Scenarios for the Future of WHO Euro

Introduction

These scenarios were drawn up to assist in developing a long term vision of the future role and position of the WHO Regional Office for Europe (WHO Euro). They are based on discussions of health trends and possible threats and opportunities at meetings of the interdisciplinary group of experts and Standing Committee members asked to consider the future of WHO EURO in 2005.

The scenarios are not predictions, they are explorations of possible futures over a 15 year period for the diverse range of countries within the European region as well as world health[[1]](#endnote-1). In the first three scenarios WHO Euro takes no clear role. This is to stimulate thinking about the essential values, roles and functions that WHO Euro must protect.

“**Muddling Through,**” sets out some of the underlying trends in economic and social conditions, health and technology affecting health in the European region and asks:

*“What should WHO Euro be doing to change the future of health?”*

**“Health Under Threat”** scenarios involving different fictional threats to health, from climate change, food safety, infectious disease and bioterrorism are examined to ask:

*“What should WHO Euro be doing to address threats to health?”*

**“Health in a Difficult World,**” examines the impact of economic and social difficulties and conflict on global health and equity. It examines changes in global health governance and asks:

*“How should WHO Euro support health governance?”*

**“Better Health,”** attempts to portray what successful intervention could mean for health, by examining potential opportunities. This is also an exploration of the position of WHO Euro and other agencies because success depends on joint actions and influence. It asks:

“*How should WHO Euro work with others to achieve better health?*”

These scenarios, which were drawn up in a two week period of review and discussion are not in in any way presented as detailed investigations or predictions, neither do they attempt to cover every possible trend, risk and opportunity. And in some cases since they were produced, evidence has changed. We know, for example that the meridional overturning circulation has now recovered. They were intended to be controversial “thinking tools” and to invite comments and additions. For this purpose the scenarios were made available on a wiki site where respondents were able to add to or change scenarios and respond to questions from the working group.

Muddling Through without WHO Euro

By 2020 much has changed in the European region of WHO, but, in this future, the Euro Office has taken no effective action since 2005.

**The population** of the 52 countries of the region, some 900 million people, is growing very slowly. Growth is largely due to migration into the European Union, which with the accession of new member states including Turkey, has a population of some 550 million people. Other countries including Russia have undergone long term population decline[[2]](#endnote-2). The population is ageing, life expectancy in 2020 has increased by 3 to 5 years and ranges from less than 70 in the South East to over 80 in the North West of the region[[3]](#endnote-3).

**Economic growth** in the EU has slowed to less than 2% per annum, partly as a result of an increase in dependency ratios and as a result of failure to achieve the modernisation reforms set out in the Lisbon Agenda[[4]](#endnote-4). While new accession states, with younger populations and more flexible economies have experienced faster growth, the poor economic performance of the EU as a whole has had negative consequences for the other countries of the region. Economic conditions vary from affluent post industrial West Europe, manufacturing economies of Central Europe, primary and agriculture production in East Europe and subsistence economies in the South East – a twenty-fold difference in GDP per capita from over €40,000 to less than €2,000. All sectors of the economy are challenged by the rapidly growing economies of China and India.

**Social conditions** have added to the problems posed by an ageing population. Traditional family support systems are under stress due to the increasing age of carers and growth of single person households. In some countries informal care, which used to deliver 80% of all care in the home, is reduced by up to 25%, with a consequent burden on formal health and care systems[[5]](#endnote-5).

In times of economic growth societies have adapted well to immigration, however, economic slowdown and unemployment has exposed rifts in societies. This has had negative consequences for the health and care of some of the most vulnerable groups in society including immigrant communities and Romany people. Globalisation has increased income differentials and the gap between the health of rich and poor within countries is widening[[6]](#endnote-6).

Expectations of health and care are changing as patients see themselves as consumers of health and care services rather than beneficiaries of welfare. This has resulted in wider engagement in choice and decision making for health, creating a social movement for health, with a rapid growth in patient and public representative bodies and self care organisations across the region[[7]](#endnote-7).

While the links between socio economic conditions and health are much discussed there has been a lack of leadership and action.**Health conditions** affecting the whole region include:

Mental illness, particularly depression, linked to stress and anomie is the leading cause of disability, mental disorders affect 27% of people during a year[[8]](#endnote-8), rates of dementia have doubled[[9]](#endnote-9).

While smoking has declined in West Europe this is offset by the increase in smoking in Central and Eastern Europe (CEE), with growing rates amongst women and adolescents. Smoking prevalence is 25-30% in most countries of Europe, causing 2 million deaths per year in the region from lung cancer and heart disease[[10]](#endnote-10).

Rates of obesity have risen rapidly, by 2020 even France records that some 20% of the population are obese[[11]](#endnote-11). Higher rates are found in most other countries where life expectancy for obese people is reduced by 7 years. Health conditions linked to obesity include: type 2 diabetes, heart disease and joint pain.

Deaths, violence and injury as a result of alcoholism and other drug use, has been a major cause for the decline in life expectancy in Russia[[12]](#endnote-12). By 2020 alcoholism and drug abuse has increased rapidly in those countries which failed to take effective action against binge drinking and other drug abuse amongst adolescents, over 70 million people across Europe are abusing alcohol and other substances[[13]](#endnote-13).

Life expectancy is still increasing in West Europe but healthy life expectancy is lagging behind[[14]](#endnote-14), many elderly people have a very low quality of life. This has increased demand for care and nursing services but due to lack of WHO action the central role of nursing has still not been fully recognised. Countries that joined the EU since 2004 have lower health status but the gap is closing[[15]](#endnote-15).

Central and Eastern European countries experience a quadruple burden of morbidity and early death[[16]](#endnote-16).Rates of non communicable diseases are increasing, due to the conditions described above. However, they also face much higher rates of communicable diseases and much higher death rates due to the failure of health care services, which also result in high rates of maternal and infant mortality. Health protection services are failing, resulting in lower levels of immunisation, increasing rates of infectious diseases such as HIV/AIDS, Tuberculosis and Syphilis, poor nutrition and iodine deficiency[[17]](#endnote-17). Basic conditions for health, such access to safe water, healthy housing and social order are lacking for many people in Central and Eastern Europe. In 2005 over 40 million people lacked access to safe water[[18]](#endnote-18) and up to 170 million people live in housing estates with poor environmental standards[[19]](#endnote-19). Levels of deaths from conflict and violence amongst young men are three times higher in CEE countries than the rest of the region. In the 15 years to 2020 the health and life expectancy gap between the CEE countries and the rest of the European region has not been reduced. WHO Euro has not been able to provide the leadership needed to address this.

**Medical technology** has advanced rapidly in the years from 2005 to 2020 with major advances arising from: genetics and stem cell research, the miniaturisation of diagnostic equipment, and the use of information and communications technology in health.

The human genome project has made it possible to identify many more targets for drug discovery and stem cell research has also led to new cures[[20]](#endnote-20). However, despite the fact that more than 50% of research is publicly funded, drug discovery is still largely directed towards profit rather than health needs. This may mean that health budgets are increased by the cost of drugs of marginal value. There have been attempts to engage the public and politicians in discussing the ethical issues raised by medical research, but there has been a lack of European leadership on such issues.

Personal health risk assessments and in some cases genotyping make it possible to detect and provide early treatment and self care advice for people with heart disease, cancer and other conditions which together account for 65% of deaths under the age of 75. Reductions of up to 30% of early deaths can be achieved for those detected and treated[[21]](#endnote-21). These are most often those who can afford access to advanced personal health monitoring. There are still no standard methodologies for measuring health risk or wellness[[22]](#endnote-22).

The miniaturisation of diagnostic and other equipment facilitates the provision of more services in the patient’s home or a local clinic. This coupled with telemetric links to specialist advice and support can reduce costs and improve the quality of treatment and care[[23]](#endnote-23).

Information and communications technology facilitate better access to health knowledge and health records not only for health professionals but also for members of the public. The spread of digital interactive television makes it possible to provide two way communications with patients and community health workers in remote locations and offers access to health knowledge through information and communications technology mediated by health technicians and advisors[[24]](#endnote-24).

In the absence of a clear knowledge management strategy for Europe information and communications systems reflect the needs of the dominant health market, the USA. The lack of technological developments appropriate to the needs and affordability of CEE systems creates a further divide between the capabilities of West and East European health systems.

In this future WHO Euro does not support knowledge management for health at European region level, though a similar function is developed by the EU Directorate for Health and Consumer Affairs (DG Sanco) focussed on the needs of EU member states. WHO Euro, WHO Collaborating Centres and Country Offices are largely ignored. There is confusion about who leads action outside the EU.

**Health systems** in Europe face increases in costs due to three factors: consumer demand for improved quality of service, ageing and the attendant demand for chronic care and the development of medical technology. These forces drive rates of increase in health expenditure of 3-5% p.a. above inflation; this is faster than economic growth so health systems face continuing funding crises[[25]](#endnote-25).

Health reforms from 2005 to 2020 have focussed on: evidence based commissioning, engaging the public in health choices and measures to improve health. Evidence based commissioning has improved the quality and cost effectiveness of service. It has helped to establish limits as to the level of cost benefit for publicly funded services, but this has been hampered by lack of consistent methodology, standards and measures and remains a highly political decision. Engagement of the public in health policy making and in personal health choices has underlined community and personal responsibility for health. However, the science and art of behaviour change is still underdeveloped, requiring very large scale experimentation. Measures to address the determinants of health still fail to gain support from politicians focussed on the short term. Cost control results in increasing co-payment and hence reduced access to health services for poor people.

Countries of Central and Eastern Europe face much greater funding problems due to the extremely low levels of public expenditure. In many cases this results in high costs for the poorest people in society, who have to meet their own medical costs and/or make informal payments to doctors. Health reforms in this area focus on different but no less difficult issues, many are still trying to establish the appropriate balance between public and private sector provision, tax, social insurance and private funding, regional and local management of services and central regulation. Many are also struggling to counter corruption. The European Health Observatory provides an evidence base but these are political decisions on which it is difficult to give authoritative guidance from outside the system.

Health reforms have introduced new structures and funding arrangements but it is clear that such changes are ineffective unless matched by leadership and management initiative from health professionals including public health specialists, health managers and clinical staff. This requires the development of new skills and relationships that encourage creativity and new ways of working across professional boundaries. In CEE countries this has proved particularly difficult, not only because it requires a cultural change, but also because health professionals and entrepreneurial talents are recruited away from the public sector. Migration of health professionals to West Europe is a further drain on these systems[[26]](#endnote-26).

WHO Euro leadership on health equity, health determinants and systems management and nursing development is greatly missed.

Health Under Threat

This scenario examines potential threats to health of people in the European region. Threats are presented as time lines, since the decision as to when and how to invoke the precautionary principle depends upon evidence that emerges over time.

**Climate change** has both global and regional implications for health. This scenario is based on a recent study27 showing that the Atlantic meridional overturning current, part of the Gulf Stream system, has weakened by 30% since 1992 due to melting polar ice. Current estimates are that this will reduce average winter temperatures in Europe by 1˚ centigrade over a 20 year period but:

2008 a further study estimates the combined effect of the weaker Gulf Stream and polar melt could reduce winter temperatures in Northern Europe by an average of 3˚.

2010 scientists show that the warming of the Gulf of Mexico and growth of the “dead zone” are linked both to the reduction of the Gulf Stream and the rise in local hurricanes.

2011 continuous monitoring of the northward flow of warm waters shows that the Gulf Stream is reducing, a conference of experts suggests a 20% probability that this marks the start of a catastrophic failure of this ocean system.

2015 it is now estimated as a 40% probability that the Gulf stream will fail over a period of 10 to 20 years, bringing winter temperatures equal to those of southern Quebec, where it often reaches -25˚C, to the western seaboard of Europe.

2020 colder winters are already resulting in much higher levels of falls and injuries for older people, cases of hypothermia increase and influenza, pneumonia and other winter illnesses are producing much higher death rates.

**Food and environmental safety** experts have for some years been concerned at the potential impact of endocrine disruptors in the food chain28, PCBs and related products are already banned but:

2007 new studies demonstrate that such chemicals can affect health in utero at much lower levels of exposure.

2009 theoretical models suggest that a range of materials still commonly used as food and drink containers in European food packaging might possibly contribute to endocrine disruption.

2010 a study sponsored by a food packaging company demonstrates that its packaging products are safe, obesity and tight underwear are the main causes of declining fertility.

2011 international studies suggests endocrine disruption is responsible for a decline in male fertility and increase in testicular and prostate cancer which doubled from 1960 - 1995.

2014 further studies identify a possible causal link between the products in general use, endocrine disruption, and testicular and prostate cancer, the products are withdrawn.

2015 projections of the decline in male fertility suggest that for many people natural conception will become much more difficult due to a combination of obesity and reduced fertility.

2018 a detailed review shows that contamination of the food chain is such that adolescent and pregnant women should avoid certain foods.

2020 health agencies across Europe adopt different approaches, some seek to ban fish and meat with levels of contamination unsuitable for pregnant women, others provide advice and labelling, some provide food packs for pregnant women others do not. Overall nutrition of girls declines.

**Infectious diseases** such as influenza represent a continuing threat to European and global health. This scenario is based on a potentially lethal transgenic swine flu with characteristics of the H1N1 virus that killed up to 40 million people in 191829.

2009 December - seemingly unconnected deaths of people with flu like symptoms in Spain, Russia, France, and Turkey unnoticed by Global Outbreak Alert and Response Network.

2010 January - the alarm is raised when clusters of a form of influenza with very high mortality rates are found in people associated with the original victims and at other sites with no apparent causal link. Those infected include relatives and friends, undertakers, police and medical personnel.

2010 February – reports are received of an outbreak of swine flu in a pig breeding station in a CEE country. The veterinary officer who reported the case had spent several hours in a Berlin airport transit lounge returning from a conference.

2010 February – it is found that all the original cases were amongst people who used the Berlin transit lounge that day.

2010 February – it now appears there is a major epicentre for the disease in the area surrounding the pig breeding station.

2010 April – emergency measures are coordinated by the European CDC network but local stocks of counter measures are insufficient and central reserves have been used up.

2010 May – across Europe some 150,000 people have contracted the virus and 25% of these have died.

2011 June an effective vaccine has been developed and the disease is under control but it is estimated that 3 million people died in Europe and 50 m worldwide. Health workers were at greatest risk and it is now necessary to rethink the provision of health services with 15% less doctors and nurses.

**Bioterrorism** has been an increasing focus of concern in recent years30. This fictional scenario expresses some current fears.

2008 25 April 4pm– authorities in a country of the European region report that an armed raid by members of an extremist sect had obtained quantities of weaponised anthrax, which had been under study to develop counter measures.

2008 25 April 6pm - latter the same day a further report is received of an apparently coordinated attack on a research laboratory in a neighbouring country from which they stole a smallpox derived virus sample this was also a study sample.

2008 25 April 10 pm - a television station releases a video message from a group claiming to have the materials: “Capitals of Europe will remember May Day as day of retribution”.

2008 27 April – details of how to obtain biological materials and use them as weapons are found on the internet.

2008 29 April 10 am official May Day celebrations are cancelled in all European capital cities, signs of mass panic ensue in some countries as people flee the cities thought to be at risk.

2008 1 May 11 pm – security and health services were on high alert but nothing happened.

2008 4 May 8.am – newspapers suggest that deaths from the panic migration may have caused hundreds of deaths, governments are blamed for over reacting to the threat.

2008 5 May 12pm – a series of attacks is reported in Berlin, Paris, London and Moscow. Attacks involved “walking dead” suicide terrorists who simply walked into crowds dispersing biohazard materials. In London terrorists used infected dogs with anthrax powder in their coats, many people petted them.

2008 6 May - attacks have been ongoing since 1 May.

2008 7 May - doctors and hospitals are besieged by anxious patients demanding counter measures and information, as yet little information is available but this clamour results in high casualties amongst health workers and is a factor in the spread of disease.

Health in a Difficult World

A peaceful future of improving economic prosperity and health may seem most likely, but this future cannot be assured. The possibility of global economic recession features in every serious long term economic projection. Conflict between cultures resulting in failed states and competition for oil, food and water resources required for a still growing population pose dangers for world peace. Global health is therefore constantly under threat, not only from the types of issue raised in the previous scenario but from the underlying determinants of health and the failure of health governance and health systems. This scenario therefore examines possible health futures in a difficult world.

**The world economy** of 2020 has slowly recovered from recession in 2009. US debt levels and the banking crisis were the immediate cause but the failure of action on global trade since Doha and rapidly rising energy prices made matters worse, following the path of the Japanese downturn of 1990 which lasted over 10 years[[27]](#endnote-27).

Global recession had greatest impact on health in the poorest countries. The Millennium Development Goals were not met, not only in Africa, but in many other regions, as aid was reduced and government expenditures were directed away from social development by International Monetary Fund restrictions. This meant that the health and wealth divide between the rich and poor countries has widened further the poorest 20% of the world now have half the life expectancy of the richest 20%[[28]](#endnote-28).

In the South Asian sub continent global recession coupled with the impact of HIV/AIDS has had a major destabilising effect[[29]](#endnote-29). By 2010 the number of people with HIV/AIDS in this region reached 20 million but prevention and treatment programmes failed as a result of lack of funding and evolution of the disease, which brought drug resistant mutations. The following five years saw a further doubling of incidence, threatening particularly police and security forces as well as teachers and health workers. This has further reduced the capability of the health services of these countries to control the development and spread of disease or to maintain civil order.

In affluent countries recession hit poor and minority groups hardest. Health services reduced spending and further increased co-payment. In middle income countries two tier health services emerged: a basic safety net service with options for additional services paid for privately or by top up insurance. Investment in health protection was cut in order to reduce short term costs. Low income countries felt the impact of aid reduction. This and failure to support the control of disease and anti-microbial resistance in poor countries has greatly increased long term health costs[[30]](#endnote-30).

**Peace and security** in 2020 are severely compromised. There is a growing clash of cultures: perceived unfairness of WTO trade rules, European farm subsidies, reducing levels of aid, lack of action on the MDGs, unequal access to medicines and global warming are seen as signs that the rich have turned their backs on the poor.

By 2005 leaders of three African states had said that their countries could become ungovernable due to poverty and HIV/AIDS. There are now failed states and failed cities across Africa, Asia and the European region. This has severe consequences for health in the areas where it is impossible to provide health services because there is no civil order. They have become havens for trade in illegal drugs, arms and people trafficking to other countries. This results in a great increase in sexually transmitted diseases, addiction and violence. They also ferment terrorism, feeding on an abiding sense of degradation, rationalised in pseudo religious terms.

Conflict between countries has focussed increasingly on access to oil, water and food. In 2005 the world was consuming more than twice the quantity of oil discovered each year, by 2020 demand has risen by 50%[[31]](#endnote-31). Fuel prices increases have profoundly affected people’s lives[[32]](#endnote-32). Oil is not only a precious resource it is a strategic necessity. In 2005 a quarter of the world population lack access to safe water, by 2020 more than half of the world population lack safe water as aquifers are depleted and water quality is contaminated by pesticides, agricultural and industrial pollution and human waste[[33]](#endnote-33).

The European Rapid Reaction Force, intended to bring peace and humanitarian aid, finds itself overstretched. Health workers from humanitarian organisations, including WHO Euro, working with or alongside security force are targeted by terrorists and others[[34]](#endnote-34). Peacekeeping forces from the UN are accused of being “crusaders” for unwelcome values and of spreading HIV/AIDS. The ideal of “health as a bridge to peace” has been impossible to achieve.

**Global governance for health** has failed to address the impact of globalisation on health or to provide funding for health as a global public good because governments have reacted to recession by trying to protect local interests and short term budgets. The WTO has prevented the worst excesses of the 1930’s, but the ILO has failed to achieve agreement on sweatshops, UNEP has made little progress on global warming, even UNICEF has had to scale back.

The UN failed to develop cohesion at national levels (One UN). WHO is under pressure to focus on specially funded programmes. Funding for global diseases is largely provided through Global Public Private Partnerships, there were over 150 such global partnerships for health in 2005, in 2020 there are twice as many[[35]](#endnote-35). At national level this results in incoherence and gaps in basic services.

**European health governance** has been transformed by the increasing role and competence of the EU Directorate for Health and Consumer Affairs and the development of the European Centre for Disease Control, from a coordinating centre to a major agency. At the same time coordination between WHO Geneva and the European regional office has been strained as differences between European values for health and the interests of other dominant countries pull in different directions.

From 2005 to 2020 Europe wide professional, NGO, foundation and patient organisations and partnerships for health have developed as key players in the governance of health. They have grown in strength from bodies to be consulted, to groups setting the agenda. This creates problems for WHO Euro, which works with health and development ministries but finds it difficult to address these groups with a reduced budget due to the difficult economic times. It has also had to cut back on its support for WHO country offices, this has reduced national capacity for leadership and knowledge sharing.

**Health governance at national level** varies, but economic circumstances have weakened the voice of public health in most countries. Health impact assessment, which was an aspect of EU health policy, has largely been ignored. Social marketing and behaviour change for health has made little headway against the global promotion of alcohol and fast food. At the same time pressure to increase spending on health services and new pharmaceuticals has been relentless. This has resulted in further growth in health expenditure but with worse health outcomes and growing inequality in health and health services.

Global partnerships compete to provide programmes addressing particular diseases in resource poor countries, but despite attempts to coordinate within and between programmes, health ministries find it difficult to cope. Health professionals are recruited out of national systems to work with the agencies leaving gaps in basic health services and health professionals are still recruited away to richer countries. This means that in many states health systems are close to or beyond collapse. They realise the need to rethink health systems based on new concepts of nursing and use of ICT but without WHO leadership they lack the ability to achieve change.

International cooperation for health system research and knowledge sharing for health, enabled by information and communications technology offers some hope of affordable health for all. In more affluent countries such an approach may make it possible to support self care for people with chronic conditions. In resource poor countries it may be possible to deliver health services through local health assistants/ advisers using ICT. However, in a difficult world of recession and conflict and without WHO leadership it may not be possible to persuade people to adopt new ways of delivering health.

Better Health: A Vision of WHO Euro in 2020

The previous scenarios have challenged the reader to think of a world without effective action by WHO Euro, as a way of encouraging a re-examination of its role and position. This scenario shows an active and successful WHO, but it is no less challenging, because it asks the reader to consider what success means and how it might be achieved. Basic health trends and threats are still relevant. So what is the role of WHO Euro in this scenario?

**The governance role of WHO Euro** is an important element of the system of governance for health in Europe and the World. It contributes to setting the WHO HQ and WHA global agenda for health, working with member governments, partner organisations and Collaborating Centres through the Copenhagen and Country Offices to articulate health values and objectives from the European region perspective. It forms a two way link, interpreting global perspectives and objectives for the member countries and Europe wide health related bodies and helps build the structures and processes of health governance for the European region. While WHO Euro shares an agenda with other agencies it maintains its own values and unique contribution in each sphere.

Success for WHO Euro does not mean that it leads action on every issue but that it steers the agenda, supports the agency best placed to take action and monitors progress against value based measures of progress. The agencies with which it works include: Member Governments, DG Sanco, the ECDC, World Bank, UNDP, professional bodies, NGOs and foundations. Joint actions include:

With the Council of Europe it has established an ethical framework for health and set value based targets for potential health risk and health inequality reduction in and between all states in the region, monitored by WHO Euro[[36]](#endnote-36).

With DG Sanco it has supported the application of health impact assessment and during the Finnish Presidency of the EU in 2006 it supported the “Health in All Policy initiative”[[37]](#endnote-37).

With other agencies it supports academic business and civic society engagement in the governance of health. For example with the European Council of Global Health it supports the European Strategy for Global Health. This engages the EU, governments, and international agencies, health services, academic business and civic society organisations[[38]](#endnote-38).

With European CDC it established a health futures network to monitor and prepare for long term trends and threats and established and trained large scale response networks.

With DG Sanco and governments it has prompted action on the health of Romany peoples and other minority groups.

**Knowledge management for health** is essential to the role of WHO. It involves: support for communities of experts, steps to improve access to and use of health knowledge through a range of health information products. This provides the base for authoritative, evidence based health policy. Actions include:

With WHO Geneva it has helped to develop networks and partnerships across the European region and with resource poor countries to give better access to health knowledge[[39]](#endnote-39).

WHO Euro broadband television supported by EU and other sponsors provides health news and can be localised to provide health advice, contact with services and education for health workers and self care[[40]](#endnote-40).

With DG Sanco it has helped to develop the evidence base for international legal action on alcohol, smoking and fast foods. This provides a model for action in other parts of the world.

With national agencies and institutes engaged in social marketing and behaviour change for health it helped to share lessons and tools to respond to the marketing of MNCs[[41]](#endnote-41).

WHO Euro works with Euro region Collaborating Centres to ensure their research is relevant to and applied in policy.

WHO Country Offices form important nodes for knowledge sharing, e.g. provide access to all health reform advice and research. Country Offices are greatly strengthened within an integrated UN presence in each country. Together with WHO Collaborating Centres European Country offices provide an important source of knowledge coordination for programmes.

**Policy analysis for health** requires the translation of knowledge into action. The European Observatory on Health Systems and Policies provides a model of the way in which WHO can develop knowledge and hence influence policy. Actions include:

Matching research with knowledge sharing and developing local capacity supported through Country Offices world wide.

Monitoring health policies and health system performance, championing best practice and pointing out policy failures.

World Health Assembly action on migration of health workers to compensate the poorest countries for loss of staff and to ensure adequate pay and career structures in all countries.

Development of health policies with DG Sanco based on international agreement where European consensus makes further action possible on issues such as tobacco and diet.

WHO Euro and Country Offices work with EU technology assessment agencies across the region to provide advice on cost effectiveness in relation to country conditions.

WHO Euro works with DG Sanco and member governments on coordination of human resource planning for health.

**Leading the health community of Europe** is the central role of WHO Euro. This includes those in government departments of health, health and care organisations, academic institutions including students, patient and public representative bodies, NGOs and foundations as well as health related industries and those concerned with occupational health. Actions include:

With European schools of public health and other institutions it has helped define and develop measures of health risk for individuals and communities as a way of focussing action on the determinants of health and health improvement.

WHO Euro works with European professional bodies on leadership and management development for health[[42]](#endnote-42) and coordinates innovation in working methods and training. It supports networks for training exchanges and links that strengthen the capacity of developing country institutions to train health workers and lead research and innovation.

With research bodies, EU pharmaceutical and device companies, EU and governments it has established long term targets for health research, including neglected diseases and areas where technologies can combine to transform services.

The revised Hippocratic Oath, expressing values for health as a human right and a global public good[[43]](#endnote-43).

WHO Euro has recognised the changing role of nursing in Europe and low income countries and gives them leadership.

**Working methods** of WHO Euro reflect the need to work with a range of other agencies in networks and partnerships that often involve cross cutting project teams. Impacts on WHO Euro include:

WHO Euro operates network management with distributed leadership, people at Country and Copenhagen level and from other organisations take lead roles based on common values.

A smaller central team is able to work with stronger Country Offices and teams from partners and collaborating centres.

Flexible multi disciplinary teams lead to a loose/tight management style, teams are allowed creative freedom but with strong project management and performance review.

Many staff work on secondment or contract basis, core staff are good bureaucrats with programme management skills.

Staff and secondees are excellent. It is important for WHO Euro to be able to cross cultural and language barriers.

Information and communication skills, including diplomacy are a common requirement.

The information resources of WHO Euro itself include advanced information and communications.

Both internally and externally WHO Euro says what it can deliver and delivers what it says.

**WHO Euro’s impact on health** is achieved through mobilising and orchestrating a vast number of institutions and people. By 2020 there are some 20 million health workers in the Euro region, the health community is at least three time this, including active patients and informal carers. Health governance at European level provides mechanisms for listening to and directing their concerns and initiating action to address them including feedback from broadband channels. Most actions are taken and funded by other agencies at European, national and local level, the important role of WHO Euro is to lead, support and empower such actions providing legitimacy and authority. WHO Euro supports the protection of health values by accrediting evidence based information and supporting action against misleading product claims.

The full engagement of society to address health requires a radical approach to empowering people to take responsibility for their personal and community health risks. As European countries are amongst the first to face this issue they need mutual support and leadership for initiatives such as risk assessment, behaviour change for health and mobilising self care and community co-care.

Success for WHO may be measured in terms of the greater willingness and ability of governments to address the determinants of health and to improve the structure and management of health systems, through exchange of knowledge. A key measure is the extent to which systems address the needs of the most disadvantaged groups in society and close their health equity gap.

WHO Euro works with CDC Europe to ensure it both addresses the health security of the region and plays a wider role in global health security and promoting a healthier environment.

A European strategy for global health, led by the EC with WHO Euro support, is an important step towards greater coherence of policy and action on this issue. As Europe is the source of 65% of grant aid and the largest proportion of trade with resource poor countries it has great opportunity to improve global health.

As a member of the UN family WHO Euro encourages a world view of global citizenship, thus improved health equity in the European region and effective support for the achievement of MDGs in resource poor countries are both crucial goals. Within the European region, greater attention to the needs of the poorest states is achieved by funding health as a global public good. This demands additional funding beyond the 0.7 % of GDP target for official development assistance.

In these ways WHO Euro makes a significant difference to health and to the creation of healthier, happier communities in 2020

Graham Lister Jan 2006

1. **Sources and notes**

   The scenarios draw on the work of the Judge Business School on health futures planning see “Policy Futures for UK Health” Edited by Morris, Z. Chang, L. Dawson, S. Garside, P the Nuffield Trust 2005 and “The Future of Health - Health of the Future” Edited by Barnard, K. Nuffield Trust and WHO Regional Office for Europe 2003. see also the 2000 report at <http://www.archive.official-documents.co.uk/document/nuffield/policyf/r2k-00.htm>

   Other useful sources on health futures include:

   A range of futures works on health related issues published by UK Department of Trade and Industry including the Foresight Futures 2020 “Revised Scenarios and Guidance” <http://www.foresight.gov.uk/>

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