Dr Tamar Khomasuridze
National Programme Officer

Dr Peer Sieven
Country Director for Georgia, Armenia, Azerbaijan and Turkey

World Bank

Mr Abdo S Yazbeck
Sector Manager, Health, Nutrition and Population, Europe and Central Asia

V. Representatives of other intergovernmental organizations

Council of Europe

Dr Piotr Mierzewski

European Centre for Disease Prevention and Control

Ms Zsuzsanna Jakab

European Commission

Ms Isabel de la Mata
Mr Canice Nolan
Dr Matti Rajala

International Committee of the Red Cross

Dr Nikoloz Sadradze
Head, Tuberculosis Department

VI. Representatives of nongovernmental organizations in official relations with WHO

Alzheimer's Disease International

Mr Marc Wortmann

Consumers International

Ms Madonna Koidze
Dr Shalva Melkadze
Ms Keti Melkadze
Dr Rezo Kobakhidze

International Association of Medical Regulatory Agencies

Dr David Watt

International Council of Nurses

Ms Eteri Kakabadze
Dr Rusudan Khatchapuridze
Ms Tamar Jincharadze
Mr Tengizi Chkhikvadze

International Federation of Medical Students Associations

Ms Yelena Petrosyan

International Pharmaceutical Federation

Dr Inger Lise Eriksen

International Planned Parenthood Federation - European Network

Ms Irene Donadio

Medical Women's International Association

Ms Nino Zhvania

World Federation of Hemophilia

Ms Catherine Hudon

World Medical Association

Dr Levan Labauri

VII. Observers

European Federation of Nurses Associations

Mr Paul De Raeve

European Forum of Medical Associations

Dr Ramin Walter Parsa-Parsi

EuroPharm Forum

Dr Inger Lise Eriksen

Georgian Country Coordinating Mechanism

Ms Nata Avaliani
Mr Akaki Lochoshvili
Ms Qetevan Nemsadze
Mr Archil Salakaia
Ms Tamar Sirbiladze
Mr Tengiz Tsertsvadze

Global Fund to fight AIDS, Tuberculosis and Malaria

Dr Philippe Creach
Mrs Ela Iashvili
Dr Andreas Tamberg
Dr Urban Weber

Regions for Health Network

Dr Pina Frazzica

Annex 4

Report of the WHO Regional Director for Europe

From Belgrade to Tbilisi

Mr President, Prime Minister, Ministers, representatives of the Member States and other organizations taking part in the Fifty-eighth session of the WHO Regional Committee for Europe, and most especially Ms Sandra Roelofs, First Lady of Georgia,

Allow me, first of all, to express my sympathies for all those who have lost their lives, or been wounded or displaced recently in this part of our Region. I would also like to thank each of you, individually, for having made the effort to be here this morning. And, on your behalf, I would like to thank the Government of Georgia for having fulfilled its commitments and made it possible for us to be here today.

My report this morning covers the period since the Regional Committee session held in Belgrade last September. It will go over in part, but only in part, the written report that has been distributed, that covers the two years of 2006 and 2007.

The major events of the year

If I were to describe this year in just a few words, I would say that it has been a true illustration of the activities and the issues in the European Region of WHO since the turn of the century.

Quite clearly, and I think we all feel this, the Tallinn Conference on health systems was a major turning point in the evolution of public health. In fact, although it was the Conference that gave both visibility and credibility to the subject, the event alone could not have achieved that. It is actually the extensive preparatory work prior to the Conference and the follow-up to come that are the main driving forces. The days in Tallinn made it possible to finalize all that preparatory work, to breathe life and impetus into it, and to work out ways of putting it into practice.

The central idea of the Conference reaffirms the need to strengthen and to modernize the way that health systems are managed. We all believe in it, as we believe in the need to assess the performance of health systems in order to improve them. The tools to do that work are under development now. Their finalization and their generalized use are the current and future phases of this long process.

I would also like to emphasize the need to include the human dimension in the concept of performance, for it lies at the heart of the field of health. The idea of performance must be understood in its broadest sense, to include all activities that help to improve health, without, of course, forgetting those contributed by other sectors. This broad vision is that of the *Health for All policy*.

Personally, something that affected me particularly this year was the suffering I saw in one of our Member States in the Region, Tajikistan. Tajikistan's health system was severely disrupted by a particularly long and harsh winter. Of course, I tried to help the Government to mobilize the international community. I must say that I saw things there that I am not going to forget. Mothers trying in vain to ease the pain of children who had been burned by makeshift heaters. Another thing I will not forget is the psychiatric care centre that had no electricity and no heating, where the patients squeezed together into the few rooms left open, the others all closed off because of lack of funds. But I also remember the motivation of the staff there who were doing their very best in those exceptional conditions. The human warmth and the smiles made up a little for the harsh temperatures. I am also very pleased with the positive response that came from the international community, both in the country and abroad, to the appeal I made on behalf of WHO. The support given by Norway proved to be essential. I would like to take this opportunity to make that appeal once again. It is an appeal for solidarity but also an appeal for

realism because, as was emphasized in Tallinn, when health crises happen, the malfunctioning of a health system puts the health of the world at risk.

Taking another event from this year to illustrate the work of the Regional Office, I would like to mention one particular situation that highlights the complex nature of our field of work and the need for our actions to be based on solid evidence. The Region has embarked on the difficult fight to eliminate measles and rubella but, in the course of that, an unfortunate event occurred in Ukraine. The consequence has been a slowdown in our progress towards the objective of elimination by 2010 hoped for by our Member States; indeed, that objective is now severely compromised. Ukraine was the most important stronghold of these diseases in the Region, so we recommended a mass immunization campaign for the whole population between the ages of 15 and 29 years. We were convinced that only such a campaign could help to eliminate the two diseases.

Unfortunately, at the beginning of the campaign, a young man died 15 hours after being vaccinated. The press and the competitors of the laboratory that produced the vaccine, as well as one part of the scientific community, rushed to tell the public how certain they were that the death was a consequence of the vaccination. A wrong diagnosis, for the hundreds of millions of vaccinations carried out using that same product may indeed have caused a number of adverse events, including a very few fatalities, but none of those showed symptoms comparable to the case in question, or death after a similar length of time. Convinced by the evidence, the Regional Office called for the campaign to be resumed, giving a guarantee that all measures had been taken to ensure the greatest possible safety of the vaccine.

And today we hope that the campaign will be resumed. We will work with the Ministry of Health towards that end. However, a special effort is needed now more than ever to win back the confidence of the public and the media; we are doing all we can to help.

I would also like to mention this morning how we have stepped up our activities in the area of health worker migration. Discussion on the issue during our session in Belgrade encouraged our active involvement in the worldwide movement on this subject, which is of vital importance to the future of health systems.

A guide to good practice in the area is under development. The Regional Office and some of the Member States in the Region, particularly Norway, have become involved in the initiative and, at a meeting in Uganda last December, they showed that, far from being indifferent, the European countries are extremely concerned by the subject. I was very pleased to be able to counter the doubts of the other regions regarding both the intentions and the interests of our own Region. Immediately after this Regional Committee session, I shall be going to London to attend a meeting of the Global Policy Advisory Council on health worker migration, chaired by Mrs Mary Robinson.

I said at the beginning that this was a representative year in terms of what we have undertaken. It was also representative in terms of continuing the different types of activity begun in previous years.

Continuing commitments

Technical work

At lunchtime tomorrow, Professor Marmot will present his report on the social determinants of health. Our discussions will certainly contribute to the decision that will be taken by the World Health Assembly on the follow-up to be given to the report. In this regard, I would like, as I am sure Professor Marmot will also do, to highlight the important contribution of the European Region to the drafting of the report, notably through the work of the Venice centre on health determinants.

I would also like, at this point, to talk about a number of areas in which we have continued our technical work towards operational ends. Under our work on tuberculosis, a European ministerial forum was held in Berlin in October 2007. The main result of the forum was the strong wish expressed by the Member States in the European Region to fight to halt the rapid rise of the epidemic and to cope with the

increasing numbers of drug-resistant cases. In 2006, 433 000 people in the Region contracted tuberculosis, and 66 000 died of it.

Climate change was the theme of World Health Day this year. It mobilized a lot of energy in the Region. You will have the opportunity to discuss it during the information session at lunchtime on Wednesday.

Our work on nutrition has continued since the Istanbul conference on obesity. We will be taking measures together with the food industry to address the presence of sodium in foodstuffs. The objective is to reduce sodium intake and to improve consumer information. For our part, cooperation with the private sector involves trying, without being naive, to achieve a "win-win" situation, where the prime beneficiary must, of course, and will be the citizen.

More detailed information on these subjects can be found in the written report. I would like to draw your attention, in particular, to the sections on HIV/AIDS, tobacco and alcohol consumption and, more broadly, noncommunicable diseases.

Under the latter, I would stress mental health and the need to maintain and strengthen our activities. We will present the results of a study on mental health policies in Europe at a meeting in London next month. Under the heading of upcoming activities, I would particularly mention the conference on accident prevention and safety to be held in Paris on 9 and 10 October.

Work with the countries

It is, of course, at country level and in positive and practical terms that all the work of the Office finds its ultimate expression. I have chosen a few examples to illustrate this objective.

First of all, there was the assistance provided for the drafting of a reproductive health strategy, 2008–2015, for Azerbaijan, in collaboration, notably, with the United Nations agencies. Another example is the mission with the European Centre for Disease Prevention and Control (ECDC) to assess the risk of chikungunya in Italy.

A further example of activities with the countries was the follow-up to the study on the consequences of toxic oil syndrome in Spain. The study, conducted with the European Commission's Directorate-General for Research, is intended to place the subject in the wider context of evidence-based environment and health policies.

The drafting, together with the Ministry of Health, of the 2008–2010 plan for the elimination of malaria in Turkmenistan is another good example of cooperation, as is the follow-up to the assessment of the National Institute for Clinical Excellence's (NICE's) programme of clinical guidelines in England.

Partnerships with other organizations

The Tallinn Conference was an opportunity for us to strengthen and translate into practice our links and collaboration with many governmental and nongovernmental organizations.

The European Commission was very actively involved in the preparations for and running of the Conference. I should like to thank Ms Vassiliou for the support given by her team, and for her own contribution. In the other direction, the Regional Office contributed to the consultative process organized by the Directorate-General for Health and Consumers (DG SANCO) to draft the European Union's health strategy.

During our annual meeting with the Commission, we reviewed our areas of cooperation. The main areas are: health security, alcohol control, tobacco control, obesity, intellectual property, the International Health Regulations, occupational health and the social determinants of health.

The Regional Office has stepped up its active participation in the initiatives launched by the successive European Union presidencies this year, with the themes of health in all policies during the Finnish

presidency, cancer during the Slovenian presidency, and health security and Alzheimer's disease now during the French presidency.

We have also, of course, continued our work, notably in the field of avian influenza, with the European Centre for Disease Prevention and Control (ECDC). A review and planning meeting was held in Stockholm in February. The conclusions reached included: a positive assessment of our cooperation; a mutual wish to step up that cooperation; and the adoption of a work plan for 2008–2009.

Elsewhere, we continued our partnerships with the World Bank, the Council of Europe and the Organisation for Economic Co-operation and Development (OECD), and these too benefitted from the impetus created in Tallinn.

Collaboration within WHO

The favourable climate for joint work between the various parts of the Organization under Dr Chan's leadership continued over the past year. I think that the Director-General will confirm that in her speech tomorrow.

For our part, we can attest to the strong, positive and stimulating relationship that exists between us, to the benefit of our services to the Member States. We work hand in hand, and are making progress on subjects such as the architecture of health and partnerships. Of course, the budget and programme are discussed at each of our meetings. We have also talked at length about the modernization of WHO and the new Global Management System, delegation of authority, our human resources policy and the reform of the United Nations system.

On that subject, the pilot study in Albania has shown both the opportunities for and the challenges to improving the results of our work through better coordination within the United Nations system.

The regular meetings of the regional directors with the Director-General are fascinating and thorough. I firmly believe that they help to improve the performance of the Organization.

The internal life of the Office

Following the discussions in Belgrade on opening a noncommunicable diseases unit in Athens, talks have continued with the Government of Greece. A report was submitted to the Standing Committee at each of its sessions. The contract between Greece and the Regional Office was put to it before being signed. In the middle of last month, we visited the premises of the new unit. We are in the process of discussing how they should be set up.

I would like to remind you that, in accordance with the document adopted by the Regional Committee in 2004, the new centre will be a unit of the Regional Office. As with other units, it will come under the Regional Office's programme, hierarchy and internal functioning. The contract signed fully meets these conditions.

I would like to conclude my presentation this morning by saying that the staff have been working in somewhat exceptional and difficult circumstances to ensure that this session of the Regional Committee should be held in the best possible conditions. I had no doubt as to their capacity for adaptation and their desire to do things well. I would like to take this opportunity to pay tribute to each and every one of them. I am sure that you will join me in doing so.

And finally, I would like to thank the Standing Committee for all the intensive work it has done to determine the content for our Regional Committee session. But, in addition this year, it played a major role in deciding to maintain the session in Tbilisi on the planned dates. Thank you to all the members of the Committee and particularly to Ms Annemiek van Bolhuis, its chairperson.

It only remains for me now to wish us all a good session of the Regional Committee, one that will stay in our memories and will contribute to our work for the good and for the health of our fellow citizens.

Annex 5

Address by the Director-General of WHO

Your Excellency, Madam Chair, honourable ministers, distinguished delegates, Dr Danzon, our Regional Director, ladies and gentlemen,

First and foremost, I would like to join previous speakers in offering my condolences to those who lost family members or suffered in recent events. Let me thank the government of Georgia for its hospitality in hosting the Regional Committee. As is true for several countries in the European region, the health care system in Georgia is in transition, with many obstacles to overcome.

Let me congratulate the Ministry of Labour, Health and Social Affairs for its plans to reform the health sector. You are grappling with a fragile economic situation, and with catastrophic health expenditures that deepen poverty.

You are seeking to improve the health of the people of Georgia by guaranteeing universal access to a package of public health services and basic health care. You have made primary health care a priority area for investment. These are laudable aims, but the challenges are great. Rest assured of continuing support from WHO.

The Regional Director's report for 2006–2007 refers to the good collaboration between the regions, and between headquarters and regions. I fully agree with his comments. I am grateful to the Regional Directors and staff throughout the Organization for their cooperation. We all realize the importance of working together to support our member states in a seamless manner.

In his report, the Regional Director identifies the development of health systems as the most important area of work for the regional office. Recent work in this area, and most especially the Tallinn Charter and supporting documents, serves health here in Georgia, throughout Europe, and indeed worldwide.

During this session, you will be tackling two of the most complex, tenacious, and elusive issues in public health. You are looking at ways to improve the performance of health systems, and this means better fairness as well as greater efficiency. And you are looking at ways to change human behaviours, again with an emphasis on health systems.

In all of public health, there is probably nothing harder than changing human behaviours. When a programme brings success, the results often cannot be replicated in another setting. Or they cannot be brought to scale. Or, most often, they cannot be sustained. We are like Sisyphus, the mythical king from ancient Greece, who is condemned to role a huge boulder up a hill, only to watch it roll right back down again.

Efforts to improve the performance of health systems also have a long history, and likewise with patchy success. This is a history of decades of experiments, shifting policy advice, huge and costly errors and an almost incomprehensible failure to learn from successes and mistakes.

I applaud your courage in tackling these problems. Though difficult, they represent two of the most important barriers to health development facing every country in the world.

The European Ministerial Conference on Health Systems sent a clear message to the rest of the world. The way that health systems are organized, financed and managed is important. Improved performance is critical, even in countries with some of the best life expectancies, and the best health systems in the world. Improved performance aims not just for greater efficiency, but also for better fairness. And it does so in ways that influence or coordinate actions in other sectors, so that health impacts are taken into

account in all policies. The achievements behind the Tallinn Charter take the international debate on health development a step forward. This time around, we have a better chance to get things right. The problem is recognized, and the motivation and momentum for change are stronger than ever before.

Stalled progress towards the health-related Millennium Development Goals, notably in sexual and reproductive health, has forced a hard look at the consequences of decades of failure to invest in basic health infrastructures, services, and staff. As we have seen, powerful interventions and the money to purchase them will not buy better health outcomes in the absence of efficient systems for delivery.

Last month, the International AIDS Conference in Mexico gave major emphasis to the importance of strengthening health systems. The successful drive to reach 3 million people with antiretroviral therapy has revealed the critical barriers caused by weak systems for drug procurement and delivery, weak laboratory support, and inadequate numbers of staff. That conference also stressed prevention as the only way to catch up with the HIV/AIDS epidemic and get ahead. It showed, in a vivid way, the great difficulty of behaviour change. In the Americas, as in parts of Europe, the AIDS epidemic has resurged in men who have sex with men. This is exactly the group that initially pioneered behaviour change for prevention, and had such good success. Once again, we have rolled a huge bolder up a hill, only to watch it roll down again.

In June, a Global Leadership Forum looked at the need to integrate the response to the closely related epidemics of AIDS and TB. This is yet another expression of the drive for more efficient service delivery. Let me remind you of the alarming rise of multi-drug resistant TB in Europe. This region has by far the world's highest percentage of multi-drug resistant TB among newly diagnosed cases. In fact, one in every five new cases is resistant to multiple drugs, right from the start. The implications for health systems and budgets are huge, as this form of TB is much more difficult and around 100 times more expensive to treat. In this region, Estonia and Latvia have shown that, when basic health system capacity is improved, high rates of multi-drug resistant TB can be contained and even reversed.

The rise of chronic diseases has uncovered further problems. It has demonstrated the burden of long-term care on health systems and budgets. It has revealed the catastrophic costs that drive households below the poverty line. It has shown us the bitter irony of promoting health as a poverty-reduction strategy at a time when the costs of health care can themselves be a cause of poverty.

Prevention is by far the better option, and this requires behaviour change and coherence of government policies. At the same time, the main risk factors for chronic diseases lie beyond the direct control of the health sector. In other words, the response to chronic diseases and many other health problems requires efficiency, fairness, and multisectoral action.

Thirty years ago, the Declaration of Alma-Ata articulated primary health care as a set of guiding values for health development, a set of principles for the organization of health services, and a range of approaches for addressing priority health needs and the fundamental determinants of health. Fairness in access to care and efficiency in service delivery were overarching goals. Above all, primary health care offered a way to organize the full range of health care, from households to hospitals, with prevention equally as important as cure, and with resources invested rationally in the different levels of care.

The values of equity, social justice, and universal coverage are solidly present in the Tallinn Charter. As the document before this Committee notes, these common values play a central role in health decision-making all across Europe. The principle of a holistic approach to health, which includes attention to prevention and addresses the fundamental determinants of health, is equally present. The approaches of community participation, particularly involving women as agents of change, multisectoral action, and technology choices aligned with priority needs have likewise shown their enduring value. As stated in the Regional Director's Report, developing high-quality services based on primary health care is the key to improving health system performance in both the eastern and western countries of Europe.

The primary health care approach, as articulated in 1978, was almost immediately misunderstood. It was a radical attack on the medical establishment. It was utopian. It was confused with an exclusive focus on first-level care. For some proponents of development, it looked cheap: poor care for poor people, a second-rate solution for developing countries. After 30 years, primary health care is no longer so deeply misunderstood. The ministerial conference has helped return primary health care to its original meaning. This is a rational approach to fair and efficient, good quality care. And its values, principles and approaches have relevance in rich and poor countries alike.

The Tallinn Charter drew on work that followed the Commission on Macroeconomics and Health. This work showed that health is not a drain on resources. Instead, it is a producer of economic gain. You have extended this thinking to health systems. A health system is not just a burdensome and expensive duty of government. It is not a system, say, like a municipal water supply that is expected to pump out some basic services, and let market forces take care of the rest. If people want fancy bottled water, let them buy it. If health services in the public sector provide poor quality care, if health services in the public sector are overcrowded and poorly staffed, it is not an acceptable solution to rely on private health services to make up for these inadequacies. To do so is to invite inefficiencies and encourage inequity. We have abundant evidence that proves this point. Good stewardship means oversight for health care in all its dimensions.

People should not become poor because of ill health. As the health plan for Georgia notes, a single episode of illness can drive an entire household into poverty. Health systems will not automatically gravitate towards greater fairness and efficiency. Deliberate policy decisions are required. This, I believe, is the most significant achievement of the Tallinn Charter and all the preparatory work that supported its development. You have recast the significance of health systems.

A health system is not a burdensome money-guzzling duty. It is a strategic opportunity. A health system provides a strategic opportunity to manage health in a foresighted, proactive way. And it provides a strategic opportunity to manage the dynamic two-way relationship between a nation's health and its wealth.

Let me use just one example, taken from documentation prepared for the ministerial conference on health systems. Demographic ageing is now a global trend. Increased life expectancy is driving the rise of chronic diseases. The costs of caring for the elderly are considered a major reason for increased government expenditures on health. The burden of caring for growing numbers of the elderly is one reason for the shortage of health care workers. Instead of accepting this burden as inevitable, you have shown how health systems can offer a better option. You have shown how a health system that makes prevention and health promotion a priority can reduce disabilities in the elderly, reduce the costs of care, and also improve the quality of life. This is the superior, far-sighted approach that emerges when health systems are treated as a strategic opportunity. This view makes tremendous good sense in the interest of efficiency, fairness, and the ultimate goal of health development: better health outcomes. This view also has some solid support.

At the end of August, the Commission on Social Determinants of Health issued its final report. The striking gaps in health outcomes are its main concern, and greater equity is the objective. The report challenges the assumption that economic growth alone will reduce poverty and improve health. On present trends, increased economic prosperity tends to benefit populations that are already well-off, leaving others further and further behind. This trend is readily apparent in parts of Europe. As the report notes, the most important determinants of health arise from the social conditions in which people are born, live, work, and age. And these conditions are shaped by government policies.

Economic growth will improve the health of the poor only when policies are in place that explicitly address these underlying social conditions. In the absence of such policies, the majority of the world's population will not achieve the level of health and economic productivity that is biologically possible. Gaps in health outcomes are not a matter of fate. They are markers of policy failure.

The report places the responsibility for reducing health inequities squarely on the shoulders of policy-makers. And it does so in sectors well beyond health. The report recognizes that nearly all the social determinants of health fall outside the direct control of the health sector. Work done in this region fully substantiates this finding, especially for chronic diseases. The report calls for a whole-of-government approach that makes health a part of all governments policies, in all sectors. In other words, health in all policies.

The Commission's findings hold true at the international level. The forces that fuel inequities in health operate within countries under the authority of governments. But increasingly, these forces operate among countries under the influence of globalization. As just one example, the industrialization of the food supply and its globalized marketing and distribution are one reason why diet-related diseases are now found the world over. Let me remind you: the health sector had no say in policies that have made climate change inevitable. We had no say in policies responsible for the crisis of soaring food prices.

When we think about the Commission's findings, we must also think about a fundamental paradox. At the international level, health has risen to a high place on the development agenda. Yet within most governments, the health ministry usually has less clout and negotiating power than other members of cabinet.

Let us be frank. In most countries, an appeal to the value of health equity will not be sufficient to gain high-level political commitment. It will not be enough to persuade other sectors to take health impacts into account in all policies. This is why I believe the work being done in this region is so important. You have elaborated a range of policy tools, incentive schemes, and legal and regulatory instruments for improving the performance of health systems. You have done so based on solid evidence. And you have used some powerful – and persuasive – economic arguments.

Primary health care is quality health care. This is health care that requires resources.
This is an approach that must be supported by powerful arguments and persuasive evidence. And this is an approach that requires enormous political courage.

As I have said, this world will not become a fair place for health all by itself. Economic growth within a country will not automatically alleviate poverty or reduce the present great gaps in health outcomes. Health systems will not automatically gravitate towards greater fairness and efficiency. These changes require deliberate policy decisions.

It is not easy to make a value, such as fair access to medicines, count at the international policy level. But it can be done. The May resolution on Public Health, Innovation and Intellectual Property was a triumph. It showed that the rules that govern the international trade system can indeed be shaped in ways that favour greater equity in health.

It is not easy to make health equity a guiding principle for health systems, especially when market forces make health care a commodity and encourage inefficient consumption. But it can be done. In October, the World Health Report on primary health care will be issued to commemorate the anniversary of Alma-Ata. The report offers practical and technical guidance for reforms that can equip health systems to respond to health challenges of unprecedented complexity.

The report asks political leaders to pay close attention to rising social expectations for health care. As mounting evidence shows, people want care that is fair as well as efficient. People want health care that incorporates many of the values, principles and approaches articulated at Alma-Ata 30 years ago.

Political leaders would be wise to heed these rising social expectations. This, too, may add to your arsenal of arguments as you strive to make health a whole-of-government concern, with health in all policies.