The BRIDGE

Issue No. 22
Summer 2008

WORLD HEALTH ORGANIZATION
EUROPE

Quarterly newsletter of WHO/EUROPE

Upfront

WHO European Ministerial Conference on Health Systems:

"Health Systems, Health and Wealth"

Tallinn, Estonia, 25–27 June 2008

Hosted by the Government of the Republic of Estonia, the Conference put health systems high on the political agenda of Europe. It brought together ministers of health from the 53 Member States in the WHO European Region, as well as health systems partners, experts, observers and representatives of international and civil society organizations and the media. Experts from other WHO regional offices and from WHO headquarters also participated and contributed to the Conference. The 2.5 days' discussions led to better understanding of the impact of health systems on people's health and therefore on economic growth in the WHO European Region. Participants took stock of recent evidence on effective strategies to improve the performance of health systems, given the increasing pressure on them to ensure sustainability and solidarity.

The Tallinn Charter: Health Systems for Health and Wealth was signed and endorsed, bringing equity, performance and accountability to health sector. By signing it, ministers committed themselves to concrete and measurable action on strengthening health systems that will allow both their own people and the international community to hold them to account.

What they discussed in Tallinn

Parallel sessions

- Stewardship/governance
- Health financing
- Resource creation
- Service delivery

Satellite sessions

- Migration of health personnel – ethical considerations
- Public health information systems in Europe
- The European Network for Health Technology Assessment
- Building capacity in the European Union for a workforce for health
- Health systems decentralization – a regional perspective

Around and about

STRENGTHENING PRIMARY CARE

In April 2008, WHO/Europe organized a consultation with international researchers, policy-makers and primary care experts to improve two WHO tools. The first one assesses mechanisms to maintain or improve the quality of primary care. Its methodology is based on the WHO health systems framework and it was applied in Slovenia and Uzbekistan. Another one – the primary care evaluation tool – assesses the current state of development of the primary care system in a country. It was pilot-tested in the Russian Federation and Turkey. Both tools are survey-based, so results rely mostly on self-reported behaviour or experience, rather than direct observation or the systematic analysis of routine data. Partners in the countries carried out the projects together with a WHO collaborating centre, the Netherlands Institute for Health Services Research (NIVEL).

The consultation participants encouraged WHO to continue this work. The representatives of pilot countries described how useful they had found these evidence-based tools for policy-making. The countries had learned valuable lessons, and they made a number of suggestions to improve and refine the tools. In addition, policy-makers from other Member States expressed interest in applying the revised tools in the future.

Ways to improve the management of quality

What?

The tool for primary care quality management examines existing and well-institutionalized mechanisms and practices to find out how a country uses the available know-how and resources to improve the quality of services. The tool consists of questionnaires for national policy experts, managers of health facilities and general practitioners (GPs).

Slovenia

Who?

The local partners for the project were the Ministry of Health, the University of Ljubljana and other stakeholders of the Slovenian health system, such as national experts, managers and GPs. Two regions in Slovenia pilot-tested the tool.

What did they find out?

At the national level, the policy experts said that:

- quality assurance is not a priority for primary care, but better supervision and coordination can help change that;
- the passage of legislation needs to speed up, as three draft laws related to the quality of care are waiting to be adopted;
- better access to protocols and guidelines can improve quality; and
- quality assessments hardly exists: the system does not permit full accountability.

At the primary care level, managers said that:

- instruments for assessing quality exist (such as attestation of physicians, voluntary certification and accreditation, and mandatory licensing), but they are not well and broadly used;
- plans for the strategic management of human resources are not utilized at large; and
- patients are treated according to the latest professional standards and evidence.

At the primary care level, GPs said that:

- quality improvement is done ad hoc and in a noncommittal manner, rather than through structured procedures;
- GPs would welcome any opportunity to improve teamwork and coordination within primary care and with specialists; and
- motivation and incentives for health workers to provide better care are to be developed.

What are the recommendations?

- The expected establishment of a national institute for quality improvement and a quality department in the Ministry of Health will help significantly.
- The legislative basis must be laid.
- Slovenia needs an integrated plan for modernizing the management in primary care.
- Patients should be given a stronger voice and clear role in their care.
- The clinical guidelines used by general practitioners should be updated and expanded.

Uzbekistan

Who?

The project was implemented with the participation of the Ministry of Health, the Institute of Health and Centre of Evidence-based Medicine of the Tashkent Institute of Postgraduate Studies, and other health system stakeholders in Uzbekistan.

What did they find out?

At the national level, policy experts said that:

- improving the quality of primary care is an explicit national priority, with the relevant legislative basis in place and strong donor support available;
- the Ministry of Health is leading, yet there is still space for local and regional initiatives (in addition, civil society needs to be more closely involved); and
- patient-centred care is still not a priority.

At the primary care level, managers said that:

- guiding documents on quality are not available everywhere;
- the instruments for assessing quality are applied quite broadly;
- the system makes fairly good use of the internal resources for quality improvement, such as information to managers, effective support or financial incentives; and
- health care staff should be more open to innovation.

At the primary care level, GPs said that:

- treatment is in line with the latest available evidence (an opinion not so widely shared by managers);
- GPs are involved in both formal and informal activities for improving quality; and
- continuous medical education and skills updating are seen as very interesting and necessary.

What are the recommendations?

- The focus should be on primary care services in cities.
- Without questioning the leadership role of the Government, more space could be made for the involvement of nongovernmental organizations and patients' organizations.
- Facilities and GPs need support in improving the electronic management of clinical information and medical records.
- Human resources management and continuously upgraded medical education are essential.

Acknowledgments

This issue of **The BRIDGE** was prepared with the contributions, stories, ideas, comments and support from: Mary Stewart Burgher, Manuela Gallitto, Maria Haralanova, Svenja Herrmann, Marijan Ivanusa, Viv Taylor-Gee, Tina Kiaer, Faith Kilford, Kristina Mauer-Stender; Matthijs Muijen, Martina Pellny, Maria Cristina Profili, Francesca Racioppi, Anna Roepstorff, Cristiana Salvi, Patricia Sondergaard, Nicoletta di Tanno, Veronica Riemer.

Editorial Office **The BRIDGE**
Albena Arnaudova, Editor
WHO Regional Office for Europe
Scherfigsvej 8, 2100 Copenhagen Ø, Denmark
Tel.: +45 39 17 17 17. Fax: +45 39 17 18 18
E-mail: thebridge@euro.who.int

Design: Tuuli Sauren
Text editor: M.S. Burgher, WHO/Europe

Primary care within the health system

> *"Primary health care and social determinants of health need each other: their common ground is equity."*
>
> *Michael Marmot*
> *University College London, United Kingdom*

The WHO European Ministerial Conference on Health Systems held parallel session on the four functions of health systems. During the session on service delivery, lively discussions about primary health care took place, addressing three concrete topics.

1. Under the heading of enhancing coordination of care for improved quality, patient satisfaction and health outcomes, the role of primary care as the leading coordinator for patients with chronic illnesses was discussed.

2. The discussion of integrating vertical programmes into primary care and health systems referred to the old paradigm of vertical versus horizontal approaches, but, by presenting examples from Kyrgyzstan and Romania, shifted the focus towards a case-by-case and country-by-country approach, emphasizing that certain preconditions for the primary care system need to be fulfilled for successful integration, and that each specialized programme has different capacities to be integrated.

3. Those debating improving performance through primary care emphasized that, since the Declaration of Alma-Ata, the role and importance of primary care in the performance of the whole health system had increased and changed dramatically.

For more information, including country reports, contact Ms Martina Pellny, Programme Officer, Primary Health Care, at WHO/Europe (tel.: +45 39 17 12 51; e-mail map@euro.who.int), or see the WHO/Europe web site (http://www.euro.who.int/primarycare).

Crossroads

SLOVENIA in the European Union spotlight

January–June 2008

For the first time, health appeared in the final report of the Presidency of the Council of the European Union (EU). This was done by Slovenia – the first of the 12 youngest EU Member States (those who joined after 2004) to hold the Presidency. WHO/Europe worked with the Presidency team on several of its health priorities and initiatives.

Cancer was the Presidency's highest priority and the subject of a ministerial conference in Brdo, Slovenia, on 7–8 February 2008. Nata Menabde, Deputy Regional Director at WHO/Europe, joined in introducing the event with the Slovenian Minister of Health, Zofija Mazej-Kukovič, the then European Commissioner for Health, Markos Kyprianou, and the co-chair of a group of members of the European Parliament against cancer, Alojz Peterle.

The Slovenian Presidency drew attention to cancer as an issue in which close intersectoral cooperation is crucial to better prevention, the health-in-all-policies approach should be extensively applied and a comprehensive approach poses a serious challenge to health systems. To support this work, the European Observatory on Health Systems and Policies and the London School of Hygiene and Tropical Medicine published *Responding to the challenge of cancer in Europe.*

The health ministries of Slovenia and Spain co-organized the third European Alcohol Policy Conference in Barcelona, Spain in April 2008. Marc Danzon, WHO Regional Director for Europe, gave an opening speech, and WHO/Europe contributed technical expertise to the discussion of building capacity for ***alcohol policies and programmes***.

eHealth was the topic of a major health-related conference during the Slovenian Presidency, and WHO/Europe's experts participated in both preparation and the event (in May 2008). The conference adopted the Portorož Declaration, which identified three crucial future steps:

- planning how to deploy telemedicine and innovative information and communication technology in chronic disease management;
- enhancing the focus on new research opportunities; and
- defining the responsibilities, rights and obligations of all the different subjects involved in the eHealth process.

A project of the EU Presidency troika (Germany, Portugal and Slovenia, January 2007 to June 2008) addressed health issues related to the ***EU Strategy for Europe on Nutrition, Overweight and Obesity***. A conference took place in Radenci, Slovenia in March 2008. WHO/Europe prepared one of the conference workshops and assisted in the preparation of a book, *Investment for health and development in Slovenia: Programme MURA*.

The ***quality of health care services*** is one of the central topics of the biennial collaborative agreement for 2008–2009 between Slovenia and WHO/Europe. During its EU Presidency, Slovenia organized an international conference called Ready for the Future – Defining European Health Care through Innovation and Quality, in Kranjska Gora in June 2008, in collaboration with the European Society for Quality in Healthcare and with technical expertise from WHO/Europe.

The Presidency also joined forces with WHO/Europe for the EU launch of World Health Day 2008, on the theme of ***protecting health from climate change***, in Brussels, Belgium on 8 April.

WHO/Europe assisted Slovenia in dealing with other health issues during its EU Presidency, including:

- the Community framework for cross-border health care and patients' rights (the sole legislative proposal expected during the Presidency);
- implementation of the EU health strategy, adopted in October 2007;
- antimicrobial resistance, to help control communicable diseases and ensure patient safety;
- a conference on mental health organized by the European Commission in June 2008; and
- pharmaceuticals and foodstuffs.

For more information, contact Mr Marijan Ivanusa, Head of WHO Country Office, Slovenia (tel.: +386 59969531; e-mail: mai@euro.who.int) or see the WHO/Europe web site for activities in Slovenia (http://www.euro.who.int/countryinformation/) and access to publications (http://www.euro.who.int/observatory/Publications/, http://www.euro.who.int/socialdeterminants/invest/).

Spotlight

Mental health and well-being

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The European Pact for Mental Health and Well-being was launched on 13 June 2008 in Brussels, at the high-level conference on mental health and well-being organized by the European Union (EU). WHO/Europe worked with the European Commission (EC) and particularly the Directorate-General for Health and Consumer Protection (DG SANCO) in organizing the conference; the other core partner was the Slovenian Presidency of the Council of the EU. The conference and the Pact form natural channels for the support of the goals set by the countries in the WHO European Region in the European Declaration on Mental Health; the Declaration was adopted at the 2005 WHO European Ministerial Conference on Mental Health. Since then, WHO/Europe has worked closely with its EU partners in this domain.

The 2008 conference was hosted by the European Commissioner for Health, Ms Androulla Vassiliou. It opened with keynote speeches by Mr Miguel Angel Martínez Martínez, Vice-President of the European Parliament, Dr Zofija Mazek-Kukovic, Minister of Health of Slovenia, and Dr Marc Danzon, WHO Regional Director for Europe. The conference gathered together high-level representatives of the European Parliament, the EU Presidency and Member States, other organizations and leaders from relevant sectors (such as health, education, employment and social affairs) and civil society.

The Pact highlights the relevance of mental health for public health, education, productivity and social cohesion in the EU. It expresses the willingness of high-level governmental and nongovernmental actors to work together to address mental health issues, using a set of agreed key principles for action. The Pact focuses on four priority themes: prevention of suicide and depression, and mental health in youth and education, in the workplace and in older people. Combating stigma and social exclusion is a priority that runs through all thematic areas.

The Pact will be implemented through a series of thematic conferences on each of the priorities in 2009–2010. It symbolizes the determination of conference participants to work together on opportunities and challenges for mental health

Three objectives to improve mental health

"A lot of progress has been made in taking mental health out of the taboo area where it was located before. Yet a lot remains to be done. One area for action is the training of health professionals. Too often, they still lack awareness and knowledge about mental health, which is incorrectly perceived as the exclusive responsibility of the psychiatric field. There is also a need for increased public information to stop the stigmatization of people with mental health problems, who often experience difficulties in their family and social relations, and are rejected at work. Most important, a shared goal is to give mental health its rightful place in the health system and in health policies. At a time when it is recognized that health improvement requires a strong health system, mental health should not be forgotten but positioned centrally."

Marc Danzon
WHO Regional Director for Europe

A measure for the humanity of our societies

"Mental health is an economic capital for nations. In today's fast changing world, it is an integrated and increasingly important part of all areas of society. Regardless of all the diversity between countries, there is a shared view of mental health as a key public health issue. In Slovenia, we have a national programme that follows the recommendations of WHO and the Council of Europe. The most important issue for politicians is to be able to give flexible responses to the needs of people with mental disorders."

Zofija Mazek-Kukovit
Minister of Health, Slovenia

Added value at the EU level

"The European Pact for Mental Health and Well-being will not be a legal instrument, but it will carry a joint political commitment. It will help us focus on delivery. Progress in tackling mental health in Europe would be inconceivable without cooperation between everyone involved. The European Commission sees mental health as central for the EU health policy. Yes, the question for us is to see what we can do on top of what Member States and WHO are already doing. The value we can add is to make data more comparable and easily available, encourage exchange of good practices and ideas, ensure that mental health is taken into account in various policy areas that deal with young people and education, workplace, the elderly, employment and social affairs. Only thus shall we demonstrate that mental health is fundamental for the wellbeing of the EU citizens."

Androulla Vassiliou
European Commissioner for Health

It is about alleviating suffering of people and their families

"The true value of the Pact is to come when we bring it close to EU citizens. The more developed a country is, the more mental health suffering is identified and thus the more people and families need and can be given support. Mental health problems are a concern for citizens individually and societies collectively. Today, appropriate treatment can help most people recover from mental disorder and lead a normal life again. Such treatments should be available and accessible to all those who need them; inequities in mental health are simply unacceptable in the context of our values of solidarity and social protection. The EU can act to help put money on the table, so that statements do not remain words only and so that ideas become solutions."

Miguel Angel Martínez Martínez
Vice-President, European Parliament

New and forthcoming from WHO/Europe

"Policies and practices for mental health in Europe: meeting the challenges"

Until now, data on mental health policy and practice in countries across the WHO European Region could not be compared. A new WHO report, co-funded by the European Commission and to be launched later in 2008, will allow such comparisons on a broad range of indicators, including health promotion and disease prevention activities, numbers of psychiatrists, financing, community services, workforce training, prescription of antidepressants and representation of users and carers on planning bodies. Data for the 43 Member States involved demonstrate the following.

1. Countries have made much progress towards supporting deinstitutionalization and establishing services close to where people live: the shift from institutional care to person-centred, community-based care.
2. The involvement of service users and carers in planning, delivering and monitoring the quality of care is already broadly accepted as good practice, and most countries are establishing programmes for the social inclusion of service users.
3. There is large diversity across the large majority of variables. Precise and comparable information is still lacking, even on fundamental indicators, and there is no collection of compatible data. There is a lack of consistency in the practice and education of care providers. Consensus on definitions is still lacking.

The report identifies gaps in information, and provides a baseline against which progress can be measured towards the vision and the milestones of the European Declaration on Mental Health (Helsinki, 2005).

"Mental health, resilience and inequalities"

A report from WHO/Europe and the Mental Health Foundation sets out the contributions of mental health and mental illness to a wide range of health and social outcomes, and shows how a greater focus on mental health as a determinant can help to explain outcomes, for individuals and for communities, for which material and other factors cannot wholly account.

Mental health brings a very wide range of positive outcomes for individuals and communities: healthier lifestyles, better physical health and recovery from illness, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships with adults and children, social cohesion and engagement, and improved quality of life. Improving mental health is a key goal in itself: people value a sense of emotional and social well-being; in addition, good mental health has many other far-reaching benefits.

"Stigma"

Published by Health Scotland with WHO/Europe support, *Stigma: an international briefing paper* and *Stigma: a guidebook for action* were designed to help people understand and develop strategies and action to fight the discrimination, stigma and social exclusion experienced by people with mental health problems and by those close to them. The publications address all those who can reduce these harmful factors. The guidebook gives examples of activities across the WHO European Region, and provides simple tools and ideas for action.

"Epilepsy in the WHO European Region"

A joint report of WHO headquarters, WHO/Europe and the WHO/International League Against Epilepsy (ILAE)/International Bureau for Epilepsy (IBE) Global Campaign Against Epilepsy provides a panoramic view of the situation in the Region, outlines the initiatives of WHO and other partners to address it, defines the current challenges and offers appropriate recommendations.

The report also explores mechanisms for involving more Member States and their partners in activities to combat stigma, restore dignity and reduce the treatment gap for people with epilepsy. It is an advocacy tool and an instrument for dialogue with governments, consumer associations, nongovernmental organizations, academic institutions and development partners.

For more information, contact Dr Matthijs Muijen, Regional Adviser, at WHO/Europe (tel.: +45 39171391; e-mail: mfm@euro.who.int) or visit the WHO/Europe web site (http://www.euro.who.int/mentalhealth).

Upfront

WHO European Ministerial Conference on Health Systems: "HEALTH SYSTEMS, HEALTH AND WEALTH"

Tallinn, Estonia, 25–27 June 2008

What they said in Tallinn

The right to health means access to care

"With ageing populations and an increased burden of disease, we know that demand for health workers will increase, meaning emigration trends are likely to persist. What is crucial now is for European countries to adopt an ethical approach to their health worker needs and thereby reduce the negative impacts of migration on health systems in developing countries. The right to health means having access to quality care, and we must all work together to achieve this goal as soon and as effectively as possible."

Mary Robinson
President, Realizing Rights: the Ethical Globalization Initiative, Co-Chair, Health Worker Migration Global Advisory Council

Systems for what people really need

"Disparities in access to health remind us that, even in the richest European countries, there are groups that are deprived of reaching their health potential. This is not right. Wealth should not be the determining factor for somebody's health, as access is a fundamental human right. To fulfil this right we all work for two goals – fighting diseases and building systems. They are not mutually exclusive, but, on the contrary, complementary."

Michel Kazatchkine
Executive Director, Global Fund

Solidarity and excellence

"Regardless of wealth, politics and social systems, inequalities exist throughout all [Organisation for Economic Co-operation and Development (OECD)] countries. The quality of care is also different for different socioeconomic groups. These are inequities – i.e. they are immoral. Improving our systems – not only health systems – is fundamentally important. We work with [the European Commission (EC)] and WHO in order to improve health data and accounting. This should help reduce the reporting burden for health professionals by the demand for excessive accounting and the scattered data gathering. Every such improvement of one part of the system is a move towards better health."

Aart De Geus
Deputy Secretary-General, Organisation for Economic Co-operation and Development

Deliver both for the next elections and for our grandchildren

"WHO means health for all; the Council of Europe means human rights for all. For me, this means that we jointly aim at health and human rights for all. Economic deficit is no excuse for rights deficit, or for health deficit, in any country. Calling for more money does not provide answers if we do not call for spending the money available in the right way. In this, our organizations cooperate, supporting Member States in achieving good governance. This means to work simultaneously for the long-term and short-term perspectives – to protect the interests of our grandchildren while trying to win the next elections."

Piotr Mierzewski
Head, Health Division, Council of Europe

Needs of children and adolescents: tomorrow is too late

"The Tallinn Charter will help countries deliver health to the most vulnerable members of society. Children are among those who suffer most if health systems do not deliver equitably. The Tallinn Charter is a strategic framework and guide to be translated into concrete policies and programmes to make it work in practice. Some of them are well known and we work with WHO for them: primary care interventions and especially immunization, strong health promotion and public health communications and preventive health strategies."

Shahnaz Kianian-Firouzgar
Deputy Regional Director, Regional Office for Central and Eastern Europe and the Commonwealth of Independent States, United Nations Children's Fund

Essential and productive investment

"The EIB is the Bank of EU Member States. We are a policy driven bank. Economic evidence suggests increasing peoples' health is a good way of increasing their productivity. There is, therefore, a clear link between healthcare and other EIB priorities - a functioning, efficient and reliable health service is essential for a stable social system and for ensuring sustainable communities. But it is difficult to invest in human capital as such. So for a bank, one practical option is to invest in the infrastructure, which supports the development of health systems. Lending in human capital (health and education) represents about 10% of our total lending. Last year we lent 2.7 billion euro for health projects. We are updating our lending strategy for health. Experience of 10 years, implications and opportunities arising from the new EU framework and strategic approach to health, and lessons from this conference will all contribute. I'm really confident that this conference and the Tallinn Charter will, quite rightly, enhance the political importance of health as an essential and productive investment."

Philippe Maystadt
President, European Investment Bank

The shared objectives cannot be achieved by the health sector alone

"Functioning health systems are the glue that holds together different actors and building blocks in order to achieve results. Strengthening health systems may sound abstract, less important than specific diseases control, and less tangible than success in research. But on the ground, it means putting together the right sequence of policies. It also is and should remain being a means to an end. Success can only be claimed after the right mix of policies actually does prevent avoidable death, disease and injuries, as well as extreme financial hardship due to illness."

Armin H. Fidler
Lead Health Policy Adviser, World Bank

We need the courage to measure outcomes

"We need to understand the far-reaching consequences of what we do now. For instance, we want to build the best possible health systems, but this takes a long time. A big organizational and cultural change cannot be made overnight; money, efficiency, financing all come into account, and we need not forget the human factor, without which change is impossible. Therefore we should not be pointing the finger at health professionals and holding them responsible for the fact that our societies are still not where we should be in terms of health systems: that we are not enjoying the health systems we want. Today, we need to have the courage to measure outcomes, to use all possible tools available to measure what we achieve. This is about providing evidence to those outside the health systems, because other sectors influence the effectiveness of what we in the health sector do. When we demonstrate where the needs are and how they can be met, we are more convincing; we show the results that could be brought. We shall set up to measure the impact of [the Tallinn Conference] on health systems. After the closure of the Conference, we shall follow up, together with Member States, and I hope we are all transparent and fair in sharing mistakes and successes."

Marc Danzon
WHO Regional Director for Europe

Unprecedented interest in health systems

"As we all know, health systems are highly context specific. No conference can produce a blueprint that works well in all settings. Nevertheless, this is a visionary meeting and a strategic one. Improved efficiency of health systems and quality of performance are important, but their ultimate objective is to reduce the gaps in health outcomes and raise the overall level of health within the population. When countries modernize, some strong assets of health systems, such as the provision of universal access to basic care, are all too often lost. That's why your frank assessment of failures and successes has significance for countries well beyond Europe. All health systems have room for improvement. Health leaders in all countries want to know how to make health systems perform better, what to do and how to measure the results. They are looking for greater efficiency, for the right incentives, for options for fair financing. As in the work on chronic diseases, this is yet another area where European ministers of health have assumed a global leadership role."

Margaret Chan
WHO Director-General

Health in all policies is a must

"It is not by chance that health has become part of the Lisbon indicators. With more health, we have more productive and happier populations. Member States are responsible for organizing and reforming their health systems. But the European Commission can encourage them to invest more in health, use funds such as the structural funds, and share good practices among themselves. I would like to see health as part of economic, financial, environmental, employment and other policies. Investing for health is not a cost. It is an investment in the future. The Conference will give us a lot of courage to continue in this work of ours."

Androulla Vassiliou
European Commissioner for Health

Without consensus on values the cannot be made rational

"There is a common perception that spending on health care is a burden on the economy. This is a deeply faulty theory. Health care is a high-yield social investment in human productivity. Even if health care does not add to human productivity, the added life years and quality life it can yield are highly valued by members of society. In addition, in many countries health care is now the major economic locomotive of national economies, a major job creator and driver of GDP. But without a clearly articulated consensus on the moral values that guide a nation's health system, that system can never be made 'rational'. Because 'efficiency' means reaching a goal with the minimum expenditure of real resources, we cannot even know whether a health system is 'efficient' unless we know the ethical goals the system is to reach."

Uwe Reinhardt
Woodrow Wilson School of Public and International Affairs
Princeton Unviersity

A moral obligation

"We have made major steps since the time when health systems were not yet recognized internationally as a key determinant for health and were rather considered as a cost category. When we started, there were not so many people convinced that this was the way; now, many partners in countries are inspired and express support for the process of health systems work. WHO brings the best knowledge and evidence that is available in Europe and in the world, to support policy-makers do that. Perhaps the Tallinn Charter will make the most and quickest impact in the countries that are worst off, because they may use it immediately as a political tool. The more sophisticated systems will have to make a more complex shift. It is important to make health ministers accountable for ensuring that the other sectors do make an effort to contribute to health. When they are politically accountable to the citizens for whether and how they influenced the others, then a real change will come. The Tallinn Charter is not legally binding, but it has a strong moral obligation. Every word in it matters, because we worked for it together with Member States. Health ministers have committed to be evaluated on performance – on how they will implement this Charter. So, in a way, this is a work that may influence thinking all around Europe and beyond."

Nata Menabde
Deputy Regional Director, WHO/Europe

A joint responsiblity

"Now it is our joint responsibility to implement the Charter. By signing it, we, ministers of health, confirm our joint commitment to work for the health of our citizens. We represent different Member States but we share the same values: equality, solidarity and participation. I believe there is nobody who yet thinks that health is the responsibility solely of the health minister. Working together with the prime minister and the whole cabinet is important for us, to be able to convey our messages."

Maret Maripuu
Minister of Social Affairs, Estonia

CONFERENCE CORE PUBLICATIONS

- The economic costs of ill health in the European Region
- Performance measurement for health system improvement: experiences, challenges and prospects
- Health systems, health and wealth – Assessing the case for investing in health systems

POLICY BRIEFS

- How can European health systems support investment in and the implementation of population health strategies?
- How can the impact of health technology assessments be enhanced?
- Where are the patients in decision-making about their own care?
- How can the settings used to provide care to older people be balanced?
- When do vertical (stand-alone) programmes have a place in health systems?
- How can chronic disease management programmes operate across care settings and providers?
- How can the migration of health service professionals be managed so as to reduce any negative effects on supply?
- How can optimal skill mix be effectively implemented and why?

See the WHO/Europe web site (http://www.euro.who.int/healthsystems2008) and online video coverage of the entire Conference, news bulletins and interviews on (http://www.whoconference2008.org/)

Shortcut

Reducing tobacco use: the work continues

In 2007, WHO/Europe became part of an initiative in which WHO is involved at the global level. The Bloomberg initiative to reduce tobacco use promotes freedom from smoking. Work on the initiative intensified in 2008.

The Russian Federation: *Tobacco Control Conference for Russian Regions, Moscow*

Poland: *launch of the national campaign promoting healthy lifestyle among youth, Warsaw*

What is the initiative?

Mr Michael R. Bloomberg, mayor of New York City, United States, made a commitment to donate US$ 125 million towards ending the global tobacco epidemic. It addresses the 15 countries where more than two thirds of the world's smokers live. Four of them are in Europe.

How will it work?

The initiative will:

- refine and optimize tobacco control programmes to help smokers stop and prevent children from starting;
- support public sector efforts to pass and enforce key laws and implement effective policies, particularly those to tax cigarettes, prevent smuggling, change the image of tobacco and protect workers from exposure to other people's smoke;
- support advocates' efforts to educate communities about the harm done by tobacco and enhance tobacco control activities; and
- develop a rigorous system to monitor the status of global tobacco use.

Who are the partners?

- The **Campaign for Tobacco-Free Kids** develops resources for advocacy, legal support and improving public information about the harm of tobacco and actions of the tobacco industry.
- The **Centers for Disease Control and Prevention (CDC) Foundation** measures the current health burden of tobacco and status of tobacco control in high-burden, low- and middle-income countries through a global adult tobacco survey.
- The **Johns Hopkins Bloomberg School of Public Health** expands training and economic studies, with a particular focus on China, and analyses, refines and optimizes tobacco control interventions.
- The **World Lung Foundation** implements a grant programme to implement in-country tobacco control measures, creates a global resource centre for effective anti-tobacco advertisements, supports measures to prevent tobacco smuggling and operates regional tobacco control centres.
- **WHO** builds national capacity, strengthens the network of in-country tobacco control experts (with the World Lung Foundation), creates or strengthens government tobacco control units to be supported by a broad coalition of governmental and nongovernmental organizations, and leads monitoring and evaluation (with the CDC Foundation), including data gathering and analysis on tobacco use, exposure to second-hand tobacco smoke, health outcomes, policy implementation and the tobacco industry.

How are funds made available?

As part of the initiative, a **competitive grants programme** supports organizations working to deliver effective, proven tobacco control measures on the ground in countries. Governments, intergovernmental organizations (including WHO), state and provincial authorities and nongovernmental organizations from low- and middle-income countries (as categorized by the World Bank) are eligible to apply for grants.

This is only one part of the funding mechanism going directly to countries on a competitive basis.

What is WHO's part?

WHO has received US$ 14 million for two years, to be distributed between headquarters and regional and country offices.

Which European countries are involved?

Poland, the Russian Federation, Turkey and Ukraine have each received funds for both activities and personnel in the WHO country office to work on the initiative.

What has been done so far?

WHO/Europe has:

- supported the Global Adult Tobacco Survey (**GATS**) – underway in the Russian Federation, Turkey, Poland and Ukraine to obtain internationally comparable data on adult smoking and related patterns of behaviours;
- provided technical advice and built local capacity for the **grants programme** in all four countries of the Bloomberg initiative;
- provided additional support to the tobacco control activities in 7 countries in the WHO European Region, which, as of the end of June 2008, have received 15 grants providing additional support to tobacco control activities;
- organized celebration of **World No Tobacco Day** on 31 May 2008 in the four countries, with a variety of events and broad media coverage;
- organized a tobacco control conference of regions to discuss the role of subfederal entities and their experiences in tobacco control, involving regional and municipal authorities in **the Russian Federation**, a study tour to France for Russian Duma members and staff of the Ministry of Health and Social Development to discuss and exchange views on tobacco control policies and their implementation in the two countries;
- supported the development and the adoption of the concept of the national action plan (including organizing a workshop with relevant national and local authorities to discuss the preparations for the plan) and held a round-table with regions and municipalities to discuss the coordination of tobacco control activities in **Ukraine**; and
- provided technical advice and supported the adoption and launch of the national action plan for 2008–2012 by the Prime Minister of **Turkey**, given technical advice on the draft legislation on tobacco control, including 100% smoke-free public and workplaces (the amended law was adopted in January and entered into force in May 2008), organized regional round-tables with local authorities and health community to promote the new law and encourage its enforcement, supported a study tour for four members of parliament to examine the smoke-free policies of Ireland and supported the translation of the WHO European tobacco control report into Turkish.

What will be done by the end of this year?

Country **tobacco control reports** in the four countries will be prepared and published in the local and English languages.

In the **Russian Federation**, the model regional tobacco control strategy will be finalized and pilot-tested in four regions, so that the strategy can be amended based on the lessons learned before it is released by the Ministry of Health and Social Development.

In **Poland**, the Health Commission of the Polish Parliament will be supported in reviewing the existing tobacco control law and strengthening the policy on tobacco use in all public places. With the ministries of health and finance, an economic seminar will be organized on price and taxation policies of tobacco products, to discuss the benefits of higher taxes to health and health systems. With the Ministry of Health, a round-table involving all major national partners will be organized to discuss the need for and benefits of a stronger horizontal approach to noncommunicable diseases in Poland.

In **Ukraine**, a conference on the national tobacco control strategy will be organized with the Ministry of Health to discuss and encourage the strategy's effective implementation by all partners.

In **Turkey**, with the ministries of health and finance and the Regulatory Committee for Tobacco, Tobacco Products and Alcoholic Beverages Market (TAPDK), an economic seminar on price and taxation policies of tobacco products will be organized to discuss the benefits of higher taxes to health and health systems. In addition, the annual Healthy Cities conference, with a special emphasis on tobacco control, will be supported.

For more information, contact Dr Agis Tsouros, Regional Adviser (tel.: +45 39 17 15 09; e-mail: ats@euro.who.int), or Ms Kristina Mauer-Stender, Technical Officer, Tobacco Control (tel.: +39 06 48775529; e-mail: kma@euro.who.int), at WHO/Europe or see the WHO/Europe web site (http://www.euro.who.int/tobaccofree/.

Around and about

SOUTH-EASTERN EUROPE HEALTH NETWORK

Health Workforce Needs and Mobility

On 30 June 2008, the South-eastern Europe (SEE) Health Network gathered in Brussels at a workshop supported by the Technical Assistance and Information Exchange Unit (TAIEX) of the European Commission (EC). It was organized jointly by WHO/Europe, the European Observatory on Health Systems and Policies, the EC Directorate-General for Health and Consumer Protection (DG SANCO), the Council of Europe and the International Organization for Migration. The workshop was attended by over 60 participants, the majority of whom came from the SEE countries (representatives not only of health ministries but of ministries of education, labour, economy and social affairs, and of professionals' organizations), as well as key experts on the topic from the EU Member States and international organizations.

As health professionals are at the core of the health systems, the needs for and mobility of health staff are of crucial importance. In the light of the growing importance of this issue more specifically in SEE, the EC and **DG SANCO in particular expressed interest in exploring this issue not only in the EU but also in neighbouring regions.** The multicountry workshop was organized on the topic "health workforces needs and mobility in EU and SEE".

The workshop:

- provided an update on the latest developments in health workforce mobility in Europe;
- reviewed the health workforce status, mobility and needs in selected EU Member States;
- prepared the SEE Health Network to contribute to the EC consultation paper (green paper) on this topic; and
- identified topics for a SEE study on health workforce mobility.

SEE and the EU – how do they differ?

Some commonalities exist between countries in SEE and the 27 EU Member States.

- Free mobility is considered as a basic human right, as are health and health care.
- Workforce needs are a key issue across the WHO European Region.
- All countries need to develop workforce policies, and improve information infrastructure and management mechanisms.
- Countries are in a transition process – making thorough reforms at enormous speed.

Certain differences should not be neglected.

- The relevance of health professionals' mobility varies between big and small countries, with a proven impact on quality. Some countries are hardly affected.
- The challenges in proper and strategic planning for the workforce vary across the Region.
- The gaps in the political context and economic development set the ground for significant differences.

Other questions raised at the debate

- Will better data make a difference?
- Will workforce policies make a difference?
- Will mechanisms for managing health professionals' mobility work?
- Can next steps be considered? How can the EC and the countries of SEE establish a dialogue and exchange practices, so as to explore all possibilities for cooperation and avoid duplication of effort?

Did you know

South-eastern Europe Health Network: regional ownership spearing ahead

The 19th meeting of the South-eastern Europe (SEE) Health Network took place in Brussels, Belgium on 30 June – 1 July 2008. It was chaired by the Moldovan Presidency on the first day and the Montenegro Presidency on the second. The meeting was attended by national health coordinators, the Network Executive Committee and secretariat, and partners and donors.

The meeting addressed the strategic directions for the future action of the Network, and reviewed the process for signing the Memorandum of Understanding and two ministerial declarations (on mental health and the implementation of the International Health Regulations).

The participants agreed that, to facilitate the Network's response to a number of documents, an accelerated procedure is often necessary and that, depending on the nature of the document, formal national agreements may be required. Thus, they decided that task groups of 3–4 national coordinators from member countries would review such documents and submit proposals for responses to the Executive Committee, which will submit them to the whole Network for written agreement. Once a final text was agreed, the Chair of the Executive Committee would transmit it to the appropriate body on the Network's behalf. The following task groups were set up:

- **public health services** – Montenegro, Romania and The former Yugoslav Republic of Macedonia (to be discussed at the 2008 WHO Regional Committee for Europe);
- **EC green paper on the needs and mobility of the health workforce** – Albania, Bulgaria and Romania; and
- **web site and project database** – Bosnia and Herzegovina, Moldova and Serbia, upon the offer from the Northern Dimension Partnership in Public Health and Social Well-being.

En route

MOVE FOR HEALTH DAY 2008: social inequalities in physical activity

Move for Health Day is intended to raise public awareness of the benefits of physical activity for disease prevention. The 2008 Day highlighted the influence of social inequalities on physical activity.

Move for Health Day 2008 in Copenhagen, Denmark

On 9 May 2008, WHO/Europe, in collaboration with Suhr's University College, held a discussion of social inequalities in physical activity to identify good practices for targeted interventions. European examples were presented, such as the "BIG Project" (Germany), "Let us live Healthily" (Slovenia), "Romsås in motion" (Norway) and "Communities on the move" (the Netherlands).

Who is less active?

The people most vulnerable to physical inactivity are **the very young, very old or disabled, families in precarious circumstances, migrants, ethnic minorities and women**. Children, especially among the poor, have more difficulty in affording opportunities to be active (and the healthiest food choices). This results in a higher probability of unhealthy behaviour, such as spending more time watching television, which increases their risk of becoming obese.

In the United Kingdom, the proportion of people engaging in physical activity declines with age; 45% of men younger than 24 are engaged in walking regularly, while this figure drops to about 8% among men aged 75 and over.

Eurobarometer surveys from 2003 and 2006 reveal that, across European Union (EU) countries, women tend to be less physically active than men and that the prevalence of obesity is highest among women from more disadvantaged groups, including immigrants.

Socioeconomic status and physical activity

People with **lower incomes** are affected disproportionately more by obesity and other chronic diseases associated with low physical activity and unhealthy eating patterns. Although they are more likely to walk or cycle to shops or work than those with higher incomes, they are less likely to be active in their leisure time.

Lack of exercise is higher among **unemployed** than among employed people, and white-collar workers are twice as likely as manual workers to take part in sports. This results from the mechanization of labour, which has brought about a general homogenization of levels of work-related physical activity among social groups.

Using leisure time for physical activity

Occupation, income, education and the environment in which people live greatly influence what they do in their leisure time. Lack of nearby sports facilities, transport or sufficient money may stop those with low incomes from taking up leisure physical activity. Where potential activities are free or inexpensive, such as those in parks or the neighbourhood, people may live in places where the rate or fear of crime is inhibiting. Last, poorer people are in general less aware of the benefits of an active lifestyle, while richer people may have the means to pay for costly activities, more leisure time, higher awareness of the benefits and more social pressure to exercise. Opportunities to be physically active also vary across countries.

Creating and maintaining activity-friendly cities

Leveraging on the health benefits of active lifestyles, health systems can stimulate collaboration with other sectors to make neighbourhoods more activity friendly. They can liaise with urban planners and the transport sector to encourage the building of cycle paths in urban areas, rejuvenate inner-city areas and create safer and more attractive green spaces, playing areas and streets. In collaboration with the sport and finance sectors, the health sector can promote and increase the number of low-cost and after-school sports facilities.

WHO/Europe promotes evidence-based good practice on physical activity and advocates the promotion of active lifestyles through raising people's understanding of the importance and opportunities of moving for health. It advises and supports countries in the European Region in developing and implementing tailored policies and actions that promote an active lifestyle through multisectoral approaches.

Physical activity improves people's physical and mental health. It reduces the risks of many noncommunicable diseases, and benefits society by increasing social interaction and community engagement. Evidence shows that at least 30 minutes of moderate-intensity physical activity, taken 5 days a week, reduces the risk of disorders related to inactivity (such as heart disease, adult diabetes and obesity) by about 50%, and substantially decreases hypertension and the psychological consequences of a sedentary life (stress, anxiety, depression and loneliness).

In the WHO European Region, one in five people takes little or no physical activity, with higher levels of inactivity in eastern countries. In the EU, two thirds of the adult population does not reach recommended levels of activity. As a result, physical inactivity is estimated to deprive Europeans of over 5 million days of healthy life every year, on average.

Physical activity is not just a public health issue; it also promotes the well-being of communities and the protection of the environment, and comprises an investment in future generations. It should then be easily accessible, culturally acceptable, appealing and convenient to everybody: the rich and the poor, the young and the old, the healthy and the infirm. All should have opportunities and live in environments allowing them to be physically active.

For more information, contact Ms Sonja Kahlmeier (tel.: +39 06 4877562; e-mail: hepa@ecr.euro.who.int), or Ms Lideke Middelbeek, Technical Officer (tel.: +45 39 17 12 94; e-mail: lim@euro.who.int), at WHO/Europe, or see the WHO/Europe web site for information on health enhancing physical activity (http://www.euro.who.int/hepa), Move for Health day (http://www.euro.who.int/moveforhealth) and key publications (http://www.euro.who.int/obesity).

Crossroads

Different mandates: complementarity in action

In May 2008, the International Federation of Red Cross and Red Crescent Societies (IFRC) and WHO/Europe signed a Memorandum of Understanding at a health and care forum organized by IFRC in Geneva, Switzerland. IFRC/WHO collaboration is based on a global framework agreement signed in 2005. Cooperation is now well established through work at both the regional and country levels. Active collaboration is taking place in central Asia, the Caucasus, Ukraine, Belarus and the Russian Federation. In total 11 countries are involved.

What is the collaboration about?

Today, the collaboration focuses on advocacy, communication and social mobilization; the main areas of cooperation in the past were work on tuberculosis (TB) control, disaster preparedness and response (including epidemic preparedness), HIV/AIDS, blood safety and injuries at the regional and country levels. The European Stop TB Partnership provides the framework for strong joint collaboration and country support; WHO/Europe took over hosting the Partnership's secretariat from IFRC in January 2008.

Apart from continuing existing joint work, IFRC and WHO/Europe are considering new areas of collaboration for the future:

- HIV/AIDS and TB prevention, treatment and care, focusing on poor and vulnerable groups, including prison health and harm reduction;
- first aid;
- public health in emergencies and pandemic preparedness, particularly capacity building/training for emergencies and disaster preparedness in general;
- health systems interventions for maternal and child health, mainly in the Caucasus and central Asia;
- traditional and emerging health and environmental risks, particularly those related to global health and lifestyles; and
- improvement in access to and equity and quality of service delivery: for example, blood safety.

Additional regional collaboration is being envisaged in the area of harm reduction and health in emergencies and disaster management.

IFRC Health and Care Forum

The main topic was primary health care – 30 years after Alma-Ata. Other issues discussed were ways to link up social and health care, monitoring and evaluation frameworks and IFRC's role in primary health care.

- **IFRC strives towards an integrated approach to health and care** because health improvement is often the most appropriate way of addressing the needs of the most vulnerable. Its activities range from blood banks, first aid and emergency services to health promotion, addressing stigma and providing psychosocial care. IFRC contributes in these areas by means of:
  - capacity building of the volunteer base
  - social mobilization and increased community involvement
  - including health support as integral part of disaster management
  - health advocacy at all levels and community empowerment: health promotion, water and sanitation and community development work.

  Its role in relation to governments and WHO is to point to gaps in health services, to start filling these gaps and finally, to integrate services into the regular health system.
- As to the **global health development landscape,** IFRC identifies the same objectives, challenges and obstacles as those WHO is facing, particularly the highly complex landscape, with many actors and hence a crucial need to build partnerships. WHO is specifically looked at, and its recommendations always considered and implemented, if and when relevant.

For more information, contact Ms Svenja Herrmann, Technical Officer, Partnerships and Communications, at WHO/Europe (tel.: +45 39 17 16 11; e-mail: she@euro.who.int).

Did you know

The International Federation of Red Cross and Red Crescent Societies (IFRC) is the world's largest humanitarian agency. By definition a nongovernmental organization, the IFRC is also a social movement, well connected to the grassroots level, as well as governments, in 189 countries through its national societies and country delegations.

IFRC can quickly mobilize resources and assistance in emergencies through its volunteer networks. It acts as an auxiliary to national governments. Like WHO, it is valued by governments as a neutral and participatory force with great political impact; both agencies base their work on the same set of values: participation, democracy and transparency. IFRC's and WHO's mandates are different but complementary, and the partnership between them increases the impact of both organizations' work at the political and grassroots/community levels.

Bookshelf

Public health significance of urban pests

The second half of the 20th century and the beginning of the 21st century witnessed important changes in ecology, climate and human behaviour that favoured the development of urban pests. Most alarmingly, urban planners now face the dramatic expansion of urban sprawl, in which city suburbs are growing into the natural habitats of ticks, rodents and other pests. Also, many city managers now erroneously assume that pest-borne diseases are relics of the past.

All these changes make timely a new analysis of the direct and indirect effects of present-day urban pests on health. Such an analysis should lead to the development of strategies to manage them and reduce the risk of exposure. To this end, WHO invited international experts in various fields – pests, pest-related diseases and pest management – to provide evidence on which to base policies. These experts identified the public health risk posed by various pests and appropriate measures to prevent and control them. This book presents their conclusions and formulates policy options for all levels of decision-making to manage pests and pest-related diseases in the future.

Children's health and the environment in Europe

A baseline assessment

This publication gives an overview of the establishment of an environment and health information system in Europe, whose aim is to provide up-to-date and reliable information about public health and the environment as well as the outcomes of methodological work. The system's main product is an indicator-based assessment of children's health and the environment in the WHO European Region in the context of the Children's Environment and Health Action Plan for Europe. This assessment provides a baseline against which the progress and effects of action taken can be evaluated. Targeted at policy-makers, public health professionals, epidemiologists and environmental science professionals, this publication offers a basis for action to prevent diseases and promote healthy environments.

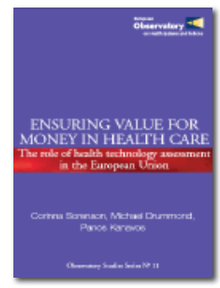
The effectiveness of health impact assessment.

Scope and limitations of supporting decision-making in Europe

Health impact assessment (HIA) is a support tool for intersectoral decision and for policy-making. It is used to assess the potential health consequences of pending decisions and it feeds this information back into the decision-making process.

This book provides a detailed map of the use of HIA in the WHO European Region across a large range of sectors, including transport, environment, urban planning and agriculture, and at national, regional and local levels. It also reviews the implementation and institutionalization of HIA with specific focus on governance, financing, resource generation and delivery. HIA's effectiveness is explored and analysed in 17 case studies, as well as the factors that contribute to the effectiveness of HIA. Overall the book demonstrates that HIA can be effective, while also revealing the uneven development and incomplete institutionalization of HIA across Europe.

Ensuring value for money in health care: the role of health technology assessment in the European Union



This is a detailed review of the role of health technology assessment (HTA) in the European Union. It examines both method and process in the prioritization and financing of modern health care, and presents extensive case studies from Sweden, the Netherlands, Finland, France, Germany and the United Kingdom. The book puts a particular emphasis on the responsibility and membership of HTA bodies, assessment procedures and methods, the application of HTA evidence to decision-making, and the dissemination and implementation of findings. It aims to highlight ways to improve the HTA process in Europe by examining key challenges and identifying opportunities to support value and innovation in health care.

Plan to Stop TB in 18 High-priority Countries in the WHO European Region, 2007–2015

Tuberculosis (TB) remains an important public health problem worldwide and in the WHO European Region. The high incidence of TB in many countries in the Region, the high level of multidrug-resistant TB, the appearance of extensive drug-resistant TB, the TB outbreaks in the growing pool of people living with HIV and the large population in prisons, and the increasing mobility of people, make TB a regional emergency that calls for effective Region-wide control. The Plan describes the main challenges, strategies and interventions to control TB in the 18 high-priority countries in the European Region: Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, the Republic of Moldova, Romania, the Russian Federation, Tajikistan, Turkey, Turkmenistan, Ukraine and Uzbekistan. The Plan aims to reduce illness and death caused by TB, while contributing to poverty reduction, by:

- achieving, sustaining and exceeding the targets of 70% detection of sputum-smear positive cases and 85% treatment success rate; and
- ensuring universal access to high-quality care for all people with TB, especially the poor and marginalized.

The Plan is intended to be a guide for the high-priority countries to use in developing their own long- and short-term national plans on TB, and a reference for the WHO Regional Office for Europe and all other partners involved in fighting the disease.

Heat–health action plans

Climate change is leading to an increase in extreme weather events, including heat-waves. Heat-related mortality has grown following recent heat-waves in Europe, but the adverse health effects of hot weather and heat-waves are largely preventable. Prevention requires a portfolio of actions at different levels, including meteorological early warning systems, timely public and medical advice, improvements to housing and urban planning and ensuring that health care and social systems are ready to act. These actions can be integrated into a heat–health action plan.

"Heat-health action plans" is a guidance book that explains the importance of the development of heat–health action plans, their characteristics and core elements, with examples from several European countries.

Member States are invited to consult this guidance to develop or improve heat–health action plans tailored to their individual system and context.