World Health Organization

REGIONAL OFFICE FOR Europe

European Advisory Committee on Health Research

Second Meeting, Copenhagen, Denmark, 20–21 September 2012

ABSTRACT

The European Advisory Committee on Health Research reports directly to the WHO Regional Director for Europe. Its main terms of reference are to advise the Regional Director on formulation of policies for the development of research for health in the Region; review the scientific basis of selected WHO European Regional Office programmes; advise the Regional Director on new findings on priority public health issues, and effective evidence-based strategies and policies to address them; and facilitate dialogue and interaction to exchange information on research agendas in the Region and address evidence gaps in priority areas. The Committee held its second meeting in Copenhagen, Denmark, on 20–21 September 2012. Its aims were to ensure that the Committee was formally established according to WHO rules; to determine how to integrate its work more closely with that of the Regional Office; and to follow up items from its first meeting. The meeting explored several key subject areas, including Health 2020. Next steps were agreed, above all the need to clarify the Committee's future role and develop a strategic plan.

Keywords

- DELIVERY OF HEALTH CARE – ORGANIZATION AND ADMINISTRATION
- HEALTH MANAGEMENT AND PLANNING
- HEALTH POLICY
- HEALTH STATUS INDICATORS
- PUBLIC HEALTH ADMINISTRATION
- STRATEGIC PLANNING

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Executive summary

The European Advisory Committee on Health Research reports directly to the WHO Regional Director for Europe. Its main terms of reference are to advise the Regional Director on formulation of policies for the development of research for health in the Region; review the scientific basis of selected WHO European Regional Office programmes; advise the Regional Director on new findings on priority public health issues, and effective evidence-based strategies and policies to address them; and facilitate dialogue and interaction to exchange information on research agendas in the Region and address evidence gaps in priority areas.

The Committee held its second meeting in Copenhagen, Denmark, on 20–21 September 2012. Its aims were to ensure that the Committee was formally established according to WHO rules; to determine how to integrate its work more closely with that of the Regional Office; and to follow up items from its first meeting.

The meeting also explored several key subject areas, with updates on current WHO priorities including Health 2020, noncommunicable diseases, mapping national health research systems, strengthening public health services and capacity, health governance, and the economics of prevention.

In the course of the meeting a number of areas were identified where the Committee could become more closely engaged with the work of the Regional Office. These included the following:

- act as a resource for peer or ‘merit’ review;
- set research priorities and frameworks;
- identify gaps and shortcomings in the evidence base underpinning WHO policies and programmes, especially Health 2020;
- liaise with partners and funders;
- undertake and promote research into political processes and the political determinants of health, and produce a report;
- advocate improvements in data standards, collection and sharing.

This, with other areas also suggested, comprised a long list, and in view of resource constraints and the need to be strategic, it was agreed that the overall purpose of the Committee should be more clearly defined. This would help to determine its strategy and priorities for its programme of work. It was agreed to hold a series of teleconferences to refine its role in the governance of the Regional Office, and identify its future structure, using a mind map to be produced by the Secretariat in due course.

Meanwhile work could proceed on a number of other action points, especially Committee input to mapping the status of research capacity in Member States that could begin with the central Asian republics by the end of 2012. Members would also be sent the draft 2012 European health report and Health 2020 framework for review.

Introduction

The reconstituted European Advisory Committee on Health Research (EACHR) met on 20-21 September 2012 at the WHO Regional Office for Europe, Copenhagen. Its aims were to ensure that the Committee was formally established according to WHO rules; to determine how to integrate its work more closely with that of the Regional Office; and to follow up items from its first meeting in June 2011. A number of key subject areas were also discussed:

- Health 2020
- noncommunicable diseases
- mapping national health research systems
- health governance
- the economics of prevention.

The terms of reference of EACHR, which reports directly to the Regional Director, are to:

- advise the Regional Director on formulation of policies for the development of research for health in the Region;
- review the scientific basis of selected WHO European Regional programmes, with particular attention to their translational aspects;
- advise the Regional Director on new findings emerging from research results regarding priority public health issues, and effective evidence-based strategies and policies to address them;
- facilitate dialogue and interaction among the public health community, research bodies and funding agencies in order to exchange information on research agendas in the Region and address evidence gaps in priority areas such as noncommunicable diseases;
- facilitate the compilation and review of the results of major research programmes addressing priority public health problems, and assess their implications for policy at the international, national and local levels;
- support the development of research potential and capability, nationally and regionally, with special attention to the eastern part of the Region;
- pursue the harmonization of research activities in the Region with the activities of other regions and at the global level;
- formulate as appropriate ethical criteria for public health research activities;
- review the status of WHO collaborating centres in the Region; support the evaluation of their activities on the basis of pre-defined criteria; and propose new centres in areas of emerging concern.

A vision for EACHR

Ms Zsuzsanna Jakab, WHO Regional Director for Europe, welcomed participants and described her vision for EACHR and its contribution to the work of the Regional Office. She reported on the 62nd session of the WHO Regional Committee for Europe (Malta, 10-13 September 2012) and Member States' unanimous endorsement of Health 2020, the new European policy for health

and well-being *(1)*. The action plan for strengthening public health services and capacity *(2)*, a pillar of Health 2020, also had great support.

Acknowledging that the potential remit of EACHR was wide, and its need to choose priorities, she suggested areas where it could have an important role:

- conduct reviews of various strategies and evidence produced by the Regional Office;
- examine the impact and implementation of materials approved at previous regional committee sessions, for example on measles and rubella (session 60), and alcohol, HIV/AIDS, and antimicrobial resistance (session 61);
- review what further evidence might be needed for implementation of Health 2020;
- report on the use of evidence in policy-making in Member States;
- offer advice on how to make evidence work for policy at country level;
- help to forge better or additional partnerships with the other voices in Europe, most notably the European Commission (EC) Directorate General for Research and Innovation and the new Science Europe organization;
- contribute to global debate through linking with WHO Headquarters, including input to the follow-up work of the WHO Consultative Expert Working Group on Research and Development: Financing and Coordination (CEWG) as needed.

The Regional Director also suggested that the Committee could provide quality assurance by reviewing all major materials related to or including research before they were put before future European regional committee sessions. An indication of what was likely to be put to the Regional Committee could be given to the EACHR in the preceding November, when the draft agenda would be discussed. The next EACHR meeting could be held in April 2013 to feed into the finalization of Regional Committee documentation. It could also assist the review of materials by the Standing Committee of the Regional Committee (SCRC) prior to the Regional Committee.

EACHR's general role in the governance of the Regional Office needed clarification and would require SCRC approval, Ms Jakab said. The chair and vice-chair might join SCRC meetings on Regional Committee planning, and the SCRC chair might attend EACHR meetings.

Committee members commented that if EACHR was to define the evidence base needed for policy, a framework was needed to determine the status of research capacity in each country, and human resources and funds would be needed. Dr Claudia Stein, Director, Division of Information, Evidence, Research and Innovation, responded that current staffing levels do not permit the Secretariat to take a lead in this. The Regional Director suggested that some research work might also be embedded in Committee members' own research.

A number of actions were agreed. These, with other actions agreed during the meeting, are listed together for convenience in the concluding section of this report.

Dr Stein outlined the EACHR terms of reference, and noted that responsibility for the Committee had been moved from the Chief Scientist's office earlier this year to her division. The transfer had regrettably caused delays on previously agreed actions. According to the rules that govern the procedures of WHO advisory panels *(3)*, members participate as individuals, not on behalf of

their governments or host organizations. WHO would welcome observers to EACHR meetings, who could make interventions after the appointed members.

Professor Roza Adany, Professor of Public Health, University of Debrecen, Hungary, was elected vice-chair of the Committee. Mr Robert Terry, Programme Manager, Research, Development and Policy, WHO Headquarters, was elected meeting rapporteur. No conflict of interest issues were reported by members.

Matters arising and actions agreed

EACHR Chair Professor Martin McKee, Professor of European Public Health, London School of Hygiene & Tropical Medicine, United Kingdom, outlined the meeting agenda and led the discussion of matters arising from the previous meeting.

He said EACHR's main focus over the coming year should be the mapping of national health research systems agreed at the last meeting, though not yet started. The Secretariat noted that the intention was to start with the central Asian republics, with potential extension later to the wider Commonwealth of Independent States. A questionnaire for face-to-face interviews and in-country work should be designed, perhaps adapting the mapping and questionnaire approach of the Council on Health Research for Development (COHRED).

Mr Terry summarized the WHO Headquarters work in this area. Two pieces of research and development mapping on a worldwide basis had been undertaken and would be shared with WHO regional offices. One was a bibliometric analysis, based on raw data provided by Thomson Reuters that analysed published health research papers compared to total research and development output by country, and made a 20-year trend analysis of published output and health research output by World Bank income group.

Dr Stein said the Regional Office was undertaking an internal exercise to integrate all its databases, platforms and systems in a single platform. It was part of the wider European Health Information System being developed via a formal agreement between WHO, the EC and the Organisation for Economic Co-operation and Development (OECD). A forthcoming workshop would pilot simple, Excel-based tools for mapping country health information with five countries. EACHR would be able to review the tools if so desired.

On the Committee's role and remit, Professor McKee said it was important to understand what was being done outside the Regional Office, to avoid duplication of effort. Members also highlighted the need to engage others and suggested contacting the Chair of the Medical Committee, Science Europe, and the President of the Alliance for Biomedical Medical Research in Europe. Stronger links would help to address the full spectrum of health research across the whole innovation chain.

The resources for EACHR work were discussed. Planning for the next biennium was under way, including resource mobilization. EACHR could embed some of its work in members' grant proposals and project work. Ms Jakab noted that 80% of WHO activities were supported by extrabudgetary sources (voluntary donations). The challenges of earmarked funds and a decentralized system that created unpredictability were being addressed in discussions on overall WHO reform, and she was chairing a WHO committee on how to generate corporate fundraising. Allocation of funds within WHO was another challenge.

Committee members underlined their interest in generating evidence for use in the Region. They needed to know where they stood internationally; clarify what funds would be available; and develop a strategy and action plan. Ms Jakab stressed her desire for the Committee to undertake all the work mentioned, but noted the need for realistic expectations. The mapping exercise was the priority.

The minutes of the previous meeting were adopted.

Action on noncommunicable diseases

Dr Gauden Galea, Director, Division of Noncommunicable Diseases and Health Promotion, gave a presentation on global research priorities for action on and monitoring of noncommunicable diseases (NCD) *(4).*

In May 2012 the World Health Assembly agreed a global target of a 25% reduction in premature mortality in NCDs by 2025 (age range 30-70). Each WHO regional committee would feed into an informal meeting of Member States in November 2012 that would produce an outcome statement with a global monitoring framework, including indicators and voluntary targets to be developed. The plan would be presented to the WHO Executive Board in January 2013.

He presented the global NCD action plan and monitoring framework (2013-2020) *(5).* An action plan would be developed for each priority area, with tools for defining the issues and potential actions for health promotion, disease prevention and treatment. The current draft of the NCD action plan had 11 indicators with targets including tobacco, blood pressure, salt intake, alcohol and fat, and provided a 'traffic light' assessment of progress.

At least 25% of European Member States surveyed by the Regional Office said they were appointing an NCD technical focal point. They preferred the 'tool-kit' approach in which interventions and policy choices came with instructions on use. All tools were evidence-based, with an inbuilt results-based management approach (reporting and evaluation from the outset), though there was no clarity on how to measure progress. Countries could pick and choose according to their local context. Ensuring the tools were sufficiently relevant to all Member States was a potential research question for the future.

There was much debate, he said, on the methods to measure between absolute targets (e.g. ideal blood pressure) and relative targets (e.g. percentage of the population with a certain blood pressure). Should a target be included if agreement could not be achieved among experts on a given measure? For example, researchers continued to disagree on spot analysis for blood pressure monitoring versus 24-hour samples to measure salt in urine.

Four research-related questions could benefit from EACHR input.

- What would a global NCD monitoring framework look like?
- What should the targets be, and how would the proposed indicators contribute to their attainment?
- What could or should go into the tool kit?
- How could the tool kit be made relevant to all Member States?

In discussion, the difference between the NCD action plan targets and those in Health 2020 was raised. The cut-off points were different, i.e. 2020 versus 2025, but the calculations were the same. The only overlap in indicators, therefore, was in mortality. There was a need to include the time frame in any calculation between intervention and outcome, and between risk factor and impact. The lags caused asymmetric relationships, which were particularly important to observe in the whole life course and across generations.

While the technical concerns were important, they should not prevent the development of targets, which provided a rallying point for action. It might be better to focus on just three core messages: improve diet, reduce tobacco use, and reduce harmful alcohol use. Implementing what was known was perhaps the best approach.

The political environment in each country was a key consideration. A strong political statement and commitment could make a big difference. The dissemination of available evidence in a language suited to policy-makers was important; they needed to know the economic benefits of an intervention if they were to endorse the way forward. Every action must be costed in an integrated NCD plan.

It was felt that the aggregate figures were probably about right to stimulate political motivation. The indicators were important as ‘what gets measured is what gets done’. The correct action was to be supported even if the targets were hard to measure. Rather than continuing to focus on methods, the focus should move to the targets themselves – it was not important whether Member States only agreed to three or one, but it was important that work was done to address them. Dr Galea said he had confidence in the ‘traffic lights’ approach, even if the specific data were not always verifiable.

A systemized organization of the evidence on prevention was needed, akin to the Cochrane Library – what works, with real examples. It was important to review the process of implementing an intervention as well as the intervention itself, especially as it was strongly linked to the national/subnational context.

It was noted that the NCD research agenda in the Regional Office was weak, as the focus was on implementing what was already known. There was a programme of work, especially comparing between countries, and promoting the so-called ‘best buys’.

There were constraints on WHO’s role. By the end of 2012 there would be no WHO country staff with a sole focus on NCDs, and no funds forthcoming. WHO’s approach was to wait until Member States demonstrated their own commitment; reaching this ‘activation threshold’ was the trigger for technical support. Its role was to provide technical analysis and to support capacity-building in the planning and implementation of preventative measures, but Member States also had to invest their own resources.

Finally, EACHR input might be limited as the process was a political one. The Committee and Regional Office might help with facilitating better dissemination of materials, discussions and evidence to encourage its uptake in policy circles in Member States.

Health 2020 – examining the evidence base

Research priorities to strengthen the evidence base

Dr Agis Tsouros, Unit Head, Policy, Cross-cutting Programmes and Regional Director's Special Projects, outlined the content and pathway to Health 2020. The process had involved the entire Regional Office as well as external commissioning, though regrettably the timing had not permitted an EACHR review of the documentation.

EACHR could now contribute by helping to identify the gaps (in the build of the evidence); helping in the implementation phase, e.g. providing useful examples to Member States; and validating ongoing work, especially in relation to implementation. The commitment was to make Health 2020 a living document subject to revision. The need now was to identify good practice and policies that illustrated the strategy and filled the evidence gaps.

The Committee commended the framework. There were no major concerns about gaps, although it was unclear exactly how the priorities were identified as there did not seem to be an analysis of the burden of disease. A short document was needed for policy-makers that identified which messages were horizontal and could apply across countries and regions, and which needed to be national or subnational and required different implementation strategies. Policy-makers needed to know about interventions that worked, and the evidence that led to them. Implementation and knowledge transfer were therefore essential in a new research agenda. The need for an implementation plan with a time line was raised.

Improving public health required complex interventions across a range of policies, so it was important not to focus solely on percentage indicators; qualitative work to explain the figures was also needed. For example, there was a tendency to talk about health systems as a single pillar of intervention, yet many determinants and interventions lay elsewhere. The Secretariat pointed out that inequalities were the defining feature of all European health data, and asked how the Committee could help address the need for qualitative indicators.

The need for different types of document for different audiences was also raised, including for donors. Policy-makers could be engaged using a single document on what worked, where and how. The forthcoming WHO 2012 European Health Report adopted this approach and covered many of the Health 2020 indicators. The Evidence Informed Policy Network (EVIPNet) for Europe could also demonstrate this type of learning from knowledge translation.

Committee members thought the main selling point of the Health 2020 policy was its equity lens, focusing on social determinants within an inclusive policy approach; otherwise health ministers might think it was nothing new. There should be a greater emphasis on research to engage other stakeholders such as scientific societies, universities and the biomedical research community.

They also highlighted the need to look beyond the old 'evidence-based' interventions, as manufacturers used increasingly innovative tactics; make better use of social media; and adopt a more horizontal approach to implementation, given the region's diversity. Sometimes the evidence might not be there, for example on the impact of social media on behaviour, but that should not stifle innovation.

Specific areas were identified where accepted policy in the document might be challenged now and in future:

- age-related influenza vaccination, and mammography – was the evidence strong enough?
- on values – had polling data been used, did people think their health systems were working?
- the issue of opiates and needle substitution was controversial; were all Member States on board?
- human (in)security was an issue but was not mentioned in sections on injuries - alcohol was not the only causal factor;
- male mortality from alcohol abuse;
- the health of migrants was not addressed;
- the indicators on health inequalities were good but more support was needed for this pillar.

Dr Tsouros responded that it was necessary to combine and harmonize the data on equity for greater impact. The indicators were the glue, particularly on reducing inequalities. EACHR could help the secretariat with this; measurement, e.g. of well-being, needed much work. The European health report, which informed Health 2020, included evidence on the disease burden.

The Committee suggested broadening the scope of 'research and evidence' such that indicators could be drawn from other sources and types of research. This entered the area of complex interventions, which was where the work on implementation needed to go. EACHR had a clear role in identifying best practice by reviewing new publications on complex interventions, and could provide legitimacy to technical programmes through peer review. It could produce a paper on complex interventions to inform Health 2020.

Dr Tsouros stressed that the Regional Office's strength lay in understanding countries' contexts, and wanted the Committee to contribute actively to Health 2020 by advising how the evidence could be made more robust and used in diverse contexts, rather than simply reviewing materials. Knowledge management and translation was a key part of this work. The European arm of EVIPNet, soon be launched, should develop strong links with EACHR and a clear joint agenda to build in-country capacity. He asked the Committee to submit any useful evidence on implementation. It was agreed that Health 2020 would be a standing item on the EACHR agenda.

Developing targets and indicators for Health 2020

Dr Stein described the development of the Health 2020 targets and the European health report, and explained how the initial 51 proposed targets had been reduced to six. The principles were to have a small number of targets, align them with global efforts, build on existing work, and operate at a regional level (i.e. no reporting of national targets). The most controversial indicator was a measure of well-being – though long part of the WHO Constitution *(6)*, there had been no previous attempts to measure it. While the well-being indicators may require more time to develop, the indicator list for the remaining targets would be ready for online consultation in the first part of 2013, and would then be refined by the SCRC for consideration by the Regional Committee in 2013. The draft European health report would be sent to EACHR as part of the internal review.

The Committee debated how this work could or should be linked with other ongoing work in the Region, notably the European Union's work on a healthy life, and the EC Horizon 2020

programme and target on life expectancy and inequalities *(7).* Development of a monitoring system would be the most difficult aspect.

A number of observations were made on specific targets. Years of austerity would be followed by harvesting years, but year-on-year reductions might be difficult during the economic crisis. Subregional and national targets would be needed, given the Region's heterogeneity. To understand reductions, agreement would be needed on starting points and baselines. Reducing differences in life expectancy between socioeconomic groups was very difficult, but data should include economic disaggregation. A 30% reduction in road traffic injuries required a complex strategy; the target should address reducing mortality, even if accident numbers were increasing. The determinants should be understood in order to interpret trends and plan interventions. There was a strong focus on mortality in the targets and indicators.

Dr Stein said summary measures of health are difficult to report for many Member States, including Disability Adjusted Life Years (DALYs) as many countries do not collate information on morbidity or disability. Vignettes were used to create disability weights and improve self-reported health status to enable comparability. One member noted that inequalities remained intact if all countries achieved percentage reductions; absolute measures might be more realistic in some areas.

There was discussion of the relative value of targets being set and applied in this manner. It was asked what the principles were: absolute or relative, Gini coefficient or socially structured (distributional) index? Were implicit or explicit value judgements being made through weighting specific issues? For example, a focus on the under-75s implied that deaths thereafter were not important. Dr Stein said a multiple-step approach was used; the process began with the principles and worked down. It was agreed that this could be done within the time frame, given how much work had already been done in national health strategies.

A Committee member said the purpose of monitoring should be clarified: for tracking and benchmarking, or for the Regional Office to take programmatic action? It was thought useful to flag areas that needed help, and thereby to make policy. Targets could be based on the best country results, i.e. aim for what was achieved elsewhere as a benchmark.

Further explanation was also required of why WHO was addressing inequalities - because some groups were suffering despite being in 'richer' societies, or because of a concern with general health? This led to the question of the subregional weighting of targets and the need to go beyond the usual tracers.

Committee members also mentioned the need to be aware of re-emerging diseases such as polio. For the target on reducing premature mortality, probability of causes of death by age should be used. Care should be taken over use of the terms 'live birth weight' and 'live births'. Data validity issues were raised - not just technical, but also data sources. The discussion moved to data stratification. One member said ethnicity was an obvious and clear stratifier, though in some countries it was used as a veil for discrimination; in countries where ethnicity was an issue there was no stratification. The issue was sensitive (also with self-identification), but WHO could make the case for the importance of this stratifier to help these groups.

Collecting data with wide utility that could be combined with other measures in a sound way should be an additional criterion. It was felt that Member States that wanted to report their data,

even if not in the final full set – perhaps as a second tier or in a closed archive – should still be encouraged to do so rather than submit nothing.

Dr Stein responded by reiterating the criteria for the targets: use existing measures where appropriate, be pragmatic, and build on what was there to produce a meaningful study. The United States government's Healthy People 2020 initiative *(8)* was a valuable comparison. The monitoring framework in the target-setting exercise was being used for benchmarking. The aim was to address gaps and to help countries help themselves to do better, as they needed to be able to use the indicators to effect change, and to be able to answer the 'so what' question.

Several Committee members commented on the work on well-being. Dr Stein noted the many indicators of well-being and the need to begin recording data. A WHO expert group was reviewing all well-being indicators and indices to see what could be used in the context of health. On relative measures, Member States did not support comparisons between countries.

The economics of prevention

Dr Roberto Bertollini, Chief Scientist and WHO Representative to the European Union, outlined Regional Office work on the 'economics of prevention' (the case for investing in public health programmes) and the growing use of economic evaluation in health. A Regional Committee report on Health 2020 focused on inequalities and the fact that the cost of ill health spanned so many sectors. It showed that:

- complex or combined interventions were often more useful than single interventions;
- cross-sectional investment was effective;
- the measurement of effectiveness was difficult, along with attribution.

The Committee congratulated the authors and agreed this was a very important issue. It was a powerful general argument if the right messages could be found, especially to policy-makers, who were strongly focused on cost. It raised the question whether clinicians ought to demonstrate the effectiveness of interventions, while the public health community then had to prove cost-effectiveness.

Headline-grabbing messages were needed that could be extracted from scientific research, perhaps using the 'solid facts' style of document. One report had wide impact in the United Kingdom owing to its headline finding on the value of investing in research and development, for example in cardiac research, where there was a 39% return in perpetuity for every £1 invested *(9)*. The Research America organization also provided good examples *(10)*.

Yet it was essential to get the analysis right in the first place. Prevention measures were complex interventions, while economic data was generated by modelling based on available data, and created estimates with caveats. Modelling was always adapted to available rather than actual data, and disease was measured rather than health. The period between intervention and impact could be long and attribution difficult; actions and preventive measures went across generations, so a life course approach to data collection should be developed. Bringing different elements together in a meaningful way was a challenge; for example, preventing the negative effects of excessive alcohol consumption was not the same as promoting well-being.

Actions outside the health sector that were not undertaken for health reasons often had an impact on health. In a well-known Russian Federation example, a reduction in circulatory mortality was related to measures to regulate unofficial alcohol production, but the main political motivation was to reduce tax avoidance. Thus the term 'interventions' might be too simplistic. Policy was rarely evidence-based so a good argument and good data did not always win. The debate on prevention was not about cost but was ideological: the role of the state, freedom of individuals and the freedom of the market should be discussed. A political science perspective was needed to analyse support for or opposition to a measure, in order to position health better.
The right balance was needed between experts generating data and robust evidence, and the different skills required to communicate with politicians. Knowledge translation skills and the involvement of the media were key to impact. The WHO mandate should be respected, providing sound data and robust evidence on public health, while accepting the need to bring effectiveness and cost together, and create headlines to get the message across.

The Committee endorsed the need to understand the political determinants of health, and to consider how to deliver more effective messages.

Strengthening public health services and health governance

The way forward on public health

Dr Hans Kluge, Director, Division of Public Health and Health Systems, gave an update on the WHO European action plan to strengthen public health services and capacity *(2).* He outlined WHO's revitalised commitment to defining and developing core public health operations in the Region.

Committee members warmly endorsed the action plan. It was key to understand how to engage with and strengthen networks, not only with national bodies but also with the best research networks, and university-based researchers as well as public health institutes. On behalf of the European Public Health Association (EUPHA), one Committee member supported the plan to make it a main theme at its Brussels conference in 2013. Committee members could help through their own networks, encouraging wide interactions across EC programmes. To assist this process, there could be a mapping exercise as part of the 10th essential public health operation, 'advancing public health research to inform policy and practice'.

A challenge was made: how could public health systems be organized more innovatively? Introducing new ways of providing health care required an understanding of how to manage complex systems and complex integrated interventions.

Governance for health

Professor Ilona Kickbusch, in her role as leader of a supporting study for Health 2020, outlined a paper on health governance presented to the Regional Committee *(11).* She stressed the need to understand the political and economic determinants of health better, and how they fitted together. There was a strong interface between the metrics of well-being and social determinants. Governance also interfaced with whole-of-government approaches in contributing to a vibrant economy. Core questions to emerge from this work were the position of health in the new economy; what other policies impacted on health; and how to deal with this complexity.

The study concluded that new mechanisms were needed to bring disparate actors together. This would not happen organically and required an active process, which in turn required funds and organization. From the research perspective there was no differentiation between the work of ministries of health and how they interacted with other ministries, so better differentiation was needed between health policies and health politics.

The guiding research questions included the need to understand the drivers in the state – what was key and how they interacted; and co-production of health governance - how could and did citizens contribute. There were considerable differences in levels of governance. Local governance could also interact at a global level.

Political scientists had developed stakeholder analysis tools to enable systematic mapping of a situation and influences, which could be better utilized in the area of health. The European Council's Lisbon Strategy had set a goal of increasing life expectancy by two years, but not clarified who would be responsible or could deliver it. The question of who was accountable remained, as responsibility should be shared, and was not only that of ministries of health (i.e. health in all policies). The role of the state had changed and the ministry's role should be reconsidered in relation to political determinants, particularly the commercial determinants of health, with analysis of why certain policies were taken forward and others not. A follow-up study was needed to produce a 'solid facts' issue.

Professor Kickbusch recommended inviting political scientists to the debate on how to position health in the current political situation, for example to learn from the repositioning of education. The next step involved undertaking more context-based (country) research.

Committee members said this challenging report offered a new perspective. Prevention was shown to require the development of a multi-method approach for data collection from many different sources. Too complex an outcome, where the message was subsequently lost, should be avoided. EACHR should advise the Regional Office on methods that delivered evidence in the right format to inform policy. Complex methods and multidisciplinary approaches were necessary, and more knowledge of what actually influenced politicians. It could help to identify the methods that generated this type of evidence; there was a pressing need to design a programme of work to define the 'how to' agenda.

Professor Kickbusch responded that the Committee could help decide how the study could be taken forward and by whom. Presenting complexity in a manageable way was an area that needed development. The United Kingdom National Health Service work on obesity maps (12) was a good example of how to put the message across.

At a broad level, different political systems (whether market based, centrally planned etc.) could impact on health, and the political determinants of health were controversial, so approaches should be chosen with care. Work on tobacco could be used to identify similar issues in other debates.

Global research policy and co-ordination

Giving an update from WHO Headquarters, Mr Terry said the CEWG report *(13)* would be discussed at each WHO regional committee in 2012. An open-ended Member States meeting

would then be held in Geneva, 26-28 November 2012, to explore options and proposals *(14).* As in the European regional consultation, the proposal that had the most support to date was to develop an observatory on research and development. The research platform of the Pan American Health Organization was seen as a model on which Headquarters and regions could build.

A global analysis was being undertaken of registered clinical trials in the International Clinical Trial Registry Platform, showing the number of active trials by country and comparing it to the burden of disease using DALYS and country of recruitment, classified by World Bank income groups.

Finally Mr Terry mentioned work on setting standards for good, ethical research practice. The global secretariat was seeking to help standardize this across regions.

Conclusions and actions agreed

In the final session of the meeting, the Committee returned to discussion of its role and work plan, and the additional areas of involvement that had been suggested during the meeting:

- determine the extent of the EACHR role as a peer review resource for the Regional Office;
- set research priorities and frameworks;
- examine linking the mapping of national health research systems to strengthening public health functions and operations, especially on research;
- liaise with partners and funders;
- address health sector leadership through identifying the need for leaders and change management, and undertaking research on how leadership and management could influence health;
- identify gaps in Health 2020, and specify what knowledge was still needed;
- reflect on multimethod approaches to address complex interventions, and make recommendations on how such research could be undertaken;
- identify how the NCD research agenda fits with the EACHR work plan, and help to define NCD research priorities;
- help advance interventional research, providing information and evidence on what is effective;
- undertake and promote research into political processes and the political determinants of health, and produce a report;
- advocate improvements in data standards, collection and sharing;
- help with reviewing technical methodology;
- advise on the right experts for future technical work on targets and indicators;
- consider how to promote the understanding of complex methods that generate evidence in the best format to influence policy.

This was a long list and it was agreed that the overall purpose of the Committee should be defined, which would determine priorities for its programme of work. It needed to differentiate between overarching and specific issues, and long-term, medium-term and short-term issues; decide what was feasible; and choose the means, such as working groups or subcommittees, with or without secretariat involvement. The work could be virtual and did not need to await the next EACHR meeting.

Action points were agreed for the Secretariat:

- refine the proposed role of EACHR in the governance of the Regional Office through a series of teleconferences;
- identify future structure;
- based on the above, produce a mind map to help the Committee with forward planning;
- clarify its direction and involvement in the research capacity mapping exercise that should begin by the end of 2012, and in the development of indicators and their application (what kind of research is required, and what kind of data);
- identify potential partners;
- define the process for interaction between EACHR and other groups including the SCRC, including advance review of Regional Committee documentation;
- establish the SharePoint for EACHR members to access materials provided by the secretariat;
- continue work on the EACHR web page;
- send Committee members the draft 2012 European health report for review;
- arrange for Committee members to comment on the current draft of Health 2020;
- consider the development a ‘solid facts’ brochure on the economics of prevention;
- consider the development of a summary for policy-makers on the costs of ill health and the political determinants of health, for the 2013 Regional Committee;
- share CEWG progress with the Committee;
- circulate the Headquarters bibliometric analyses, and where possible raw data, to enable regional and country-based analysis.

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Annex 1

AGENDA

Thursday, 20 September 2012

09:00	**Opening, welcomes and introductions** Chair: Professor Martin McKee, London School of Hygiene and Tropical Medicine **A vision for the Committee and its contribution to the Regional Office** (Ms Zsuzsanna Jakab, Regional Director)
09:45	Opening and formalities (Professor Martin McKee and Dr Claudia Stein, Regional Office) *Formalising the role of EACHR* *Appointment of vice-chair and rapporteur* *Adoption of previous meeting minutes* *Outline of meeting agenda* *Appointment of topical subgroups*
11:00	**Noncommunicable diseases** Framework, action plan and research priorities (Dr Gauden Galea, Regional Office)
13:45	**Health 2020 – examining the evidence base** Establishing a framework of research priorities for strengthening the evidence base of Health 2020 (Dr Agis Tsouros, Regional Office) Developing targets and indicators for Health 2020 (Dr Claudia Stein, Regional Office)
17:00	**Report to the Committee** Update on the national health research systems mapping exercise (Professor McKee)

Friday, 21 September 2012

09:00	**The economics of prevention** State of the art and research questions (Dr Roberto Bertollini Regional Office)
10:30	**Strengthening public health services and health governance in the WHO European Region** Update on the WHO European Action Plan to Strengthen Public Health Capacities and Services 2012-2020 (Dr Hans Kluge, Regional Office) Supporting Health 2020: governance for health in the 21st century: research challenges (Professor Ilona Kickbusch, Graduate Institute of International and Development Studies, Geneva)
11:45	**Update from the secretariat / any other business** Research policy and coordination – an update from WHO Headquarters (Mr Robert Terry, WHO Headquarters) EACHR agenda for action over the next 12 months Closing remarks

Annex 2

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