First meeting of the European Health Policy Forum
for High-Level Government Officials
Andorra la Vella, Andorra
9–11 March 2011

Developing the new European policy for health – Health 2020

The attached concept paper on the new European health policy – Health 2020 has been prepared as a discussion document, with proposals on a number of key issues on the scope, form and content of Health 2020, including an annotated outline. It also offers proposals for country involvement and partnerships for Health 2020.

Earlier versions of this document provided the basis for extensive discussions and input from Regional Office staff, and framed the discussions of the external advisory steering group for Health 2020 and academic groups established to provide key evidence to inform Health 2020.

Three meetings, to be held on the first day of the European Health Policy Forum for High-Level Government Officials in Andorra on 9 March 2011, will be devoted to discussing the overall scope and vision of Health 2020; the key issue of governance for health in the 21st century linked to intersectoral action and health in all policies; and options for engaging Member States in the Health 2020 process.

Participants will be encouraged to share their experiences and expectations and consider how Health 2020 can contribute to their efforts to address current and future health challenges.

In this context participants will have the opportunity to consider:

- how this new policy can best capture and address the major global and European trends and drivers that influence health;
- the importance of adopting a “whole of government” approach to governance for health and health equity and a strengthened capacity of ministries of health to lead intersectoral policy processes and advocate for health equity in all policies; and
- the need to create a movement for health and wellbeing, inspired by Health 2020, through a truly participatory process that will engage and connect with decision-makers and professionals at all levels, as well as with civil society.
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Background

1. In September 2010, the sixtieth session of the Regional Committee for Europe (RC60) called for the development of a new European policy for health – Health 2020 –and for public health capacities and services in Europe to be strengthened. It further recalled the progress made in health policy made past initiatives and requested that the Regional Director maintain a commitment to strengthening health systems, renewing commitment to public health capacity and working hand in hand with Member States to support their development of comprehensive national health policies and plans.

2. The Regional Director for Europe put forward her vision for better health in Europe and identified several strategic priorities for its implementation. One such priority is related to strengthening the policy-making role of the Regional Committee, and achieving greater interaction with Member States in the development of major initiatives. The European Health Policy Forum for High-Level Government Officials has been established to meet this need.

3. In this first meeting of the Forum, the following basic aims relating to Health 2020 are to be achieved:
   - consultation on the scope, overall purpose, key objectives and content of Health 2020; and
   - discussion on options for partnership between Members States and the World Health Organization Regional Office for Europe to advance the Health 2020 policy.

4. The present document is divided into four sections, reflecting the above aims and providing the necessary background information for those discussions. The document also poses a number of questions to be discussed during the meeting. Participants will also be encouraged to raise other issues that their experience suggests will be important for health policy development during the coming decade.
Section I. Proposed scope, form and content of Health 2020

Introduction

5. Health is not only an important component of human well-being, but is also critical for modern societies and their economies. Health 2020 comes in response to the need to re-examine the kind of governance mechanisms and instruments that can improve health policy and deliver health outcomes in an equitable and sustainable manner and to consider how priorities are set and strategic goals are implemented. A number of overarching trends have emerged over recent decades, which require innovative responses from all stakeholders.

6. Participants in the Andorra meeting will be asked to consider in particular:
   - the challenges and opportunities for closing health gaps
   - the essential factors for achieving a whole-of-government approach
   - the proposed annotated outline and content of Health 2020
   - the values and principles on which Health 2020 should be based.

7. The participants’ national experiences will be extremely valuable at this initial stage in formulating the new health policy for Europe.

8. The intention is to reach consensus on the main strategic strands and key elements of Health 2020 based on a series of evidence-gathering and analytical exercises, including: studies on the social determinants of health and the health divide and on governance for health; an analysis of key trends and country experiences; and the outcomes of consultations with Member States and stakeholder constituencies in countries and at the level of the European Region.

9. In the context of formulating and adopting Health 2020, three papers will be presented for discussion during RC61:
   - a first draft of the European Policy for Health – Health 2020
   - a paper on European Social Determinants and Health Divide Review
   - a study on governance for health in the 21st century.

10. A fourth paper on strengthening public health capacities and services in Europe: A framework for action, which will be closely linked to the Health 2020 white paper, will also be presented at RC61.

11. The draft Health 2020 document (about 40–50 pages long) will be linked to a resolution. The white paper will inform a series of political debates at RC61. The final Health 2020 policy will be launched at RC62 in Valetta, Malta in September 2012.
Scope and purpose

12. Health 2020 is intended to be inspiring, challenging and practical. It should achieve three things.
   • It should bring together and interconnect new evidence on population health and its determinants, on promising and appropriate governance solutions and on effective interventions for better health, equity and well-being.
   • It should provide a unifying and overarching value-based policy framework for health development, along with strategic goals, realistic but challenging targets and the tools for monitoring, planning and implementation.
   • It should be relevant to low-income, medium-income and high-income countries in the Region and offer practical ways to address current and emerging public health challenges.

13. Given the very different conditions in the 53 Member States, Health 2020 will provide a framework for action to accelerate the attainment of better health and well-being for all, adaptable to the different realities in the Region.

14. The Health 2020 development process will address the following six questions:
   a. Which types of policy and intervention would make the biggest difference to the health and well-being of the people of the Region?
   b. What opportunities and types of innovations hold the greatest promise?
   c. How can we prepare for the next 10 years?
   d. How can we accelerate action to reduce inequalities?
   e. What is important for countries and how can the WHO Regional Office for Europe support decision-makers in their efforts to achieve better health and well-being for their people?
   f. How can the Regional Office and Member States join forces and work with international partners in the European Region within a unifying and coherent policy framework?

Please comment.

Strategic approach

15. It is important, from the beginning, to identify the essential ingredients of a forward looking basis for health policy and public health action, including the main concepts, approaches and strategies to be used.

16. These include:
   a. agreement on key values;
   b. recognition of the new policy environment, including key drivers of change, dominant concerns, windows of opportunity for action;
   c. focus on determinants of health, health in all policies, intersectoral or whole-of-government approaches;
   d. recognition of the local global interface and global and regional interdependencies;
e. greater recognition of the economic dynamics of investing in health, and the consequences of no action;
f. recognition of the added value given by setting strategic goals, targets and defining indicators for desired health, social and economic outcomes; and
g. recognition of the need to move towards:
   i) comprehensive, integrated and sustainable approaches;
   ii) population-based public health, including mental health;
   iii) patient-centred health services focusing on equity in access, performance and outcomes, disease prevention, chronic disease management;
   iv) life-course and gender perspectives, and vulnerability pathways;
   v) evidence-based interventions.

Please comment.

Values

17. Health 2020 will be governed by values that WHO Member States have repeatedly endorsed over the years. The time has come to ensure that these values are not merely given lip service but rather that they firmly underpin government policy at all levels, as well as action in the public and private sectors and in civil society.

18. The suggested core values (of the policy itself and of the process for formulating it) include:
   • universality of the right to health and health care;
   • equity;
   • solidarity;
   • sustainability;
   • the right to participate in decision-making relating to personal health and the health of the society in which people live; and
   • dignity.

Do you consider that these core values appropriately reflect the most important values for Europe today and in the future?

The vision for Health 2020

19. “Our vision is for a WHO European Region where all people are enabled and supported in achieving their full health potential and well-being, and in which countries, individually and jointly, work towards reducing inequalities in health within the Region and beyond.”

Please comment.
Guiding principles

20. The new European health policy, Health 2020, will set out an action framework to accelerate the attainment of better health and wellbeing for all, adaptable to the different realities in the WHO European Region.

21. Health 2020 should be guided, however, by the following principles common to all:

• to strengthen commitment to common values
• to reduce the health gap between countries in the Region
• to improve cooperation on major health challenges faced throughout the Region.

22. Several principles should be considered when embarking on policies within countries.

• Information and knowledge systems should adequately reflect possible inequalities in health and their causes.
• Policies for health and health care should be based on the best available evidence.
• Alliances and common platforms for research, capacity-building and learning exchanges should be strengthened.
• Coherence and cooperation between different levels of government, across sectors and disciplines, and between professionals and laypeople should be strengthened to break down the present silo mentality.
• Health system performance should be enhanced to ensure equal access to care for equal need and appropriate patient-centred care with a particular emphasis on patient participation and dignity.

Do you agree that these should be the main guiding principles for Health 2020? Have other important principles been omitted?

Goals

23. The following are proposed as the main goals of Health 2020 as a common effort of all Member States (grouped as follows):

• to work together: first and foremost Health 2020 aims to harness the joint strength of the WHO Regional Office for Europe, together with its Member States, to further promote health in the Region though joint action between Member States and action within each and every country;
• to create better health: the ultimate goal of the policy is to further increase the number of years in which people live in health (healthy life-years), to reduce the health inequities in the region and to deal with the impact of demographic changes;
• to improve health governance: the policy aims to illustrate how the drivers of change may affect health, and to consider health itself as a driver of change by ensuring that key actors and decision-makers in all sectors are aware of their responsibility for health and their potential role in health promotion and protection;
• to set common strategic goals: the policy will set strategic goals to promote and support the development of policies and strategies in countries, at the appropriate level, to give stakeholders and potential partners a clear map of the way forward. These goals will also raise awareness of the vital importance of health not only for human well-being but also for social and economic development and the future of coming generations;
• to accelerate knowledge sharing: Health 2020 aims to increase the knowledge base for developing health policy by enhancing the capacity of health and other professionals to adapt to the new approach to public health and the demands of patient-oriented health care in an ageing and multicultural society; and

• to increase participation: the policy aims to empower the people of the European Region to assess the health challenges facing them and to address them by increasing health literacy, as well as to ensure that health systems become patient-centred.

**Should these constitute the main goals? Should others be included?**

### Objectives and targets

24. Objectives will be set in relation to:
- addressing how the main drivers of change affect health
- tackling the social determinants of inequity in health
- tackling specific health issues
- ensuring appropriate high-quality health services.

25. Setting selected strategic goals and objectives is considered to be an essential element of Health 2020. Targets will therefore be set to monitor progress towards achieving those objectives. These will be both qualitative and, where appropriate, quantitative and innovative. For example, targets relating to structures and processes to ensure a whole-of-government approach; targets for facilitating access to health care and capacity-building; intermediate targets relating to health risks and health literacy, and outcome targets relating to health status (see Annex 1 on target setting).

**Please comment. We would be interested to learn in which areas you would expect to see targets set at the European level.**

### Critical issues and approaches

26. In developing and drafting Health 2020, and for its future perspective, some critical issues and approaches will need to be incorporated. These are:
- Health 2020 must focus on reshaping health governance to ensure that it is horizontal and based on integrated policy development and implementation;
- Health 2020 should strengthen the leadership role of ministers of health as key actors and advocates of health and well-being;
- Health 2020 must be aimed at a broad range of stakeholders;
- Health 2020 must speak to intended sectoral and intersectoral users in ways that are both inspirational and practical;
- Health 2020 should be accessible and achievable, and should include practical tools to assist in advocating health investment to the whole spectrum of intended audiences;
- Health 2020 could provide a framework for entering into agreements with other key constituencies and actors; and
- Health 2020 should offer clear options for contributing to global health-related issues.
The four content and process priorities for developing the Health 2020 and milestones

27. Health 2020 will be developed over a period of two years in a highly participative process. This will be based on the following four content and process priorities:

- developing a policy framework and governance for health approach that fit the context of the 21st century, and which are informed by a strategic and anticipatory analysis of drivers, trends and the policy context related to health and well-being, with a 10-year outlook;
- gathering and using the best evidence of the causes of ill health and inequalities, public health concepts and effective solutions;
- consulting with a wide range of stakeholders, decision makers, public health professionals, civil society and international agencies; and
- using partnerships with countries to strengthen know how and the capacity for addressing major policy and governance challenges.

Main milestones and timetable of important events (January 2011 – September 2012)

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<th>January 2011</th>
<th>Technical discussions on Health 2020 involving all EURO staff</th>
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<td>Launch of the second phase of the European Social Determinants &amp; Health Divide Review</td>
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<td>February 2011</td>
<td>Launch of the Governance for Health study</td>
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<td>February 2011</td>
<td>Second meeting of the Health 2020 external advisory steering group</td>
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<td>March 2011</td>
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<td>March 2011</td>
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<td>March–June 2011</td>
<td>Negotiating/establishing country partnerships for Health 2020 and consulting with different stakeholder constituencies</td>
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<td>April 2011</td>
<td>Draft consultation report</td>
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<td>April–October 2011</td>
<td>Consultation with countries and different stakeholders</td>
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<td>May 2011</td>
<td>Finalization of document for Regional Committee</td>
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<td>May 2011</td>
<td>SCRC prior to World Health Assembly</td>
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<td>June 2011</td>
<td>Third meeting of Senior Review Advisers</td>
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<td>September 2011</td>
<td>Presentation of first draft Health 2020 policy at RC61 in Baku, Azerbaijan</td>
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<td>November 2011</td>
<td>Health 2020 Conference in Israel</td>
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<td>November 2011</td>
<td>Fourth meeting of Senior Review Advisers to consider the findings of the task groups</td>
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<td>December 2011</td>
<td>Task groups submit their final reports</td>
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<td>March 2012</td>
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<td>April 2012</td>
<td>UCL to deliver final report to WHO</td>
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<td>September 2012</td>
<td>Presentation of final Health 2020 policy document and recommendations at RC62 in Malta</td>
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Section II. Health 2020 – Annotated outline

The Health 2020 document

28. The Health 2020 document will be structured around 3 main parts.

Part 1. The case for a big shift in dealing with health – the rapidly changing global and regional context for health

29. The first part of the policy document will set the scene and will be based on a strategic and anticipatory analysis of major trends, drivers, political changes, determinants and the policy context related to health and well-being, with a 10-year outlook. It will demonstrate the need for a big shift and the important implications such a shift will have on addressing health within and beyond the health sector. Part 1 will look for dominant concerns as well as windows of opportunity for action, and the need and scope for a new policy for health for the European Region. It will clearly state the need for a new approach to developing health policy for the European Region.

1.1 The global context for health

30. The way in which health is considered is changing rapidly. Gone are the days when health meant only health care services, which were complicated and expensive to plan and manage. Health is now seen in a much more complex and nuanced way, with many determinants spread across the whole of society. It is also viewed as one of the key drivers, as well as one of the most important outcomes, of societal development.

31. WHO still faces huge challenges in meeting its objective of “the attainment by all peoples of the highest possible level of health”. Yet it is possible to be optimistic. Over recent decades, health has improved both globally and in the European Region: life expectancy has increased and technological advances by modern medical science have revolutionized opportunities for the prevention, cure and control of disease at among populations and among individuals.

32. Health is increasingly understood as an important component of human well-being. Access to health and health care is seen as an important human right. Investment in health is considered critical for the successful political, social and economic development of modern societies.

33. At the global level, however, there are new challenges and trends. These can be summarized as: globalization, “marketization”, widening inequities in the distribution of wealth and the access to health and social services, increasing population migration, growing urbanization, accelerating technological innovation, increasing environmental pollution and climate change, and a shift towards more horizontal and inclusive approaches to governance. These trends are having a profound impact on health and health equity, as well as on the ways in which society responds to health challenges.

34. All these developments and changes over recent decades have given rise to the need for a renewed paradigm for health improvement. The context of change is so compelling and rapid, and the influences of health are so diverse, that a new vision of health governance at the global, regional and national levels is required. Health as a vital element in development must be considered a whole-of-government responsibility, and structures for the advancement of health improvement must reflect this. Present structures and processes are not adequate in this new environment, and need urgently to be re-examined.

35. Health 2020 comes in response to this need to re-examine health policy development and the mechanisms by which health policy is made, as well as changes to its content and governance.
1.2 The European Context

36. Within this global context, Health 2020 is being developed for the WHO European Region. In addition to the global trends identified above, there are also some Region-specific trends: a profound demographic shift with decreased fertility rates and a rise in the old-age dependency ratio; dramatic inward migration; the international migration of health professionals often leading to health staff shortages in areas of the Region where they are most needed; the changing nature of work, and recently growing unemployment; and a profoundly unequal distribution of health and wealth. These changes coincide with an important shift in the role of health professionals and citizens, as well as increasing pressure to use health system resources efficiently and wisely.

37. A major trend is the role of the European Union as a key player in the field of health development. Health 2020 will be informed by a systematic analysis of the strategies and action plans of international agencies concerned directly or indirectly with health.

1.3 Building on experience

38. Health 2020 will be developed with consideration of several questions: what has been the experience, at the national, subnational and local levels in implementing comprehensive health policies such as Health for All, HEALTH21, and commitments through Charters such as the Tallinn Charter and the Resolutions of the ministerial conferences on Environment and Health? What have been the lessons learned, for governance, the processes of policy development, and the management of public health and health care delivery systems? What was the experience of countries of working together and learning from one another during this process?

1.4 The epidemiological context

39. Health inequalities persist between and within countries, stratifying populations according to ethnicity, gender, socioeconomic status, educational level, and geographical area. In 2009 in the poorest countries in the European Region the average life expectancy for both sexes was 14 years lower than in the richest ones, and in 2007 the infant mortality rate in the poorest countries was twenty five times higher. These are profound differences, which touch the very heart of the human right to health. The differences cannot be explained in terms of health care systems and access to these systems alone, but only by consideration of the political, institutional, social, economic and environmental circumstances of peoples’ lives.

40. Noncommunicable diseases, particularly cardiovascular diseases and cancer, are the primary cause of mortality and morbidity in the European Region today, and much of this burden is preventable. There is also an increase in the burden of mental disorders. However investments in noncommunicable disease prevention and mental health remain low, accounting for just 1% and 5.9% of overall European health expenditure respectively, which is well below the average for member countries of the Organisation for Economic Co-operation and Development (OECD).

41. Emerging and re-emerging communicable diseases also remain a priority area in many countries of the Region, including HIV/AIDS and tuberculosis, as well as global outbreaks such as the H1N1 influenza pandemic in 2009.

1.5 The determinants of health

42. These are multiple and varied. Political, social and economic circumstances are extremely influential. The report issued by the Commission on Social Determinants of Health (CSDH) in 2008 demonstrated the ethical imperative of acting on inequalities in the distribution of power, influence, goods and services, as well as in living and working conditions and access to good quality health care, schools and education.
43. Environmental factors also play a role in influencing health. These factors include water and air quality, environmental pollution caused by hazardous substances and emissions, urbanization, climate change, rising temperature and sea levels, and an increased frequency of natural disasters and extreme weather conditions.

44. Lifestyle and behavioural factors, which are mainly influenced by structural determinants, also have a significant impact on health outcomes. Smoking, alcohol and substance abuse, diet and exercise have powerful effects on health, particularly in relation to the rising prevalence of noncommunicable diseases. While efforts to tackle smoking prevalence have been successful, an effective package of health interventions that address all of these risks should be developed in the context of a strategy to address the surging burden from noncommunicable diseases.

45. Finally the capacity and efficiency of health systems is an important health determinant and will therefore be an important component of Health 2020. The issue facing Member States in the European Region is how to improve performance and reduce costs while maintaining the European values and principles agreed in Health for All and the Tallinn Charter.

46. These determinants are inevitably interrelated. Many of them are amenable to effective interventions. Increased investment in health promotion and disease prevention is essential, as well as more efficient therapy and rehabilitation for those affected by disease. In many countries current investment in population-based health promotion and disease prevention services is lamentably low.

1.6 The way forward

47. In order to shape responses to new knowledge and opportunities for health and well-being in the next 10 years, this section of the Health 2020 document will provide an overview of the key implications, influences and pathways for change, and the need for a new European policy for health.

Part 2. The policy framework for health up to the year 2020

48. The second part is the main body of the Health 2020 policy document. It begins with a definition of a common purpose, setting the values, principles and main strategic strands of the policy and providing the rationale and scope of Regional targets for health and well-being. Leadership and governance for health and the key commitment to addressing equity in health will underline the new approach setting both the breadth of the scope and the innovative operational context of the new policy. The subsequent sections set priorities for action from the perspectives of different population groups, and state the main areas for public health action, as well as articulating appropriate and innovative responses through health care and public health services (the core business of the health sector) but also, very importantly, going beyond the conventional boundaries of the health sector.

2.1 Vision, values, guiding principles, strategic goals and objectives and setting targets

49. The values and principles underpinning Health 2020 will be outlined in this section, along with an explanation of why these values are essential and what their policy implications are.

50. The values underpinning Health 2020 will be those that have evolved since the introduction of Health for All, but will basically remain those that have been endorsed several times by Member States, most recently in the Tallinn Charter. These values are similar to those promoted by the European Union. In Health 2020 these values must be seen as cross-cutting, affecting practice at all levels and in all sectors of society.

51. It is important to ensure that the Health 2020 values are not merely given lip service but rather that they firmly underpin government policy at all levels, as well as action in the public and private sectors and in civil society.
52. These values are:
   • universality of the human right to health and health care
   • equity
   • solidarity
   • sustainability
   • the right to participate in decision making
   • dignity.

53. Health 2020 will explore the practical implications of being attentive and responsive to the voices and needs of citizens and patients.

54. These values underpin the proposed vision for Health 2020, namely:

55. “A WHO European Region where all people are enabled and supported in achieving their full health potential and well-being, and in which countries, individually and jointly, work towards reducing inequalities in health within the Region and beyond”.

56. A core aspect of the new European policy for health will be to identify, through appropriate process and outcome, qualitative and quantitative targets for the European Region. These targets will be both realistic and challenging, and will be informed by an in-depth analysis of trends and modelling where appropriate.

2.2 Leadership for health and development

57. Leadership for health and health equity is the cornerstone of the new European policy for health. It will explore and identify new roles and leadership opportunities for health ministers and the expanded role of the health sector in the pursuit of health and well-being. The roles of other key actors, including civil society, will be central to the development of the Health 2020 framework. A series of accompanying documents is foreseen, which will focus on the role of different sectors and different levels of government: national, regional and local.

2.3 Governance for health

58. This section will be informed by the Governance for Health study (see Annex 2). The multiple determinants of health require a multisector, multi-actor response. We need more effective intersectoral action to tackle these determinants and address inequalities, but achieving this has proved difficult. To ensure an integrated approach to health and development it is necessary to re-think mechanisms, processes, relationships and institutional arrangements across all sectors, and at all levels of governance, as well as internationally. This section will address the most important factors shaping health systems and health development in the future, and the implications for governance for health in a world of interdependent policies. It will provide a strategic vision for the whole-of-government approach, and make proposals for achieving the necessary shift in thinking and practice. It will address the question of how health and well-being can be a whole-of-government objective (as an integral dimension of policies for well-being that take us beyond Gross Domestic Product (GDP) as the only measurement of success for societies) and the preconditions and solutions for making this happen. The concepts of intersectoral action, health in all policies, and national health policies will be also be an integral part of the Health 2020 governance for health approach.
2.4 Tackling the social determinants of health

59. This section will be informed by the European review of the social determinants of health and the health divide review (see Annex 3). The section will consider the social determinants of health, their impact on inequity in health, life course and gender, and how these challenges might be tackled, including through universality and targeted approaches and by addressing the needs of the most vulnerable and taking a social gradient approach.

2.5 The economics of health and well-being

60. For most countries health poses a financial challenge, and there is little knowledge of how to cut costs and organize health systems. This section will systematically address the multifaceted economics and financing aspects of health and health systems, including the burden of disease and the costs of inaction, addressing inequality in health, the consequences of unhealthy public policies, the impact of medical technology and advocating integrated disease prevention.

2.6 Pathways to health and well-being

61. This section will consider innovative and effective ways to address public health challenges by considering the key issues in the domains of public health action: social and economic determinants, lifestyle and behaviour, the environment and health care. It will also consider the policy and action implications of major trends and cross-cutting issues that affect those areas, as well as discussing where there is potential for innovation and what evidence is available on the most promising interventions relating to:

- people: age-groups, sex, special population and vulnerable groups
- behaviour related determinants of health
- environmental determinants of health
- places: physical and built environments, urban and rural areas
- priority topics related to health conditions and health risks: noncommunicable diseases, communicable diseases, obesity and accidents.

2.7 Innovation in public health and health care services

62. The organization and financing of health systems in the Region continue to be extremely varied. Unfortunately, in many countries primary care services and treatment regimens remain insufficient, in particular in relation to mental health and chronic disease management. Other countries inadequately invest in public health systems and human resource development, especially in disease prevention and health promotion. This poses major challenges to addressing the human and social burden of noncommunicable diseases and their underlying determinants. Most countries do not have structures for intersectoral work or approaches that support health in all policies.

63. This section will address the shaping of the health and social care interface and public health services to new needs and new potential. Drawing on the work related to the Tallinn Charter: Health Systems for Health and Wealth, and new evidence, this section will identify the key strategic concepts and forces that will shape health and public health services in the future, such as:

- creating resilient public health infrastructure and capacities, taking an assets based approach;
- establishing a stronger and more systematic role for health promotion and disease prevention;
- developing new roles for health care and health professionals, considering the composition of the health care team and the position of health professionals in the health market;
- managing chronic disease in various settings;
• ensuring high performance and accountability with a focus on the practical implications of patient centred care; and
• considering the effects of new medical technologies and taking advantage of the potential of modern information and communications technologies.

Part 3. Making it happen

64. The third part of the Health 2020 document identifies the key processes, instruments and tools to translate the Health 2020 vision into reality.

3.1 Enhancing capacity

65. This section will examine ways of facilitating the changes needed to implement Health 2020, including:
• formulating policy: stakeholders, objectives and targets;
• developing national health policies, strategies and plans;
• working with other sectors;
• strengthening public health capacities (this goes together with drafting the new WHO Regional office for Europe plan for strengthening public health capacities);
• engaging the health care and public health community and reaching to other relevant professional groups and disciplines;
• providing education and training for health and related professionals;
• improving and sharing information, knowledge, good practices and identifying preconditions and barriers to change;
• using, effectively and creatively, the great potential of new information and communication technologies; and
• monitoring and evaluation.

3.2 Partnerships for change at the European Regional and global levels

66. Health 2020 will make specific practical proposals for the proactive engagement of other sectors, institutions and organizations at the European Regional and global levels. These will focus on:
• countries acting together for health at the European Regional and global levels;
• creating partnerships with major international actors and agencies, including the European Union, World Bank, OECD, and others;
• creating partnerships with public health constituencies and health care professionals;
• engaging civil society;
• engaging the private sector; and
• establishing the new role of the WHO Regional Office for Europe in the European Region and globally.

Please comment. Do you agree with the proposed structure of Health 2020?
Section III. Main products and outputs

Main product: European health policy Health 2020 publication
- First draft to be presented at RC61 (2011)
- final policy document to be presented at RC62 (2012).

Companion publications
- Supporting evidence underpinning Health 2020, including evidence on interventions (policies, programmes and delivery systems) and instruments and guidance for setting priorities and reviewing progress at the level of the WHO European Region;
- publications specific to the role of different sectors and levels of government; and
- guidance and tools on developing national and subnational Health 2020-based policies and implementation systems;
- all to be presented at RC62 (2012).

Main product: Report on the European Social Determinants of Health and Health Divide Review
- Interim report to be presented at RC61 (2011)
- final report to be presented at RC62 (2012).

Companion publications
- Supporting evidence underpinning the social determinants of health and the health divide in the form of a series of reports from the task and reference groups, including evidence on interventions (policies, programmes and delivery systems);
- guidance on developing national reviews of social determinants and the health divide;
- all to be presented at RC62 (2012).

Main product: Report on Governance for Health study
- Report to be presented at RC61 (2011)
- publication with case studies to be presented at RC62 (2012).

Instruments and guidance publications

67. A series of instruments and additional guidance publications will be designed to support countries in implementing the agendas of Health 2020 and the European Social Determinants of Health and Health Divide Review at the national, sub national and local levels.
Section IV. Country partnerships for Health 2020

68. The new European health policy, Health 2020, will be developed in partnership with Member States, civil society, academic institutions and networks and professional associations. These partnerships will develop existing and new political and technical support, evidence, tools and capacities for improving health.

69. In doing so, Health 2020 intends to work in partnership with countries to:

- generate demand for health equity, within countries and across the region, and “democratize” health;
- strengthen the architecture, robustness and impact of national and local health policies, strategies and governance arrangements in order to systematically tackle major health challenges;
- develop mechanisms for innovation and exchange of know-how and capacity in advancing public health goals and sustaining their impact over time; and
- counter attempts at the national and Regional levels to cut back on public health investment in the face of the continuing global economic and financial crisis.

70. A range of options are proposed, to be considered by Member States, with regard to partnerships with the WHO Regional Office for Europe for developing and implementing the new European health policy, Health 2020. A guiding principle of these partnerships is to ensure they allow for diversity of country voices and perspectives in developing Health 2020, while supporting countries’ efforts (at the national and local levels alike) to advance action on health and health equity.

**Advocacy and awareness-raising partnerships: generating support for health and health equity and shaping the content and approach of Health 2020**

71. Examples of partnership activity:
- participating in and/or hosting Health 2020 consultations and forums, at the country, subregional (i.e. among a group of neighbor countries) or regional (pan European) levels; and
- gathering intelligence and acting as a sounding board on emerging opportunities and challenges to the goals of Health 2020.

72. Advocacy and awareness raising partnerships aim to stimulate debate on critical health challenges in Europe and to inform the content of Health 2020 and related studies /reviews. These partnerships will ideally promote intersectoral and multistakeholder commitment to action for health. They will also play an important role in informing WHO and other partners of emerging opportunities or challenges that may help or hinder the development of Health 2020 and its implementation.

**Knowledge generation partnerships: contributing to the development and relevance of Health 2020 scientific products**

73. Examples of partnership activity:
- reviewing and testing emerging findings, priorities and key messages from Health 2020 and companion studies;
- documenting, locally and nationally, positive practices and their impacts with regard to addressing critical European health challenges; and
- carrying out national, local or subregional companion studies and reviews to feed into Health 2020 scientific products.
74. Knowledge generation partnerships will ensure that the recommendations of Health 2020 are relevant to policy challenges and contexts across Europe and that they are formulated in a way that supports countries’ efforts to take action. These partnerships will also ensure that Health 2020 tools and companion studies build on existing learning from across the region.

**Capacity building partnerships: supporting action on common challenges between countries.**

75. Examples of partnership activity:
   - encouraging structured action learning between countries in problem solving, and testing approaches to addressing policy and governance challenges; and
   - hosting and organizing workshops, policy dialogues and seminars on Health 2020 issues and themes and subsequently documenting and sharing learning from such events.

76. Candidate themes still require further consideration but could include health in all policies, monitoring and analysis of health equity, strengthening the impact and effectiveness of public health programmes and services, redesigning public health, and addressing the health needs of vulnerable groups.

77. Capacity building partnerships are based on the assumption that many countries share common challenges, yet no single country has a perfect model for policy development, and many are experiencing implementation challenges. There is therefore a strategic benefit to structuring policy learning between countries and supporting the development of know-how by building on and sharing existing learning and positive practices, and disseminating the know-how and experiences gained from policy development and implementation.

78. Where appropriate, lessons learned from capacity building partnerships will contribute knowledge and a variety of stakeholder perspectives to the interim and final products of Health 2020. Capacity building partnerships will draw on the resources of WHO technical programmes, WHO centres of excellence (formerly geographically dispersed offices); WHO collaborating centres and other expert networks and institutions across the Region.

**Policy and governance innovation partnerships: establishing Health 2020 policy innovation sites (at the individual country level) and hubs (at the subregional level or among networks of countries)**

79. These partnerships would provide guidance for implementing national health policies and enabling governance systems to function in line with the goals of Health 2020. They would also make learning and materials available to other countries, and use experiences acquired to advocate for health investment and for the commitment from stakeholders required to achieve and go beyond the European health potential set out in Health 2020.

80. In order to identify potential Health 2020 policy innovation sites, a number of criteria are being considered, such as: political commitment to health and health equity at the highest level; commitment to proactive engagement of stakeholders; inclusion of sufficient countries and range of country contexts (e.g. development conditions, health status and priorities, and governance systems); and willingness to host events and to document and share policy and governance lessons and experiences.
Annex 1. Defining objectives and setting targets

Objectives

81. The most common criteria for selecting objectives are:\(^1\)
   - the extent of a health problem as a major cause of mortality, or morbidity;
   - whether solving the problem could reduce health gaps;
   - the scope for improvement through interventions that have been shown to be effective and are politically acceptable;
   - public and professional opinion regarding whether the health problem is a major concern;
   - whether there are reliable indicators to measure progress towards achieving the objective or target, and whether data for measuring progress are available or can be easily collected; and
   - constraints, including cost constraints.

82. As we move towards an assets based approach, available assets would be added to the list of criteria.

Targets

83. Some countries and cities have been deterred from setting quantified targets for a number of reasons including:\(^2\)
   - the difficulty of providing scientifically credible evidence for some targets;
   - the reluctance of politicians and health professionals to set targets for which they will be held accountable, particularly if the targets are in areas over which they have little or no influence; and
   - the danger of appearing to give priority to issues for which targets can be easily quantified, when other issues that are less easy to quantify might be considered equally or more important.

84. On the other hand, as was clearly stated in HEALTH\(^3\) there are a number of advantages to setting targets.
   - The target setting process requires an assessment of the present situation and expected future trends on as scientific a basis as possible.
   - Monitoring targets offers an excellent learning experience through discussion of the goals set, the extent to which they have been reached, and why.
   - Targets provide a powerful communication tool.
   - Targets inform potential partners of goals to be achieved and their role therein.
   - Targets can provide a rallying call for groups at the grassroots level to demand action.
   - Targets can be an excellent tool for strengthening accountability for health (which is one reason why some groups would like to avoid them).

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\(^2\) Ibid.

\(^3\) *HEALTH\(^2\)1: The Health for All Policy Framework for the WHO European Region*. Copenhagen, WHO Regional Office for Europe, 1999 (European Health for All series No. 6).
• Certain targets can provide a reference point for assessing the advisability of day-to-day actions.
• Involving people in the process of setting targets raises awareness and can be the first step towards implementing health policy.

85. On a global level, the setting of the Millennium Development Goals, which are in fact quantified targets, may have influenced the target setting process in countries. It is clear, however, that in recent years an increasing number of countries, regions and cities have begun setting targets for health.

86. These include:
• outcome (sometimes called primary) targets, which relate to changes in the health status of a certain group, usually expressed in terms of overall or disease specific mortality or morbidity rates;
• intermediate targets relating to risk factors:
  – health conditions or symptoms
  – exposure to risks or hazards
  – behaviour;
• input and output targets relating to resources or services that must be available to achieve the primary and/or intermediate targets;
• process or action targets (for example developing and implementing standards or protocol); and
• targets relating to social determinants of health (i.e. poverty reduction, improving working conditions etc.).

87. Targets may be absolute or proportional. They may be set relevant to a certain benchmark (such as reducing a local level average to be equal to a national average), or threshold level. It is frequently accepted that targets should be SMART, that is Specific, Measurable, Achievable, Realistic and Time bound.

88. In addition to what might be called the technical targets above, WHO and countries have also set aspirational targets, which are targets designed to inspire. The equity target, which was Target 1 of the original 38 Health for All targets, was an aspirational target. It was for this reason that when the 38 targets were revised, Member States opted to keep the equity target, even though it was not considered to be scientifically based.

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5 van Herten, Loes Defining health targets. Eurohealth Vol. 5 No. 3 Autumn 1999.
Annex 2. Governance for health in the 21st century –
a study conducted for the WHO Regional Office for Europe

89. This horizontal and cross-cutting study will feed directly into development of the new European health policy (Health 2020) and it will also inform the governance aspects of the European Review of Social Determinants and the Health Divide. The findings and recommendations of the study will also be of great value for development and implementation of the Framework for action on strengthening public health capacity and services in Europe. The final report on governance issues will be based on the conclusions from a number of in-depth studies authored by eminent experts.

90. Professor Ilona Kickbusch is the lead investigator of this study, which will be conducted between January and June 2011. The study is funded by the Swiss Federal Office of Public Health within the Federal Department of Home Affairs of the Swiss Government

Background

91. Together with Member States, the WHO Regional Office for Europe is, developing a new European health policy, Health 2020. Within this overall framework, the Regional Office is promoting the strengthening of public health infrastructure, capacities and processes across the European Region.

92. Investment for health is understood to be an essential prerequisite for economic and social development. The relationship between health development, wealth and well-being is increasingly understood in terms that make health development a responsibility of the whole government and of a wide range of stakeholders in society. The complex interplay of the various determinants of health, in particular the role of economic and social factors, and the ways in which resources and influence are distributed across societies require new approaches to health governance.

93. Governance is about how governments and other social organizations interact, how they relate to citizens, and how decisions are taken in a complex world. Governance is thus a process whereby societies or organizations make their important decisions, determine whom they involve in the process and how they render account. Since good health is a fundamental enabler, and poor health is a barrier, to meeting policy challenges, the health sector needs to engage systematically across government and with other sectors to address the health and well-being dimensions of their activities. The health sector can support other arms of government by actively assisting their policy development and goal attainment, in order to create win-win situations.

94. Following the discussions at the first meeting of the internal and external steering groups for Health 2020, which highlighted the need for a better understanding of the “new governance for health”, the Regional Office commissioned a study on “Governance for health” – referring to the principles, mechanisms, processes, relationships and institutional arrangements for health that involve all sectors of government as well as other social actors, with consideration to the interface between various levels of governance. Professor Ilona Kickbusch has been appointed to lead this study. It will be conducted between January and June 2011.

Context

95. The study on “Governance for health” will be one of a number of major studies supporting the development of Health 2020.
96. These studies include the European Review of Social Determinants and the Health Divide, to be led by Professor Sir Michael Marmot, that will look (in a European context) at the growing body of knowledge and evidence concerning the impact of socioeconomic determinants on health “experience” and differences. The magnitude of health inequities is clear, and we now need to seek solutions through good governance and effective mechanisms for policy development and delivery. To harness health and well-being, governments need institutionalized processes that value cross-sector problem solving and address power imbalances between sectors. This includes providing the leadership, mandate, incentives, budgetary commitment and sustainable mechanisms that support government agencies to work collaboratively on integrated solutions for health. This will require new and changes responsibilities for health departments.

97. Strengthening governance to address the social determinants of health requires a strategic approach, strong political commitment, effective health systems with a strong public health infrastructure, and policy coherence across government. The study on “Governance for Health” will complement and support the European Review of Social Determinants and Health Divide as an academic study serving to inform the new European Health Policy “Health 2020” by providing an overview of new governance arrangements, including case studies, for promoting and protecting health.

**Aim of the study**

98. This study is designed to respond to the need for new forms of governance for health, in the face of changes in context and new challenges for health. The study is designed to provide answers, including a set of case studies, to the following seven groups of questions:

a. Why do we need to be concerned with governance for health? What creates the need for new governance approaches? How does “new governance” help resolve problems?

b. What do we mean by governance for health? What general governance trends are reflected in governance for health? What does this mean for ministries of health?

c. What is the context of 21st century governance for health? What big shifts are under way? What imperatives drive the new governance? How do they affect ministries of health and the health system? How do they call for action beyond the health system’s present boundaries?

d. What constitutes “good” governance for health in the 21st century? Can we define the value base and principles of 21st-century governance for health? Can the concept of “smart governance” support better health and well-being outcomes? How can it create win-win situations?

e. What are the characteristics of smart 21st-century governance for health (democratic and participatory, anticipatory, horizontal and relational; multilevel)? How does present governance for health compare: who are the players? Who has influence? Who decides? What does this require of the health sector?

f. How can priority challenges for health be governed in new ways using an integrated and dynamic policy response across portfolio boundaries? How can the health sector be better prepared?

g. How will the above best be reflected in the new Health 2020 policy?
Key concepts and focus

**Governance**

Governance is about how governments and other social organizations interact, how they relate to citizens, and how decisions are taken in a complex and globalized world.

99. The study defines governance for health as “the attempts of governments or other actors to steer communities, whole countries, or even groups of countries in the pursuit of health and well-being as a collective goal.”

100. It is a process whereby societies or organizations at all levels of governance set directions and make their decisions in relation to population health and the organization of the health care system; determine whom they involve in the process of decision-making and delivery and how they render account. While key issues remain organized in sectors, “new modes of governance” increasingly aim to achieve collective goods such as health through collaboration; these approaches are less prescriptive, less committed to uniform approaches and less hierarchical in nature. In terms of policy-making, they refer to “soft law” approaches or new types of “steering instruments”; examples are international regimes, policy networks, alliances, public–private partnerships, high-level groups or platforms. WHO/Europe’s approach based on targets for Health for All (HFA) is a typical example, as is the European Union’s Open Method of Coordination. This requires a health sector that is outward looking, open to others, and equipped with the necessary knowledge, skills and mandate.

Key trends

101. The starting point of the study is an analysis of the key factors that have led to the consideration and practice of new modes of governance in relation to health. Joseph Nye identifies three major trends that lead to shifts of governance: globalization, “marketization” and the information revolution. For health, we would have to add innovation and individualization. These major trends will be analysed and illustrated with a range of “new governance” responses from both within the health sector and outside it. From a health perspective, the study identifies three additional important trends:

a. **Health is undergoing a major revolution**
   Health is shifting from being a functional sector to constituting a major economic force and a social objective. This shifts the pressure for policy innovation from a focus on the existing health system to a reorganization of how we govern for health in 21st century societies. Today, health is high on the political agenda and moving from low to high politics. Connectivity and technological and medical innovation all create extraordinary new opportunities to improve health and health care – but they also challenge society with new ethical conflicts. They have further opened the opportunity for citizens and patients to become a decisive force in shaping health and health care. The number of health actors has also increased significantly. Many of the solutions to the most challenging health problems reside with other social and policy arenas – this fundamentally changes the role of the health care sector.

b. **European societies face major health problems and challenges that can only be solved jointly (between sectors, between stakeholders, between countries)**
The health of populations is critical for social stability and economic development – for each country and for Europe as a whole. Demographic and epidemiological shifts and the ensuing financial pressures call for new priorities and action in other sectors and by other stakeholders, as well as for new approaches in health sector organization. Yet the goals of improving the affordability, quality and efficiency of the health care system and those of improving the health of populations are not dealt with as an integrated whole. Often the health sector lacks the authority and the instruments to lead a coherent approach to key challenges. In an interdependent world, countries need to act together to ensure the health of their populations. In Europe, a large number of countries are cooperating for health in the context of the World Health Organization; they also do so in the context of the European Union or as its partners. The new governance models that have emerged from this situation will be presented and discussed.

c. Europe faces a major moral imperative in health

Social solidarity and universal access to health care are deeply rooted in the European value system. Major inequities in health between and within countries in Europe are not acceptable. European citizens expect both protection from health risks and access to high-quality health care – health has become a factor of democratic rights, social stability and state legitimacy. Yet in view of the financial crisis and other economic and political developments, some of these tenets are proving difficult to uphold. The understanding of health as a “public good” remains predominant but requires constant vigilance, in view of the structural asymmetry (at national and European levels) between market forces and social rights and protection. Often health ministers are caught between multiple powerful interests, both within government and outside it.

The big shifts in governance for health: horizontal governance

102. The study will shed light on some of the big shifts in our understanding of the governance of health and provide numerous examples of this process. In Europe over the past 150 years, health has not only shaped the modern nation state and its social institutions, it has also powered social movements, defined rights of citizenship and contributed to construction of the modern self and its aspirations. Access to health and to medical care has become a synonym for social progress and social justice. It is integral to how Europe defines itself today. The European Member States of WHO have committed themselves to shared values of “solidarity, equity and participation” (as expressed in the Tallinn Charter).

103. Health, as we understand and live it today, is not only an outcome of a wide range of political, social and economic developments; it is also linked to the capabilities and resources of individuals, communities and society as a whole. The most obvious case in point is the improved level of health and greater life expectancy that are redefining every arena of personal and social life and policy. The knowledge society, democratic developments, the nature of health problems and technological innovations are all pushing towards new modes of shared governance.

Health governance in the 21st century is defined by two great horizontal revolutions: shared governance and shared care.
104. Health governance today follows a conceptualization of health as “well-being beyond the absence of disease”, as defined by the World Health Organization in its Constitution, and it is again at the forefront of how we define governance relationships in 21st-century societies. It heralds a new quality of democratization, linked in particular to equality, transparency, participation and representation.

105. Health departments’ new responsibilities must include:

- understanding the political agendas and administrative imperatives of other sectors;
- building the knowledge and evidence base of policy options and strategies;
- assessing the comparative health consequences of options within the policy development process;
- evaluating the effectiveness of intersectoral work and integrated policy-making;
- building capacity through better mechanisms, resources, agency support and skilled and dedicated staff; and
- working with other arms of government to achieve their goals and in so doing advance health and well-being.

106. Since the global risk society is also a knowledge society, with wide access to media and information, agendas are increasingly set initially in the social rather than the political sphere. Every issue of everyday life can be transformed into a political issue, and a wide range of groups not involved in the “normal” political process set agendas related to their lifestyles and “life worlds”; in the health arena, HIV/AIDS is the most obvious example. A new political space has emerged where an ever-increasing cast of social actors continuously pose new challenges for ownership of the health agenda by civil society. This is critical for the governance of health at the interface of the individual,
the state and the market. Obesity is the symbolic disease of the global consumer society. It will be a test case for the health governance of the 21st century, as was the introduction of water and sewage systems at the end of the 19th century – and (as then) it will take governance for health far beyond medical care.

**A closer look at “good” governance for health**

107. The study will develop the principles and characteristics of good governance for health, based on a set of declared values: a commitment to human rights, equity and sustainability. The principles of good governance for health, such as universality, access to good quality care and solidarity, will be further discussed. Do other principles need to be added – such as dignity? Good governance for health requires capable states with clearly defined and coordinated decision-making hierarchies, a strong administrative apparatus, fiscal resources, policy instruments, legitimacy and well organized social ties between state and society to achieve public goals. There are clearly major differences between Member States in the WHO European Region in relation to these criteria.

108. The United Nations Development Programme has developed eight criteria of “good governance” – the study will explore their value as criteria for the new health governance and the new role of ministries of health and the health sector at various levels of governance.

![Fig.2]

**Good governance**

109. The boundaries of what we call the “health system” have become increasingly fluid. Health is not a sector, it is a complex adaptive system of dynamic networks and relationships with many spillover effects. WHO states that a health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This primary intent must be better prioritized and coordinated in the broader context of the health system and the health sector itself.

110. Considering governance for health in the 21st century, however, also takes us beyond that primary intent into other sectors and systems which contribute to or endanger health (for example the food system) or which consider health to be a significant part of their own intent but with goals that
differ from those of the health system (for example the economic development sector or foreign policy). Health is increasingly being shaped by forces such as the speed of modern societies, the globalization of markets, the increasing mobility and insecurity of individuals, energy expenditure and climate change, food security and concerns regarding risk and safety, and the reach of the media. These forces cut across many of the acknowledged social, environmental, and economic determinants of health. The health sector must therefore learn to work in partnership with other sectors to create win-win situations. Joint exploration of policy innovation, new mechanisms and instruments, as well as better regulatory frameworks, will therefore be imperative.

111. This multidimensional character of health challenges needs an integrated and dynamic policy response across portfolio boundaries, making health a shared goal across all parts of government and linking it more explicitly than hitherto to the well-being agenda that is gaining traction in a number of European countries. It requires modes of governance across boundaries which prioritize coordination by means of “soft” mechanisms (contextual guidance), with strong self-steering of subsystems but based on an agreement on the strategic purpose of the entire system. These will be described in the study – an example is the Health in All Policies approach.

112. The study is based on a communicative and collaborative understanding of governance. From the examples it analyses, it will further develop the concept of “smart governance” for health. It takes into account the fact that the need for change is faced not only by the health sector; in general, sector-based approaches to governance do not fit the interdependent “wicked problems” of the 21st century. Just as health seeks the support of other sectors, so do they begin to consider how health contributes to or hinders their agendas. One example is health security, another is nutrition. As governments are under increasing pressure to improve their performance, they gradually add new administrative forms of governance, for example by forging new strategic relationships, both within government and with non-state actors. The solutions to the most challenging health problems require “smart governance” under which:

• a clear mandate makes joined-up government an imperative;
• systematic processes take account of interactions across sectors,
• mediation occurs across interests,
• accountability, transparency and participatory processes are present;
• engagement occurs with stakeholders outside of government; and
• practical cross-sector initiatives build partnership and trust.
This relational approach to governance is necessary as the number of health actors has increased significantly (in the market, in civil society and in government, as well as at all levels of governance) and as health care is in principle a relationship between health professionals and patients. This expansion of health – combined with the information and technology revolution – is one of the key reasons for the need to develop new modes of governance. The governance system or framework upon which this process rests is a critical component of smart governance for health – it includes the agreements, procedures, conventions or policies that define who gets power, how decisions are taken and how accountability is rendered. An analysis of several “tipping points” in governance for health will be presented: what type of problems called for new solutions, which new governance mechanisms were established, what led to change, how sustainable has it been? Examples include HIV/AIDS, bovine spongiform encephalopathy (BSE), severe acute respiratory syndrome (SARS) and tobacco.

**Key characteristics of 21st-century governance for health**

114. Governance means that the state is involved in more complex relationships with other governmental and societal actors, but it does not inevitably reduce its role or power. Similarly, this applies to ministries of health and the health sector. They remain responsible for ensuring that governance arrangements are effective, accountable, legitimate and democratic. Indeed, in many countries, the state is responding to a number of health challenges by expanding its regulatory power, its reach into everyday life and its control of markets. In Europe this has become even more complex as governance dynamics have changed in view of the role of the European Union. A key conflict of all 21st-century governance for health is how to balance the interests of health and the interest of the market, the public good and individual interests.

115. At this stage, four distinguishing features of smart governance are being explored using examples of policy innovation in health:

- democratic and participatory
- anticipatory
- horizontal and relational
- multilevel.
116. Measures and instruments will be presented and a matrix will be developed to create categories, all of which will indicate the role of ministries of health and the health sector in their implementation. Examples include: using the authority of the prime minister, president or chief executive to require other departments and agencies to collaborate; embedding cross-cutting and participatory perspectives through law; ensuring protection and accountability through new kinds of anticipatory agencies; engaging in intersectoral action and cooperation between departments, based on a shared conviction of the need for change; strengthening “bottom-up” collaboration, particularly at the community level; and introducing measures that emphasize data, monitoring and impact assessments.

117. Based on these analyses, an attempt will be made to identify pathways for innovation: exploring which governance mechanisms will create dynamics in the system to move in the “preferred” direction for health. This, we feel, could help with making decisions on which strategies to propose in the context of development of the new European health policy, Health 2020.

Process and structure

118. In order to substantiate and further inform the study on “Governance for health”, seven background papers will be prepared by experts in various fields of governance. They will serve to further explore and illustrate the following aspects of “new governance”:

- the value base and key ethical challenges of health governance (health protection, disease prevention, health promotion)
- governance challenges (solidarity)
- democratic and participatory governance for health: the role of the public and patients
- anticipatory governance: responding to challenges posed by innovation and technology
- relational governance for health: strategic relationships and new forms of interface between public, private and civil society actors
- multilevel governance for health: the impact of global and regional processes (global-local)
- the impact of social media and web 2.0 on governance for health.

119. Contributing experts include:

- Dr Vural Ozdemir, Associate Professor, Centre of Genomics and Policy, Department of Human Genetics, Faculty of Medicine, McGill University, Quebec, Canada
- Dr Olivier Raynaud, Senior Director and Head, Global Health and Healthcare Industries, World Economic Forum, Geneva, Switzerland
- Dr David McQueen, Senior Biomedical Research Scientist and Associate Director for Global Health Promotion, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC), Atlanta, Georgia, United States of America
- Mr Edward Andersson, Deputy Director, Involve, London, United Kingdom
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- Dr Armin Fidler, Lead Adviser, Health Policy and Strategy, Human Development Network, World Bank, Washington DC, United States of America
• Ms Tünde Szabó, Health care consultant, UNAIDS, Geneva, Switzerland

120. Full use will be made of other studies and materials already produced by the lead investigator (for example on Health in All Policies) and by centres and divisions of WHO at European and global levels.

121. The Study will be further shaped through a meeting of the contributing experts with members of the external and internal steering groups for Health 2020 in Geneva on 18 February 2011, to be followed by input from the internal and external steering groups of the European Health Policy Forum. The SCRC will be updated on the study.

122. The Global Health Programme at the Graduate Institute of International and Development Studies, Geneva will serve as the secretariat supporting this study and will work in close cooperation with the WHO Regional Office for Europe. Two researchers working under the supervision of the Director of the Global Health Programme, Professor Ilona Kickbusch, will further support the research and writing process.

**Objectives**

123. The final product will be a document of about 60 pages entitled Governance for health for the 21st century, which will explore the key questions as outlined above. It will be based on intensive literature research, interviews with key stakeholders, expert meetings, and commissioned background papers. It will set out concepts and principles, highlight the governance challenges and give examples of best practice in all areas of governance. The Study will advise on and provide input into the development of the new European health policy, Health 2020.

**Timeline**

- **January 2011**  Development and launch of the study
- **February 2011**  Meeting of the expert group; finalization of study outline; Finalization of outlines of background expert papers
- **March 2011**  Extensive research and writing; Interviews
- **April 2011**  Submission of background expert papers
- **May 2011**  Consultation round on draft study
- **June 2011**  Completion of study
- **July 2011**  Paper prepared for the sixty-first session of the Regional Committee for Europe
- **September 2011**  Presented as an information document at the sixty-first session of the Regional Committee for Europe
Annex 3. European review of the social determinants of health and the health divide

124. The WHO Regional Office for Europe has commissioned a review of the social determinants of health and the health divide in the WHO European Region. Professor Sir Michael Marmot has been appointed to chair the Review. It will take place from July 2010 to September 2012. The Review will provide evidence-based policy recommendations to reduce health inequalities across the Region and a framework for future action. This Review will inform and feed into development of the European Health 2020 policy.

125. The analysis produced by the Review will aim to increase awareness of the scale and nature of health inequalities within and between European countries, and to build knowledge for action within the Region by identifying the most effective policy interventions and governance arrangements for countering the problem.

126. The Review is steered by a group of senior advisers. The content of the Review will rest on the work of several task groups and on evidence and experience gained by countries and subregions within the Region. Several publications will be produced in the course of the Review, and a final publication is scheduled for September 2012.

127. This paper provides an update on the Review’s process and on the studies and the evidence review being conducted by different task groups.

Main goals

128. A. To conduct a European review of the social determinants of health and the health divide, including review of the evidence, development of recommendations and promotion of uptake of the findings of the review (time frame: June 2010 to September 2012).

129. B. To advise on and provide scientific evidence and input into development of the new European health policy – Health 2020 (time frame: June 2010 to September 2012).

Context of the work

130. A number of interrelated and interlinked exercises have been initiated by the WHO Regional Office for Europe to inform the development of the European health policy – Health 2020. Those related to the social determinants of health (SDH) are in two phases:

Phase 1: The European Review of SDH and the Health Divide focuses on documenting and synthesizing the evidence on health inequities and SDH in the European Region. An interim report was considered by the WHO Regional Committee for Europe at its sixtieth session in September 2010 and finalized at the end of December 2010 (July –December 2010).

Phase 2: The European Review during this phase includes a focus on:

- reviewing Member States’ capacity for action on SDH and strategies to implement such action;
• documenting and recommending policies that help speed up action on SDH and health inequities. This will include identifying key policy areas in the European Region that are likely to be most effective in addressing SDH and reducing health inequities;
• providing scientific evidence and input into development of the new European health policy (Health 2020).

The process

Phase 1 – Reviewing the evidence

131. During the first phase of the Review (July – December 2010), work was focused on reviewing the available evidence on health inequities in Europe, in order to establish a baseline for further work during Phase 2. An initial draft interim report was presented at the Regional Committee session in Moscow in September 2010.

132. Following the discussions at the technical briefing in Moscow, and further consultation and input from staff from the WHO Regional Office for Europe and other experts, the interim report has been further revised and will be issued in March 2011. The finalized product includes extended data sets and further analysis of determinants.

Meeting of senior advisers

133. The Review’s inaugural meeting was held in October 2010 in Madrid, at the invitation of the Spanish government. The meeting was convened by the Review Chair, Sir Michael Marmot, and the Review’s Secretariat at the University College London (UCL) focused on establishing ways of working with the different task groups, while the senior advisers and Review Chair discussed the overall direction and focus of the work.
Scope and purpose of task groups

134. Following the first meeting of senior advisers (Madrid, October 2010), task group chairs worked with the UCL and WHO secretariats to develop and refine their workplans.

135. This involved identifying task group members, defining the scope and purpose of the individual studies and reviews to be commissioned by each task group, and identifying lead researchers for research to be undertaken. Discussions with task group chairs involved identifying the approach that they will take, in order to ensure coherence across the different areas of work on the Review and to avoid overlap and duplication. Each task group covers either one or more determinants or a life stage (for a full list of task groups and chairs, see Appendix 1). Despite the differences in the areas covered by task groups, in some cases they will explore the same issue from a range of perspectives. For example, the issue of the health status of migrants will be reviewed by different groups.

136. The task groups have started reviewing and investigating the evidence on social determinants and health inequities in the European Region and will continue working until the end of 2011, when they are expected to provide final reports to the UCL Secretariat, which in turn will draw on these findings when finalizing the Review.

Working group of Regional Office focal points

137. In addition to the WHO and UCL Secretariat staff, focal points have been identified from all relevant technical areas covered by the WHO Regional Office for Europe. These Regional Office focal points are working with individual task groups, bringing their specific expertise, key resources (including networks and contacts) and experience to the work – particularly their experience in working with countries on implementing many of these ideas. This will ensure that the Review reflects WHO’s experience of working with Member States. Regional Office focal points have been actively involved in drawing up the workplans of the different task groups, further defining the scope of research, identifying key pieces of work to form a baseline, and recommending further task group members.

138. To ensure coordination and coherence of the input provided by focal points to the different task groups, an in-house working group has been established at the Regional Office. This in-house working group meets on a regular basis. The first meeting of the working group in November 2010 marked the constitution of the group and focused on establishing methods of working. The second meeting, held towards the end of January 2011 (when most task groups had defined individual studies and reviews to be commissioned), focused on identifying potential gaps, overlaps and areas for synergy in the overall body of research commissioned for the Review.

139. In addition to ensuring that the Review and its different task groups draw on the expertise and experience of staff at the Regional Office, the in-house technical working group provides a crucial link which ensures that knowledge generated through the Review process informs WHO’s work and is transferable to Member States. This includes development of the new health policy for Europe – Health 2020.

Preparing for the next phase of the Review

140. In preparation for the next meeting of senior advisers that will take place in Malmö, Sweden on 3–4 March 2011, the WHO and UCL Secretariats have been working on further developing arrangements for the next phase of the Review. This has included working jointly to develop options for involving countries as partners and consulting different stakeholders in the Review process. The process of country consultation is closely linked to the country partnership process, as part of Health 2020. A document based on the initial work done by task groups, setting out the key emerging themes
and the approach adopted to policy recommendations, will be prepared by the UCL Secretariat for these consultations, which will take place between April and December 2011. A paper setting out the initial findings from these consultations will be tabled for discussion with representatives of Member States at the sixty-first session of the Regional Committee (Baku, Azerbaijan, September 2011).

141. Possible options for different approaches to consultation with countries will be discussed at the Malmö meeting of senior advisers. These include:

- **Testing findings that have emerged, to understand their applicability to different parts of the Region.** Specific consultations will focus on reviewing likely policy recommendations that have emerged from the work done by task groups, to see how these resonate with different countries. This will allow lessons to be learned about how they fit with different country contexts across the European Region. Such feedback will also allow for research findings to be further refined, ensuring that the Review and its outcomes speak to all countries in the Region and that they will be taken up and implemented by Member States. This could include, for instance, a consultation with policymakers from countries in the Commonwealth of Independent States (CIS), to test the applicability of findings in that subregion.

- **Thematic consultations around key policy areas examined by the Review.** Certain key policy areas are being explored by a number of task groups from the perspective of a variety of different determinants and life stages. These include issues related to migration, child poverty and the impact of the economic crisis. It is envisaged that such thematic consultations would involve a wide range of stakeholders in discussing these issues and exploring them through the “lenses” of different life stage and determinants. These consultations will ensure that a different range of voices will inform and contribute to the Review’s findings. For instance, a consultation on migrants in the European Region could explore the findings from task groups such as those on global factors and on vulnerability. It would involve a wide range of stakeholders, including physicians’ associations and other civil society organizations.

The studies

142. The evidence review is being undertaken by 13 (topic-specific and cross-cutting) task groups, covering the main social determinants of health and key issues related to the life course and delivery systems/mechanisms. The task groups have commissioned a total of more than 40 in-depth studies and numerous country case studies, in order to assess and analyse recent evidence of successful action to reduce inequalities in health.

*Studies envisaged by the topic task groups*

143. The Task Group on **“Early years, education and family”** will acknowledge the strong association between development and learning during childhood and adolescence, on the one hand, and health during this period and into adulthood, on the other. More importantly, it will identify interventions, policies, strategies and approaches that can make a difference to developmental and learning outcomes for children and young people, and so impact on health and health inequalities. Children and young people will be looked at as agents in a series of contexts (e.g. the family, the school/wider educational system, communities). The Task Group intends to study the impact of interventions on health and health equity in childhood and adolescence within these contexts.

144. The Task Group on **“Employment and working conditions”** will provide a summary account of current evidence on the adverse health effects produced by unemployment and precarious work. It will identify and discuss interventions and policy measures at different levels to promote work-related health, including basic occupational health services. Furthermore, the Task Group will draw on evidence collected under the PRIMA-EF (Psychosocial Risk Management – Excellence Framework) project, which focuses on interventions at work that have an impact on mainly psychosocial working conditions and health.
145. The Task Group on “Social exclusion, disadvantage and vulnerability” will identify the key characteristics of action by governments and other actors that has the potential to impact positively on (or exacerbate) disadvantage, exclusion and/or vulnerability and hence to reduce (or widen) health inequities. On the basis of the findings, a preliminary action framework will be developed and its generalisability tested across diverse socioeconomic, cultural and political contexts in the European Region. The Task Group is paying special attention to vulnerability issues related to the Roma population, child poverty, migration and displacement, and disability.

146. The Task Group on “Gross domestic product, taxation, income and welfare” will undertake a focused review of how income, poverty and income distribution are related to health and health inequalities. The study will review, among other things, how institutions and programmes entailing income redistribution could be designed to improve public health in general and the health of low-income groups in particular. Another study commissioned by the Task Group will review comparative welfare policies and see how social policy institutions and programmes can impact on health and health inequalities.

147. The Task Group on “Sustainability and community” intends to review the impact of natural, built and social environments on health inequalities. It will study the interplay between natural, built and social resources, and how they influence human health and health inequalities, directly or indirectly. The study on natural environments includes the health consequences of a) greenhouse gas emissions and climate change, b) the generation, scarcity/availability and deployment of energy, and c) the degradation/depletion and safeguarding of natural resources. The built environment study considers issues related to areas such as housing, spatial planning, design and construction, civic facilities and transport. Social networks, trust and security, supportive relationships and shared responsibility will be components of the study of social environments.

148. A descriptive analysis by the Task Group on “Prevention and treatment of ill health” will assess the causes and impacts of preventable diseases (both infectious and chronic) that play the greatest role in health inequalities; differences between specific countries and groups of countries (western Europe/central and eastern Europe/CIS countries); estimation of the most important direct risk factors: smoking, alcohol, nutrition/obesity, etc. (with special attention to alcohol). Case studies from Poland, the Czech Republic, Lithuania, the Russian Federation, Norway and the United Kingdom are planned, in order to analyse education and health indicators. Moreover, the Task Group will review the improvement and decline in health (in times of transformation) after 1990 in selected countries. Moreover, case studies will assess competence and capacity for public health and health promotion in the new European Union member countries in eastern Europe and in “control” countries.

149. The Task Group on “Gender” will synthesize evidence and suggest policies, programmes and institutional arrangements that modify the association between gender as a social determinant of health and health equity and thereby enhance opportunities for greater health equity, taking into consideration women’s as well as men’s concerns and experiences. The Task Group will study gender differences in the quality of life, mortality and disability in different countries in the WHO European Region. It will also review the evidence on gender-specific exposures to health risks and their relation with other determinants, such as income, place of residence (urban/rural), ethnicity and education. Interventions and policies to tackle gender-biased values, norms, practices and behaviour within households and communities will be analysed; they can influence aspects such as the home–work balance, work and interpersonal stress, domestic violence, other gender-related chronic stress factors, reproductive health, child bearing and fertility.

150. The Task Group on “Older people” will review differentials in health and well-being between and within countries by gender, age and indicator of socioeconomic status. The five health indicators selected are mortality, disability, mental health/depression, subjective well-being (including indicators of social isolation), and health-related behaviour, particularly smoking. The Task Group will also assess inequalities in the use of health care (with some consideration of social care) by older people and discuss policy implications based on the findings.
Studies envisaged by the cross-cutting task groups

151. The Task Group on “Economics” envisages four in-depth studies. The first will identify relevant survey data to be used for any assessment of the relationships between socioeconomic factors and policies and health. The second study will include a quasi-experimental/econometric analysis of the causal effect of policies on health outcomes. The aim of the third study is to quantify the “costs of doing nothing”, i.e. the costs of health inequalities or the expected benefits of different scenarios for reduction of health inequalities. The fourth study will reassess the relative income hypothesis for a multitude of countries.

152. The studies commissioned by the Task Group on “Governance and delivery systems” will make an attempt to answer the following questions: 1) how to address the lack of systematic and appropriate investment in infrastructure development aimed at initiating and supporting effective intersectoral action on the social determinants of health; 2) how delivery mechanisms should be appropriately allocated within specific country policy contexts; and 3) how human resources could be developed and deployed across government, have adequate skills and know-how and be accountable for attainment of targets and goals concerning social determinants of health and health inequalities. The envisaged studies will look at European experience and countries’ efforts to develop well-performing institutional arrangements and delivery mechanisms, supported by a critical mass of human resources in health ministries and across government, focusing on key elements of good governance in addressing social determinants of health. The synergy between this study and the study on “Governance for health in the 21st century” is strong and will be maximized.

153. The Task Group on “Global factors” will assess the impact of the global financial crisis on public health, which includes the short-, medium- and long-term consequences on aspects such as consumption, social protection, income and employment. The review will also include an analysis of trade policies and health, such as the impact of trade treaties on European Union member countries’ regulatory policy “space” regarding tobacco, alcohol and food. Finally, one of the commissioned studies will analyse development policies, considering questions such as whether European bilateral and multilateral donor practices are in line with commitments expressed in the Paris Declaration on Aid Effectiveness, the International Health Partnership and related initiatives (IHP+), etc. in terms of harmonization, quality, effectiveness, quantity, donor country ownership.

154. The aim of the Task Group on “Equity, equality and human rights” is to develop a conceptual framework on equity and human rights issues that are important for tackling health inequalities. It also intends to identify the human rights instruments (international, regional or national) that offer opportunities to support health equity in a broad spectrum of policies addressing the social determinants of health. Furthermore, it will identify the conditions under which the human rights approach can be successfully applied in policies to tackle health inequalities.

155. Finally, the Task Group on “Measurement and targets” will compile an overview of sources of information, their availability and the quality of data on health outcomes and their social determinants in the WHO European Region. Special attention will be paid to data and measurements collected/required by European Union institutions.
## Appendix 1. Task groups and task group chairs

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<th>Topic task group</th>
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<td>Early years, education and family</td>
<td>Alan Dyson,</td>
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<td>Naomi Eisenstadt (co-chairs)</td>
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<td>Employment and working conditions</td>
<td>Johannes Siegrist</td>
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<td>Social exclusion, disadvantage and vulnerability</td>
<td>Jennie Popay</td>
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<td>Gross domestic product, taxation, income and welfare</td>
<td>Olle Lundberg</td>
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<td>Sustainability and community</td>
<td>Anna Coote</td>
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<tr>
<td>Prevention and treatment of ill health</td>
<td>Gauden Galea, Witold Zatonski (co-chairs)</td>
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<tr>
<td>Gender</td>
<td>Maria Kopp</td>
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<td>Older people</td>
<td>Emily Grundy</td>
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<th>Cross-cutting task group</th>
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<td>Economics</td>
<td>Marc Suhrcke</td>
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<td>Governance and delivery systems</td>
<td>Harry Burns, Erio Ziglio (co-chairs)</td>
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<td>Global factors</td>
<td>Ron Labonte</td>
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<td>Equity, equality and human rights</td>
<td>Karien Stronks</td>
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<tr>
<td>Measurement and targets</td>
<td>Claudia Stein, Martin Bobak (co-chairs)</td>
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### Key milestones

- **March 2011**  
  Second Meeting of Senior Review Advisers, Malmö (3–4 March)
- **April 2011**  
  Draft consultation report
- **April – October 2011**  
  Consultation with countries and different stakeholders
- **May 2011**  
  Finalization of document for Regional Committee
- **June 2011**  
  Third Meeting of Senior Review Advisers
- **September 2011**  
  Discussions at the sixty-first session of the Regional Committee (Baku, Azerbaijan)
- **November 2011**  
  Fourth Meeting of Senior Review Advisers (to consider emerging findings from task groups)
- **December 2011**  
  Task groups submit their final reports
- **April 2012**  
  UCL delivers final report to WHO
- **September 2012**  
  Report with final recommendations launched at the sixty-second session of the Regional Committee