WHO STRATEGIC OBJECTIVE 10: “To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research”

Strategic Objective 10 covers two divisions: the Division of Health Systems and Public Health, and the Division of Health Information, Evidence, Research and Innovation.
We aim for healthier populations and improved and more responsive health systems, and these objectives will be at the core of Health 2020

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Introduction

Strengthening health systems and public health services is at the core of WHO’s work with countries and with the regional and global health community. In the WHO European Region, Member States committed to strengthening health systems for better health and wealth by signing the Tallinn Charter in June 2008.

The health landscape has changed. The financial crisis has prompted policy-makers to scrutinize health expenditures, while at the same time they face a rise in non communicable and chronic diseases, coupled with renewed challenges in communicable disease control, increasingly ageing populations and rapid technological advances. These are among many factors putting pressure on health systems and highlighting once again the need for comprehensive planning and response.

An effective response requires a systemic approach that encompasses not only action to enhance health care services but also - and as importantly - measures on disease prevention, healthy lifestyles, and the social determinants of health. For the most efficient use of scarce resources it is vital that preventive measures take a more prominent role than before, strengthening the public health elements of health systems, and promoting and advancing health in all policies.

Fragmented health systems will struggle to do this. However if all parts of a health system work in synergy and foster efficiency, there is more chance of reaching the health system goals of better health and more equity, where systems and services are responsive to the needs of the population, where financial contributions are fairly distributed and people protected against financial risk.

The WHO Regional Office for Europe supports Member States in developing such synergies through a variety of means including support to national policy frameworks, and the various key aspects of health systems such as governance, public health services, health financing, human resource, primary health care, information systems, research and quality assurance.
Executive summary

The Health systems financing programme supports Member States in improving the financing of their health systems and through this, overall health system performance. The programme is based at the WHO Barcelona Office for Health Systems Strengthening, and promotes improving health systems through the application of a results-oriented approach. This enables the transformation of WHO’s core values into practical tools for the diagnosis and development of health financing policy.

The Public health services programme works with countries to put public health high on the political agenda, and to support them as they identify the strengths and weaknesses of their public health services, the better to target investment and reform. It develops tools and products to streamline, strengthen and upgrade public health services, taking a comprehensive horizontal approach to inform decision making across the many vertical areas of public health.

The Primary health care programme supports countries to generate evidence for policy development in primary care, so that strategic information on primary care organization can underpin a good primary care system – one that is comprehensive, accessible, coordinated, and ensures continuity. It offers a structured overview of the strengths and weaknesses of a country’s primary care services, including the voices of the professionals and patients concerned, and interested professionals, policy-makers and stakeholders.

The Governance programme supports countries in developing a vision for health, and builds national capacities to realize that vision, assisting in national health planning and health reforms. In its strategy to promote good governance in health, WHO/Europe guides governments towards system-wide, evidence-based approaches, facilitates links and partnerships between stakeholders, and promotes the inclusion of health in all policies.

The Health workforce programme works with countries to ensure an available, competent, responsive and productive health workforce in order to improve health outcomes. This covers key technical areas such as health workforce governance and planning, migration and retention, and education and training. Building on the recent momentum on this issue, the programme assists countries in the development of national health workforce policies and strategies.

The Health care quality programme supports Member States in improving the quality of health care, of which patient safety is a crucial part. This involves developing active networks of patients and providers; sharing experiences; learning from failure and pro-active risk assessment; facilitating effective evidence-based care; using framework interventions, and activities on specific technical areas with tools such as hospital performance assessment.

The Division of Information, Evidence, Research and Innovation houses or has direct access to essential databases providing authoritative health data from the 53 countries in the Region. It provides regular summaries of health statistics across Europe. It also supports countries in the establishment, enhancement and evaluation of integrated and effective health information systems, and works with international partners to ensure the standardization, international comparability and quality of health data. The Division also provides tools and capacity building initiatives for the translation of scientific evidence into policy, engages in knowledge management and dissemination and advised on e-health and innovation.
Health systems financing

The health systems financing programme works at country, Regional and global levels, drawing on the expertise and experience of its staff and bringing together current and former health financing implementers and experts in the field.

Challenges

Countries face difficult challenges and choices in financing their health systems. New medicines and other technological developments, rising expectations and ageing populations all fuel increased demand for health care and hence put upward pressure on system costs. Concurrently, macroeconomic, demographic, and fiscal constraints limit the extent to which governments can simply allocate more public revenues for health. This combination, of upward pressure on costs and limitations on spending, forces countries to consider reforms to the way that their health systems are financed.

There is significant diversity in health spending patterns across the European Region, reflected in wide variation in the benefits enjoyed by populations, and in the

Government health spending and dependence on out-of-pocket payments, European Member States 2008

Source: WHO European Health for All database
attainment of health system objectives. Approximately a third of the countries spend less than $500 per person per year; another third spend between $500 and $1000; and the remaining third spend over $1000. Similarly, the public–private mix of health spending also varies across the Region, with private payments accounting for between 12% and 78% of total health national health expenditures.

What WHO Regional Office for Europe is doing

While the countries in the European Region may share underlying core values and agree on the broad goals of health systems, they are very diverse. This diversity extends to fiscal capacity, health spending patterns, and the mix of mechanisms they use to finance their health systems. Recognizing this, WHO tailors its financing policy advice to fit the particular needs of each country, while sharing generic lessons from design and implementation of health financing policies from across the Region. Our approach of providing policy guidance to Member States entails three major steps:

- articulation of health finance policy objectives;
- analysis of functions and institutions of the health financing system in achieving these objectives; and
- recognition of the way in which key contextual factors, particularly fiscal constraints, affect a country’s ability to attain policy objectives or implement certain types of reforms.

Hence, while our approach is firmly rooted in a common set of values and objectives, it enables analysis and recommendations that are country-specific and realistic.

Country example: Republic of Moldova

In 2004, the Republic of Moldova introduced a system of national health insurance under which general tax and payroll tax were transferred into a single national pool of funds. This new arrangement maximized the potential for risk-sharing and solidarity through a single payer, and made allocations more equitable due to the introduction of new provider payment mechanisms. However, non-contributing families, who formed around one-quarter of the population, were left with limited access to services. Subsequent legislation in 2009, following recommendations made by WHO, addressed this issue by making primary health care universal for all citizens irrespective of their health insurance status. In addition, compliance amongst small businesses was improved and the premium was made fairer for those who self-insure. New policies which improve the targeting of government health insurance subsidies are also being considered.
Practical support

The programme offers countries many different kinds of support.

- We lead policy dialogues to inform and influence decision-making and build consensus on addressing health financing challenges. High profile policy dialogues were held recently with senior government officials and other stakeholders in Bulgaria, Estonia and Latvia on reform options in the context of the economic crisis; others were held in Kyrgyzstan, the Republic of Moldova and Serbia on reforms to improve risk protection afforded by their national health insurance agencies.

- We contribute to capacity building and institutional development for health financing policy analysis, and improving the links between evidence and the policy process. We work closely with policy analysis units in several Member States, such as Kyrgyzstan, the Republic of Moldova and Tajikistan. Our dialogue and analytic work with countries takes a problem-solving approach to policy development that incorporates institutional capacity building, seeking opportunities for hands-on learning that enables countries to better address both current and future health policy needs and demands.

- We contribute to structured cross-country learning and good practice dissemination among Member States. This is supported by state-of-the art expertise using our Health Financing Policy Paper Series, our recently published book Implementing Health Financing Reform: Lessons from Countries in Transition, and other cross-country comparative studies. For example, the Spanish health authorities and their stakeholders have synthesized and analysed their 30 years of experience with different models of health service purchasing in a

What additional progress can be achieved with more resources?

- The recent financial crisis has highlighted the fragility of health financing arrangements in many countries, and thus working towards greater financial sustainability will be a key work area.
- Many countries continue to struggle with providing universal coverage due to limited resources, low priorities afforded to the health sector in the allocation of public budgets, and an incentive environment that does not promote efficiency in the organization and delivery of services. We will continue to support Member States to move towards and sustain universal coverage.
- Particular attention will be paid to the intersection of health systems, and health financing arrangements in particular, with the delivery of health improving interventions such as for noncommunicable diseases and multidrug-resistant tuberculosis.
Global strategies tailored for the WHO European Region

The WHO Regional Office for Europe contributes to global processes on health systems and health financing and in turn tailors these processes, tools, and outputs to Regional country needs. This is exemplified by our engagement with colleagues globally in the production of the World Health Report 2010 Health Systems Financing: the Path to Universal Coverage. This report is now a key instrument in our policy dialogue with Member States, as it provides a clear statement of broad goals underlined by core values. It is also not a blueprint: while the broad goals are clear, we engage with Member States to tailor responses to their own specific context.
Public health services

Public health services are defined as the “goods, services, facilities and activities that are designated to promote health, prolong life and prevent diseases within the health sector” and they are distinct from other parts of the health sector. Their main emphasis is on protecting health, promoting health and preventing disease and they focus on the health of entire populations, rather than on that of individuals.

Public health services are very broad and are delivered at all levels of the health system and by many sectors in society. They include services in:
- health protection, such as environmental health, food safety, and occupational health;
- disease prevention, including communicable and noncommunicable disease surveillance and control;
- disaster preparedness and response; and
- health promotion.

Public health services also inform decision-making across the broad range of vertical areas of public health, such as health information systems, population health information and surveillance, health impact assessment, approaches and policies in the area of health inequalities, tackling social and health determinants, the inter-sectoral dimensions of pro-health policies, dissemination of best practice and sharing of knowledge.

Challenges

There is a lack of a comprehensive, horizontal evaluation of the state of public health services in European countries that can facilitate appropriate policy making, resource allocation and strategies for reform, to improve performance of the structures and services of public health.

The political, social and economic transition that has occurred in Europe since 1990 has had severe implications for the health systems of many countries. The last two European Health Reports show the great discrepancies and inequalities in the status of the populations’ health throughout the Region.

Many countries of central and eastern Europe still have inadequate public health services. There remains a lack of a comprehensive and common understanding of what constitutes public health and public health services.

Progress with tackling social and health determinants and the main risk factors remains unsatisfactory. There needs to be a clearer grasp of the importance and cost-effectiveness of public health and public health services in tackling the broad socio-economic determinants of health, including lifestyle issues and risk factors of the environment.

Both individual and population-based public health services need to be further streamlined, strengthened, and upgraded. Their performance need to improve and be more cost-effective.
There is a continuing challenge of non-communicable disease such as cardiovascular disease, cancer, and liver disease, along with new lifestyle-related challenges, including obesity and type II diabetes.

Some countries are seeing a rising incidence of communicable diseases.

While there has been important progress in public health training, public health services have generally been neglected by the reform process and remain under-funded. They are one of the main areas that need to be reformed.

This is at a time when the challenges of public health are multifaceted and some key questions remain to be answered:

Challenges to health and equity: How can we improve the level and distribution of health, wealth and social well-being through health systems and public health policies?

Challenges to societies and health systems: How can we ensure that health systems are sustained in the future?

Challenges to health systems and public health capacities: How can we monitor, manage and improve performance for greater effectiveness and efficiency?
The WHO Regional Office for Europe is stimulating Member States of the Region to prioritize the strengthening of their health systems and public health services, and is committed to help Member States to accomplish this goal.

What WHO Regional Office for Europe is doing

The Public health services programme develops tools and products to support Member States in their efforts to further streamline, strengthen and upgrade their public health services.

For example, in the last four years the WHO Regional Office for Europe has developed and piloted the “Ten essential public health operations”. Together with a web-based self-assessment tool, these form a universal framework for broad-ranging and in-depth assessments of public health services provision. Currently, 17 countries are using the framework, their number increasing steadily, particularly in western Europe and among countries with decentralized health system structures.

Ten essential public health operations

1. Surveillance and assessment of the population’s health and well-being.
2. Identification (assessment, investigation and prediction) of health problems and health hazards in the community.
3. Health protection: technical assessment of needs and actions required to ensure health protection; development and enforcement of laws and regulations that protect health and ensure safety.
4. Preparedness and management of public health emergencies.
6. Health promotion and health education.
7. Initiation, support and carrying out of health related research.
8. Evaluation of the quality and effectiveness of personal and community health services.
9. Assuring a competent public health and personal health care workforce.
10. Initiation, development and planning of public health policy.

The Dubrovnik Pledge signed on 2 September 2001, and brokered by WHO Regional Office for Europe, was the first-ever political document on cross-border health development in south-eastern Europe. It committed the governments of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Republic of Moldova, Serbia and Montenegro (as it then was), Romania and The former Yugoslav Republic of Macedonia to modernizing nine areas of common interest in public health.
WHO Regional Committee for Europe Resolution EUR/RC60/R5 endorsed strengthening public health capacity and services, including prevention, and carrying out a thorough review of the effectiveness of the public health instruments that are currently available, as main avenues for addressing key public health and health policy challenges in Europe.

The programme supports Member States in introducing modern public health concepts and approaches into practice, to increase their public health capacities, to develop national strategies for public health services strengthening and new public health laws, to reform agendas, and to mobilize partners, both domestic and external.

It also facilitates the work of major multi-country initiatives for public health. The South-eastern Europe Health Network, a forum of high-level officials from ministries of health of nine countries in south-eastern Europe is one of them. It was established in 2001 as a regional peace building initiative. For the past ten years, it has been instrumental in promoting development in south-eastern Europe in the areas of mental health, communicable diseases, food safety and nutrition, blood safety, tobacco control, information systems, maternal and neonatal health, public health services and health systems.

WHO also supports other international public health networks such as the International Network of Health Promoting Hospitals and Health Services, which WHO set up in the 90s. Today this network is an international nongovernmental organization, working closely with WHO and helping to disseminate evidence-based implementation and practices through over 800 health promoting hospitals, and networks of health promoting hospitals, and health services in and far beyond Europe.

**What additional progress can be achieved with more resources?**

The programme will significantly contribute to the efforts to decrease the health gap and inequalities in Europe by:

- launching and sustaining a process for defining and developing a common understanding of the concept of public health, its values, definitions, boundaries, functions, services, models of operations, and indicators for performance measurement;
- strengthening the delivery of the Ten Essential Public Health Operations and population-based public health services;
- scaling up preventative health services for primary, secondary prevention of diseases at all levels of the health system;
- introducing and/or scaling up the monitoring and evaluation of public health services performance;
- building capacities and introducing practical and efficient mechanisms for implementing pro-health policies, strategies, actions and interventions for public health by other sectors of society; and
- strengthening the network of existing national schools of public health, and sustaining the public health professional workforce needed to implement reforms and to support the cultural changes for improved public health.

**FOCUS COUNTRIES:** Albania, Armenia, Andorra, Bosnia and Herzegovina, Bulgaria, Croatia, Estonia, Kyrgyzstan, Latvia, Montenegro, Republic of Moldova, Romania, Slovenia, Serbia, Switzerland, Tajikistan, Uzbekistan, The former Yugoslav Republic of Macedonia.
Primary health care is health care received in the community, usually from family doctors, community nurses, staff in local clinics or other health professionals. It is the first-contact care that should be accessible to people when they need it, and by means acceptable to them. Primary health care workers focus on the long-term health of individuals, and they also coordinate the use of specialized health care when needed.

The term primary health care refers to the concept elaborated in the 1978 Declaration of Alma-Ata, which constitutes the central function and main focus of country’s health system, and is based on the principles of equity, participation, intersectoral action, and appropriate technology. The WHO World Health Report “Primary health Care. Now more then ever” (2008) further reaffirmed the role of primary health care in achieving universal coverage, providing people-centered care, pursuing healthy public policies across sectors and calling for an inclusive and participatory leadership.

Ageing populations in the European Region, and the increase of chronic diseases requires important adaptations of the way in which primary health care is organized in many countries.

Challenges

- Citizens and Member States are increasingly impatient with the inability of health services to deliver levels of national coverage that meet the public’s needs and demands, and with the failure to meet expectations or match the investments made.

- This generates a widespread and growing demand for primary health care all over the world, recognizing that strengthening primary care is the way to make health systems more equitable, inclusive and fair.

- The issues of diminishing exclusion and social disparities in health are not yet properly addressed. Very often primary care services are not organized around people’s needs and expectations: they need to be more responsive to the changing world while producing better outcomes.

- Integrating primary care into public health policies means working across sectors, which is another challenge.

- There are important untapped efficiency gains for better integration of primary health care to provide a continuum of care for chronic diseases.
What WHO Regional Office for Europe is doing

- We support Member States in generating evidence for policy development in primary care. Strategic information offers a structured overview of the strengths and weaknesses of a country’s organization of primary care services, including the voice of the professionals and patients concerned, to interested policy-makers and stakeholders.

- With WHO’s support, ten Member States have conducted studies on primary care organization and provision, as well as quality management aspects. Decision-makers in Belarus, Kazakhstan, the Russian Federation, Romania, Serbia, Slovakia, Turkey, Ukraine, Uzbekistan and other countries, developed recommendations for strengthening primary care by using evidence generated by the studies. In Slovenia, the study helped to develop a national strategy on quality management in primary care which paved the way for reforms for the decade to come. In Serbia, the results of the primary care evaluation helped to generate high level support to implement the reform. The interest in applying WHO methodology for primary care evaluation is growing in the region: more countries are planning to conduct similar studies with WHO support.

- We generate data to facilitate international comparisons on primary care performance against explicit indicators, in order to influence Regional and national policies. We are conducting international analyses of primary care evaluations in countries that uses comparable indicators to measure primary care access, continuity, coordination, and comprehensiveness.

What additional progress can be achieved with more resources?

Much more needs to be done to make health promotion and disease prevention a routine task of primary care teams, thus integrating public health action with primary care. This is especially relevant given the increasing burden of chronic conditions and co-morbidities, which calls for improvements to patient pathways across levels of care and across professions.

Although there is common recognition that primary care increases equity in service provision, there is little sound evidence to prove that this is really so. Health inequalities in primary care need to be measured, monitored, and addressed. WHO is currently developing ways in which this can be done together with partners, so as to support Member States in addressing health inequalities in primary care, and improve the prevention and management of noncommunicable diseases, including rehabilitation and care.

For more detailed information of primary health care programme’s support to countries please visit http://www.euro.who.int/country-work
Health governance

“Governance is about how governments and other social organizations interact, how they relate to citizens, and how decisions are taken in a complex world. Thus governance is a process whereby societies or organizations make their important decisions, determine whom they involve in the process and how they render account.”


European Member States and partners have given the WHO Regional Office for Europe a strong and clear mandate to develop a new European health policy – Health 2020 – to address key public health and policy challenges so that Europe can accelerate progress to achieving its health potential by 2020. WHO is working to develop a vision and policy that can be embraced by all stakeholders.

In an increasingly complex environment, health has become the business not only of ministries of health but of a vast range of stakeholders spanning professional organizations, donors, industry, citizens and patients. In particular, governments are becoming increasingly aware of the importance of broad public participation in policy making, and the demand for due consideration for public values, priorities and concerns.

Good governance enhances health system performance through transparency and accountability. Informing policies and programmes by evidence on health system performance and the impact of implemented actions are key instruments of good governance. This was central to the Tallinn Charter on Health System Strengthening. Countries that have achieved a shift in culture towards a more evidence-informed approach to policy have succeeded in establishing a high quality supply of health evidence, for which there is a regular demand by policy makers, and sustainable institutional solutions linking demand and supply.

WHO has proved to be a solid neutral information broker and has recognized expertise in the fields of evidence-to-policy, policy analysis, sector monitoring and health information systems with practical country applications of well tested tools and applications.

Challenges

Many public health problems are not amenable to a hierarchical approach but rely on effective networks and partnerships that lead to integrated policy approaches and are based on a whole-of-government approach with horizontal policy development and implementation mechanisms. Issues related to, for example, health inequalities, transcend the mandate of a single organization or governmental sector, and must be addressed through the consolidated and combined effort of multiple organizations. The regulatory, institutional and funding aspects of moving to a comprehensive approach require further exploration, along with sound evaluation of new mechanisms.

The patient is now empowered, organized and mobile, and takes informed decisions. Health governance must take into account these new characteristics of its key player and ensure the role of the patient on the health stage.
Ministries of health are not always empowered sufficiently to engage in an economic discussion about the contribution of health to the society and the economy. This impacts on the position of health improving policies in the budget discussions. This issue became particularly acute and visible at the time of the recent financial crisis.

Sound evidence and linking it to the policy process is a prerequisite for informed dialogue among stakeholders, formulating a common vision, monitoring reforms, and assigning accountability.

What WHO Regional Office for Europe is doing

In its strategy to promote good governance in health, WHO guides governments towards system-wide, evidence-based approaches, facilitates links and partnerships between stakeholders, and promotes the inclusion of health in all policies. The generation and use of evidence in policy underpins WHO’s activities. WHO supports countries in developing a vision for health, and builds national capacities to realize that vision, assisting in national health planning and health reforms. This entails active policy dialogue where WHO supports Member States to analyse the health needs and aspirations of individuals and communities based on evidence and transparent information sharing and analysis. It also entails a similar effort in assessing policy choices, taking into consideration the institutional, political, economic and social context in which these policies are to be taken forward.

- Supporting development of national health plans and strategies and processes for health system performance assessment (HSPA): recognizing the central role of sound national health plans and related processes, the Regional Office prioritizes support to Member States in this area. In line with this, WHO has supported HSPA and national health plan development in Estonia and Portugal. Technical assistance for HSPA was also provided in Armenia, Azerbaijan, Estonia, Georgia, Kyrgyzstan, Portugal, and Turkey. WHO builds on the wealth of experience in the Region and works for example on the development of practical guides built on case studies. In addition, WHO is compiling a compendium of performance indicators together with indicator passports which identify the definition, functions and key associated issues for selected indicators. This is a useful resource when selecting and interpreting indicators, and discussing policy options.

- Sustaining and building capacity in evidence generation, analysis and use: WHO supports the enhancement of countries’ capacities to gather integrated information and process data, to strengthen policy analysis and evidence uptake. This is a long process, sometimes involving setting up a health policy unit, including current work in four priority countries where this has become the subject of long-term technical assistance, and WHO has, in collaboration with partners, put in place resident policy advisers working closely with the ministries of health. This close relationship has made it easier to work together to demonstrate the use of evidence in making informed decisions, and in conducting high quality policy dialogue with key stakeholders. This in turn fuels further demand for health evidence to strengthen policy analysis capacity.

- Acting as a catalyst for health: WHO supports Ministries in aligning stakeholders and building coalitions and consensus. WHO facilitates the sharing of good practice within and between countries, encouraging policy dialogue, and vigorously advocating the inclusion of health in all policies and intersectoral action. WHO also facilitates sector-wide approaches to incorporate perspectives from all angles of the health scene and supports ministries in mapping the roles of the multitude of players and stakeholders as part of the platform for strategy development.
In Kyrgyzstan now, the monitoring and evaluation unit of the Ministry of Health:

- produces an annual sector monitoring report which is used by all development partners and the government to assess progress towards jointly agreed objectives;
- coordinates an annual plan of policy analysis studies, (usually about ten) which is then contracted out primarily to the Health Policy Analysis Centre, a not-for-profit private organization, but also to other public and private agencies; and
- organizes knowledge translation platforms whereby evidence is channelled to the policy process. This arrangement is the result of ten years of institution building between the Ministry of Health and WHO with the support of the United Kingdom Department of International Development.

Tajikistan

In Tajikistan, WHO worked with the Ministry of Health and partners in the development of a new comprehensive national health strategy, providing direct technical advice on governance, health financing, human resources, infrastructure and pharmaceuticals, social determinants and public health parts of the strategy. WHO has also supported a review of development coordination arrangements between partners and the Ministry. These efforts combined with contributions from other partners have helped create the conditions for the European Commission to consider sector policy support in health – a preferred aid modality when conditions are in line with international commitments.

What additional progress can be achieved with more resources?

The positive experience in bringing evidence closer to Member States’ governance structures has generated increased interest from Member States and the donor community. It is critical to sustain and scale up this impact.

> WHO is increasingly engaging with countries to develop national health plans encouraging a whole-of-government approach to health and equity improvement and to a participatory development process

> WHO, with partners, will work towards empowering Ministries of Health to engage in the economic discussion on investing in health using evidence-based sound arguments. Further, WHO will aim to strengthen the capacity of health ministries to participate in the prioritization of resource allocation decisions, particularly at the time of economic crisis in order to protect the poor and vulnerable.

> WHO will continue to work with Member States to strengthen the link between evidence and policy through supporting production of evidence, organizing creative knowledge translation events, and advising on sound institutional relationships. WHO will initiate a regional network for policy analysis which will provide opportunities to obtain formal technical knowledge and peer-to-peer learning.

> WHO will develop performance assessment tools which will be user friendly, action oriented and built on the countries’ experience. Such a dynamic process supposes a high “maintenance cost” in order to continuously incorporate new evidence and examples of policy uses (and related challenges) so as to continue to inspire with innovation. This will include emerging policy fields such as better coordination of care at the boundary between health and social care.

> International comparisons of health system performance can exert a major influence on national policymakers. Successful initiatives require concerted attention to data availability, validity and comparability. WHO can help support the development of benchmarking networks for formative evaluation.
The health workforce is central to managing and delivering health services. The ability of any health system to perform well in meeting the new health challenges – or achieving the goal of improved and equitable distribution of health outcomes - depends on the availability, skills, knowledge and motivation of health workers.

Human resources form the largest single cost element in any health system – as much as 60 to 80% of total recurrent expenditure. There are also significant additional costs associated with education and training. These costs are strongly linked to how effectively and efficiently health workers are deployed and used. Since health organizations are faced with severely limited resources, it is important for policy-makers and managers to use them well.

Challenges

There is a chronic shortage of health workers. WHO estimates a current global deficit of around 2.3 million health professionals, and the shortage has the potential to deepen in the coming years. Demand for health workers will escalate markedly in all countries, rich and poor. Richer countries face a future of low fertility and large populations of elderly people, which will cause a shift towards chronic and degenerative diseases. Many poorer countries are dealing with infectious diseases and the emergence of chronic illness complicated by the magnitude of the HIV/AIDS epidemics and resistant forms of tuberculosis.

The health workforce is strongly linked to global labour markets. Shortages in richer countries send strong market signals to poorer countries with an inevitable response through increased flows of migrant workers. The exodus of health professionals is jeopardizing the right to health in their countries and represents a major policy challenge for their governments.

In the European Region, the number of health professionals varies widely. Looking at the extremes for example, Finland has 1547.16 nurses per 100 000 people, but Turkey has only 139.7. There are 105.8 midwives per 100 000 people in Azerbaijan but only 4.17 in Slovenia. Greece has 601.05 physicians per 100 000, but Albania 115.36. There is considerable heterogeneity in the geographical distribution and composition (skill mix) of health workers between and within countries in the European Region. There is wide variation in the density of health professionals per 1000 population: ratios between the countries with the lowest and highest numbers are 1:6 for physicians; 1:11 for nurses; 1:25 for midwives and 1:70 for pharmacists.

European health systems are currently undergoing complex transformations at the same time as countries face specific human resources challenges, such as:

Trends in health worker density over the past 20 years in the WHO European Region

Source: WHO European Health for All database
shortages of the right people with the right skills in the right place, particularly nurses;

skill imbalances: the skills of professionals not well matched to the local profile of health needs;

uneven distribution of health workers characterized by urban concentration and rural deficits;

poor working environment: unsupportive management, insufficient social recognition, weak career development, low wages and lack of incentives are common complaints; and

health worker migration: many countries are also concerned with the possible impact of migration of health workers, or are looking to inward migration as a solution to their skills shortage.

What WHO Regional Office for Europe is doing

The Regional Office supports countries in addressing their health workforce challenges in key areas, which include:

- promoting and expanding data on the health workforce, generating evidence for decision-making;
- strengthening governance capacity, policy and strategy development, and health workforce planning;
- education and training of health professionals, and regulation;
- enhancing health workforce performance;
- work on health workforce migration, retention and ethical recruitment; and
- advocacy, resource mobilization, effective partnerships and networking.

Our vision is equitable access for all people to an adequately trained, skilled and supported health workforce to contribute to attaining the highest possible level of health. Our overall strategic objective is to enable Member States to provide equitable access to an adequately educated, skilled and supported health workforce to meet population health needs.

What additional progress can be achieved with more resources?

Adoption of the WHO Global Code of Practice by the 63rd World Health Assembly in May 2010 is a success for Member States and all other interested stakeholders. The Code is the only global framework for international cooperation on health workforce recruitment; it provides key guidance to Member States on internationally-accepted ethical norms and principles related to health workforce migration. The Code should make a strong and ongoing contribution to addressing the global health workforce crisis.

The Code gives a central role to Member States and to other stakeholders for implementation. WHO has the key role and responsibility to further support the implementation of the Code. It will work in partnership not only with Member States but also with international organizations and partnerships such as the Global Health Workforce Alliance (GHWA), professional and non-professional organizations and other relevant stakeholders to achieve commitment and action on the Code. It will also be essential to strengthen synergies within WHO, global, regional and country offices.

Resource mobilization will be crucial for the Code’s successful realization given that the resources currently available are insufficient. The recent adoption of the Code should therefore be viewed as a very good opportunity to make a difference.

For more information, see http://www.euro.who.int/bloodsafety
Health care quality

WHO is committed to enhancing the quality of health care, and patient safety is a crucial element of that quality. The simplest definition of patient safety is the prevention of errors and of adverse effects to patients associated with health care. To do this effectively encompasses sharing experiences; facilitating effective evidence-based care; promoting best practices and building capacities; learning from failure and pro-active risk assessment; monitoring improvement; developing active networks of patients and providers; and empowering and educating patients and the public as partners in the process of care. Access to safe blood transfusion services is seen as matter of health security and is an important part of the patient safety wider agenda.

Political commitment

European Member States gave political endorsement to systemic approaches to health promotion, disease prevention and quality of care and patient safety in a dedicated World Health Assembly (WHA) resolution in 2004 and the Tallinn Charter on Health System Strengthening for Health and Wealth in 2008. Recently, the WHA also endorsed a new resolution addressing blood transfusion services (in 2010). Work in this area will help in the achievement of the Millennium Development Goals. It will also have a direct impact on public health policies, interventions and health outcomes, reflected in the new Health 2020 strategy for Europe.

Challenges

- Health care has become more complex, treating older patients with often significant co-morbidities.
- Increasing economic pressure in a diverse environment often shifts priorities, driven by agendas which go beyond health care.
- Safety failures are usually the result of convergence of weak legal and regulatory oversight of health service delivery, inappropriate infrastructure, outdated or overused technologies, insufficiently distributed and trained health care personnel, and uninformed patients/consumers.
- European data, mostly available for Member States in the European Union, consistently show that medical errors and healthcare-related adverse events occur between 8% and 12% of hospitalizations¹. Healthcare associated infections affect an estimated one in twenty hospital patients on average every year. In addition these are often difficult to treat due to antimicrobial resistance of the causative microorganisms. The United Kingdom National Audit Office has estimated the cost of hospital associated infections at £1 billion per year².
- The Eurobarometer on medical error in 2006 found that 23% of Europeans consider to have been directly affected by failure in health care. Almost all respondents (98%) felt that national political support for patient safety was of high importance for good quality health service delivery. The 2010 Eurobarometer on patient safety and quality of care showed a limited knowledge among the general public about what role consumers/patients could play in reducing the potential failures.

¹ Room for improvement; Strong patient safety systems could limit health, social and economic harms from medical error. RAND Europe:. http://www.rand.org/pubs/research_briefs/2009/RAND_RB9472.pdf
The modelling prepared by RAND research in their report for the European Commission estimated that strategies to reduce the rate of adverse events in the European Union alone would prevent more than 750,000 harmful medical errors per year, leading in turn to the reduction of over 3.2 million days of hospitalization, 260,000 fewer incidents of permanent disability, and 95,000 fewer deaths per year. Evidence on medical errors shows that around 50% of such harm can be prevented, but this requires comprehensive systematic approaches to patient safety.

Increasing cross-border movement and the changing epidemiological background reflect directly on the demand for, and equitable access to, safe blood transfusion services. The availability of safe and reliable blood supplies is part of the patient safety agenda, and the wide variation across the region in blood donation rates (from 0.4 to 6.5 per 100 population) as well as safety practices in blood production and transfusion use, needs immediate attention.

What WHO Regional Office for Europe is doing

The Regional Office supports its Member States through various activities in the field of patient safety and quality of care, using both framework interventions as well as activities focused on specific technical areas of work, such as blood safety.

The health systems of the WHO European Region’s 53 Member States are very diverse. The costs of patient safety, of both a human and financial nature, require a comprehensive response to increase the performance, quality and efficiency of health care, preventing adverse events, making them visible and mitigating their effects when they occur.

A culture of safety is an integral component of the quality of health care, raising awareness and increasing confidence in the system, and overcoming barriers generated by low investment. This lack of investment may be in system redesign, limited use of information technology or inadequately resourced or competent staff. Patient empowerment and the availability of general information related to health are shown to enhance the improved performance of health care and increase satisfaction. WHO tackles quality of care issues at Regional level and with selected target countries based on nationally agreed priorities, through:

- advocacy and policy advice for integrated approaches to patient safety, including blood safety;
- dissemination and promotion of quality and safety interventions with emphasis on patient safety (safety of patients, health-care workers, products, medical facilities and environment);
- evaluation of quality monitoring mechanisms in health care, with emphasis on reporting and learning systems and patient empowerment;
- capacity building in patient safety education and research, including quality management for blood services and bio-safety;
- promotion of quality of care initiatives for chronic care management, including better coordination of care for people with functional limitation; and
- patient education and health care consumer health literacy, fostering civil society involvement.
What additional progress can be achieved with more resources?

The European Health 2020 strategy will encourage patient-centred approaches that value and promote citizen participation and community empowerment with a stronger focus on public health. Activities in the field of patient safety, including blood safety, are directed towards promoting, disseminating and supporting wider implementation of patient safety solutions and challenges, such as clean care/ hand hygiene and safe surgery.

WHO will support development of technical tools, addressing also social and legal related aspects. Currently research is planned around the enhancing the role of the patient in reducing safety risks within three priority themes of

- blood transfusion;
- hospital infections and hand hygiene; and
- communication during patient handovers.

This is expected to provide the basis and inspiration for further addressing safety as a shared responsibility, with the patient as co-producer of health reflecting a proactive approach in health promotion, protection and care. In addition, WHO will support and contribute to, the quality of care movement that aims to increase the efficiency and effectiveness of care coordination for people with chronic diseases.

Performance assessment tool for quality improvement in hospitals (PATH)

PATH is a performance assessment system designed by WHO to support hospitals in defining quality improvement strategies, questioning their own results and translating them into action for improvement. Starting with performance measurement, PATH encourages hospitals to learn about their strengths and weaknesses and initiate improvement activities. To reach their strategic goals, hospitals need an integrated system to monitor progress against a set of performance indicators linked to these goals and this is what PATH provides. It also focuses on the interpretation of results within the strategic local context of each hospital as well as within the hospital network, especially at country level. PATH also offers an opportunity for international benchmarking based on, for example, hospitals’ specialties, types or geographical locations. PATH helps hospitals identify best practices in the field through a network of hospitals as it facilitates contacts between the participants (both hospitals and providers) in order to initiate learning activities.
Health systems and multidrug resistant and extensively drug-resistant tuberculosis (MDR-TB and XDR-TB)

The rates of MDR-TB throughout the Region remain very alarming. The proportion of MDR among new TB cases and previously treated TB patients in 2009 was 11.1% and 36.7% respectively. Many countries in the Region have reported extensively drug-resistant TB (XDR-TB). Despite the still very low coverage of drug susceptibility testing on second-line drugs in countries that are not in the European Union (EU) or the European Economic Area (EEA), the total number of such patients with extensively drug-resistant TB (XDR-TB) notified in the Region almost tripled from 132 in 2008 to 344 in 2009. The vast majority of them (80%) were notified in the non-EU/EEA sub-region.

In 2009, from an estimated 81 000 MDR-TB patients, only 27 760 cases (34.2%) were notified due to the low availability of bacteriological culture and drug susceptibility testing or molecular methodologies (Table 1). From this number of MDR-TB patients, only 36.4% (10 107 patients) received adequate treatment with quality second-line drugs (SLD). In order to diagnose the extensively drug resistant TB (XDR-TB), there is a need to have access to second line drug susceptibility testing which is not readily available for all patients. Despite this, the total number of notified XDR-TB patients almost tripled from 132 in 2008 to 344 in 2009. This number decreased in EU/EEA countries (from 91 to 66), where diagnosis services for identifying resistance to SLD are believed to be available for all MDR-TB patients. This is while XDR-TB notification increased by 6.7 times in non-EU/EEA (from 41 to 278) where such services are extremely limited.

Many of the reasons for the WHO European Region lagging behind in the attainment of the Millennium Development Goals and for the increase in M/XDR-TB lie far beyond the authority and capacity of the national TB programmes. They can be successfully addressed through an integrated health systems approach and may require changes that involve the “macro-design” of health systems.

1 The 30 EU and EEA countries are: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom. The 24 countries in the rest of the European Region (non-EU/EEA) are: Albania, Andorra, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Croatia, Georgia, Israel, Kazakhstan, Kyrgyzstan, the former Yugoslav Republic of Macedonia, Moldova, Monaco, Montenegro, Russia, San Marino, Serbia, Switzerland, Tajikistan, Turkey, Turkmenistan, Ukraine and Uzbekistan.
Active involvement of the primary health care sector in TB control seems to be an essential prerequisite for earlier case finding, prompt diagnosis and ensuring treatment adherence. The primary health care provider can and should carry out a variety of tasks and contribute to the decisive progress in TB case detection, case management and follow-up, prevention and health education. Comprehensive coverage of TB control interventions in the basic benefit’s packages would be an important step forward. Together with a health system strengthening approach, TB and M/XDR-TB must be tackled by addressing the broader socio-economic determinants of health.

For the above reasons, the WHO Regional Director for Europe, supported by the 53 Member States at the 60th Regional Committee for Europe in Moscow, 2010, decided:

1. To make M/XDR-TB a Regional priority and the Regional Director’s Special project,

2. To develop the Consolidated Action Plan to Prevent and Combat Multidrug and Extensively-drug resistance tuberculosis (TB) in WHO European Region 2011-2015 as a roadmap to strengthen and intensify efforts to address the alarming problem of drug resistant TB in the Region,

3. To link, within the Regional Office, the TB & M/XDR-TB Programme with the Division of Health Systems and Public Health.

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3 5738 in non-EU/EEA under GLC projects and 4368 in the EU/EEA countries assuming a 100% access to the proper treatment.
Health evidence, research and information

The recently established Division of Information, Evidence, Research and Innovation provides regular summaries of health statistics across Europe and also supports countries in the establishment, enhancement and evaluation of integrated and effective health information systems.

Challenges

Policy-makers in all countries require evidence-based information to make rational choices for health intervention and prevention efforts at national level. Past experience has shown that the uptake of research results through policy makers is based on numerous factors, including the availability, usability and reliability of health information. Much of the information collated, however, cannot be directly translated into policy. Health data from routine statistics or epidemiological studies are not available in all countries in Europe. Where they do exist, they are often fragmented, frequently concentrate on fatal health outcomes, or may only be partially available. Studies which investigate particular conditions may exaggerate claims on mortality. This is largely a reflection of co-morbidity where several co-existing pathologies contribute to and compete for the cause of death.

What additional progress can be achieved with more resources?

Together with its partners, WHO aims to make further progress in the following areas:
> development of high coverage and high quality health information systems in all European countries;
> ensuring that policies affecting health across Europe are informed by solid scientific evidence; and
> integration of the generation, dissemination and management of health information knowledge;

The Regional Office contributes to global processes on health information, evidence and research through a number of initiatives. We collaborate closely with colleagues in WHO headquarters on the annual health statistics, and have taken the lead on providing an innovative Atlas on Inequalities in Health. We contribute to the Global Guidelines Review Committee, the Global Advisory Committee on Health Research and work closely with WHO headquarters on the implementation of tools and capacity building in the area of translation of evidence into policy.
Moreover, traditional statistics use a variety of different measures, which do not permit direct comparisons of the cost-effectiveness of different interventions.

Countries are looking towards WHO to advise on mechanisms, tools and strategies to establish health information systems which—ideally—also permit comparisons across countries and regions. The availability of reliable health information, however, is not sufficient to ensure the translation of evidence into policy. This process is influenced by many factors, including opinions, national networks, political considerations, and financial constraints.

**What WHO Regional Office for Europe is doing**

WHO works with countries to maximise the process of evidence-informed policy making through its Health Evidence Network which provides policy briefs for a variety of different policy questions.

The Division which also houses the translation, knowledge management and dissemination units of the Regional Office aims to ensure that knowledge generation, translation and integration into policy are consistently linked. The Division is planning to step up its support for countries in the following areas of health information:

- the development of a comprehensive health information strategy for Europe;
- the establishment of a Europe-wide integrated health information system in partnership with the European Commission;
- a full review and streamlining of all existing health databases in the Regional Office;
- the provision of tools and networks for countries to enhance evidence-informed policy making by establishing the network of knowledge translation (EVIPNet) in Europe; and
- the elaboration of a knowledge management strategy for Europe.
Partnerships for health at key stages of people’s lives

Collaboration with stakeholders is at the heart of the work of the WHO Regional Office for Europe. The ultimate focus of WHO partnerships is to add value and maximize support to Member States, at Regional and country level. All these programmes have established long-standing collaboration with institutions of the European Union, international organizations, other United Nations agencies, nongovernmental organizations and foundations, and continue to explore opportunities for new strategic partnerships, based on shared health values and objectives.

To date, key partnerships include:

- Council of Europe http://www.coe.int/
- International Organization for Migration http://www.contraception-esc.com/
- Global Fund to Fight AIDS, Tuberculosis and Malaria http://www.theglobalfund.org
- The GAVI Alliance: (http://www.gavialliance.org/)
- UNICEF (http://www.unicef.org/)
- World Federation of Medical Education http://www3.sund.ku.dk/wfme/
- Global Health Workforce Alliance http://www.who.int/workforcealliance/en/
- European Forum for National Nursing and Midwifery Associations
- European Forum for primary Care http://www.euprimarycare.org/
- European Centre for Disease Prevention and Control http://www.ecdc.europa.eu
- Organisation for Economic Co-operation and Development (OECD) www.oecd.org
- European Investment Bank www.eib.org
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WHO’s Strategic objectives

With a specific focus on inequalities, social determinants of health and health in all policies, 2020 provides a European platform for achieving the 11 Strategic Objectives which frame the work of WHO in the European Region.

Briefings are available in each of the Strategic Objective areas:

1. Reduce the health, social and economic burden of communicable diseases.
2. Combat HIV/AIDS, tuberculosis and malaria.
3. Prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.
4. Reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.
5. Reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.
6. Promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.
7. Address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.
8. Promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.
9. Improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development.
10. Improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.
11. Ensure improved access, quality and use of medical products and technologies.