



World Health Organization
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How to keep people at the centre of health and sustainable development policies

25th annual meeting of the
Regions for Health Network

Aachen (Germany), Maastricht
(Netherlands), Liège (Belgium),
Hasselt (Belgium)
26–28 June 2019





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Abstract

The 25th annual meeting of the WHO Regions for Health Network took place in the Euregio Meuse-Rhine, straddling Belgium, Germany and the Netherlands, over 26–28 June 2019. The main theme was how to keep people at the centre of health and sustainable development policies. There were three main topics. The first was reducing health inequity, centred on a report on the WHO European Health Equity Status Report initiative. The second was progress on implementing the United Nations Sustainable Development Goals. The third theme was issues relating to the health workforce of the future. Each topic included not only a formal presentation, but also comment from an expert panel, discussion by regional representatives and a report back on the views of citizen summits held in the local area. There were also a number of reports on other initiatives and activities within the host region. Further issues discussed included gender health, environmental factors that caused health inequities and the relationship between the health system and the economy. The event also incorporated the business meeting of the Network, including a report on partnership working between regional universities and regional administrations and a presentation on primary care reform in Flanders.

Keywords: HEALTHY PEOPLE PROGRAMS, HEALTH POLICY, HEALTH PLAN IMPLEMENTATION, INTERNATIONAL COOPERATION, GLOBAL HEALTH

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- EMR, for hosting, funding and organizing the meeting;
- CoR, for technical inputs throughout the preparation of the meeting and during the meeting itself;
- euPrevent, for overseeing and coordinating all the numerous stakeholders during the entire event, including its preparatory stages;
- Klinkhamer, for everything related to logistics and for making sure that such a complex event (presented over multiple locations in three different countries) ran perfectly; and
- Ingrid Nouwens, for her clever witty drawings capturing the essence of what was said, some of which are included in the report.

The meeting was made possible due to the financial contribution of the Province of Limburg (the Netherlands), the Province of Liège (Belgium), the Province of Limburg (Belgium), the German-speaking Community (Belgium) and the Land Nordrhein-Westfalen (Germany).

The WHO European Office for Investment for Health and Development also wishes to thank the Regions for Health Network Steering Group and colleagues at the WHO Regional Office for Europe for their contributions, which helped in no small way to making the meeting a success, the speakers and participants for their invaluable input into the event, and Christopher Riley, WHO consultant, for writing the report.



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Foreword

The Regions for Health Network has an annual meeting. Each year is similar to those before – a focus on health and human flourishing, a gathering of people with knowledge, experience and enthusiasm, in a venue known to some but not to most. But each meeting is different. There are new issues and new people in a new context, and a chance to discover something unexpected and extraordinary.

The 25th annual meeting had to be something very special, and was. There were several topics, but from the beginning a realization that conversation could not be restricted. What was discussed and what was learned came from the shared and differing understanding of those present on the day. The one constant people were asked to hold in mind was to focus not on “what”, but on “how”.

The event generated fertile and wide-ranging discussion. The careful design and generosity of the hosts provided a continually stimulating sequence of experiences and suggestions. The meeting moved – literally – across a changing landscape of history, culture, challenge and achievement. Formal presentations introduced the latest initiatives from WHO and from across Europe and beyond. Panel discussions and interaction with the wider audience teased out evidence on what worked, where and why. These sessions were complemented by the chance for semi-formal discussions around defined topics and, of course, a free exchange of ideas and opinions in breaks.



There were disturbing facts, heartening ambitions, good news, serious debates and an artist to capture the points – and some of her images are included in these pages.

This report aims to capture some of that variety and effervescence. It suggests that, after a quarter of a century, the Regions for Health Network is fit and flexible, receptive and creative.

Work has already begun on the 26th meeting.

Francesco Zambon

Coordinator

Investment for Health and Development in Healthy Settings

WHO Regional Office for Europe

Acronyms

EMR	Euregio Meuse-Rhine
EPECS	European Patients Empowerment for Customised Solutions (foundation)
GP	general practitioner
HESRi	(WHO) European Health Equity Status Report initiative
LAG 21	Landesarbeitsgemeinschaft Agenda 21
PCZs	primary care zones
RHN	(WHO) Regions for Health Network
SDGs	(United Nations) Sustainable Development Goals



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Executive summary

Each year, the members of the WHO Regions for Health Network (RHN) meet with others to discuss important issues in public health and share ways of tackling them. The 2019 meeting, the 25th, was on the topic *Keeping People at the Centre of Health and Sustainable Development Policies*.

The meeting was organized by the Euregio Meuse-Rhine and euPrevent in association with the Committee of the Regions of the European Union and the WHO European Office for Investment for Health and Development in Venice, Italy. The public's voice was brought into the meeting through the publication of the findings of some citizen summits and the presence of some who had attended them.

The conference took place not at a single location, but at several places across the Region.

There were three main topics – reducing health inequity, progress on achieving the United Nations Sustainable Development Goals and preparing the health workforce of the future. Other issues discussed included gender health, environmental factors that cause health inequities and the relationship between the health system and the economy.

The meeting included a report on the recent WHO European High-level Conference on Health Equity and the Health Equity Status Report initiative.

The event also included the business meeting of the RHN, when current and future activities were discussed.



1. Introduction – something special

The annual meeting of the WHO Regions for Health Network (RHN) in 2019 was unusual in several ways. The meeting is always a chance to review what is happening in regions and in WHO, and especially to learn more about the host region.

This conference was in a sense a double celebration. First, it was the 25th annual meeting, an opportunity to look at what had been achieved by regions working with WHO and what lies ahead. The RHN was formally established just outside the area hosting this meeting through the signing of the Declaration of Dusseldorf in 1992, with the first annual meeting held the following year in Barcelona, Spain.

Second, it was held in a very unusual part of Europe, the Euregio Meuse-Rhine (EMR) (Fig. 1), which is itself a union of several regions in different countries with a history extending over 40 years, in association with euPrevent, a network of 35 partners that focuses on promoting health.

Fig. 1. Euregio Meuse-Rhine – “Europe in miniature”



Source: EMR (1).

The Committee of the Regions, which helps ensure that the regional voice is heard in decisions of the European Union, was also a partner in preparing the conference. With the WHO European Office for Investment for Health and Development in Venice, Italy (the WHO Venice Office), that means four bodies worked together on this event.

The format of the meeting allowed participants to appreciate to the full the nature of the area in which the event took place.

The main topic for consideration was *Keeping People at the Centre of Health and Sustainable Development Policies*. “Keeping people at the centre” can be interpreted in various ways. The meeting was preceded by two citizen summits in the region, which aimed to explore local people’s views on these issues.

Clearly, improving health and implementing sustainable development are wide-ranging issues deserving of serious attention. Within the limitations of the meeting, there was a focus on what could realistically be managed. So three narrower topics were chosen as the principal themes for the meeting:

- what could be done to make sustainable development a reality within regions, engaging every citizen;
- the part regions can play in tackling health inequities, starting with the root of the problem; and
- how best to ensure that the future health-care workforce – whether in broad terms what currently exists or something radically different – meets people’s needs.

The programme for the meeting is shown in Annex 1, and the participants in Annex 2.



2. The context – Euregio Meuse-Rhine

2.1 A TIME AND A PLACE

The meeting was the 25th annual meeting of the RHN. The RHN agreed its formal foundation document in November 1992, at a time of great change in Europe, just after the coming together of the eastern and western parts. The early years of the Network saw a great deal of innovation and experimentation, including twinning of regions from the two sides of the former divide and many different forms of regional groupings.



The meeting also celebrated the long-lasting success of the host region, the EMR. While they differ in detail – in structure, legal status and purpose – euroregions are all structural arrangements for enabling neighbouring administrative areas to work with others across national boundaries. The EMR was created in 1976, includes parts of Belgium, Germany and the Netherlands (Fig. 1) and acquired legal status in 1991. It comprises 11 000 km² and has around 3.9 million inhabitants. The administrative centre is Eupen in the German-speaking part of Belgium (2).

This part of Europe has had a long and often ferocious history of international conflict. Yet at the same time, perhaps since Charlemagne made Aachen his imperial capital, there has been a sense of the region having a common heritage, despite language differences and political boundaries. The legacy of Charlemagne was mentioned several times throughout the meeting.

Unusually, the meeting made use of five different venues. These were:

- the Coronation Hall in Aachen – once the place where celebrations were held to celebrate the crowning of German kings and now a tourist destination and centre for major international meetings;
- the regional parliament building in Maastricht, where the Treaty on European Union was signed in 1993 in a town that was once a key border strongpoint in this part of Europe;
- a boat from Maastricht to Liège along the river Maas/Meuse;
- a building in Liège that was once a bathing and entertainment complex, completed during the Second World War, and now an arts and cultural centre; and
- a former factory in Hasselt, where the compact disc – the CD – was invented; it has now become a thriving business development centre.

These venues gave those attending a far more extended opportunity to appreciate the host region than is normally the case. They were also profoundly symbolic of how a peaceful, prosperous era has now made possible good relations across borders and boundaries where once there was war, suspicion and religious strife. It is this progress that gives hope for further success in addressing the themes of the meeting. The variety of settings created a changing opportunity for those at the meeting to mix together and with others from the region.

In welcoming meeting participants, politicians and senior officials from the organizing bodies and other local organizations made a number of observations on the area and conference themes. This had long been an area where health had been a priority, with Aachen known from Roman times as

having healing waters. It was also a place where a strong emphasis had been given to reducing the impact of borders and raising the status of regions. The 1993 Treaty signed at Maastricht had helped advance integration within the European Union and paved the way for the Committee of the Regions, strengthening the idea that regions as well as countries matter in Europe. In 2016, the Committee signed a Memorandum of Understanding with WHO, and the two bodies agreed a common work programme (3). The Committee is eager to reduce barriers to cross-border collaboration on health.

Health does not always get the priority it might. While it is a vitally important matter to the public, the public's voice often goes unheard. Politicians know that policy initiatives in health seldom show a rapid return, and many health problems are deep-rooted and do not admit of simple solutions. Examples include obesity, health inequalities and concerns about vaccination.

The way the meeting was organized represented regional collaboration of a high standard of effectiveness. The RHN and the WHO Venice Office had worked together with the five regions in the EMR, euPrevent and the Committee of the Regions to organize a programme over three days that went more or less like clockwork, despite its ambition and complexity.



Much of the organization had been undertaken by euPrevent. The Euregio operates across many domains, but euPrevent is the major force in the field of cross-border health improvement, helping to overcome differences in language, culture, and legal and regulatory systems (4).

2.2 THE CITIZEN SUMMITS

Another very unusual element in the meeting was the organization at an earlier stage of citizen summits. These were intended to bring the voice of ordinary people into the discussions. Two were held within the host region area, one in Eupen and one in Aachen.

The European Patients Empowerment for Customised Solutions (EPECS) foundation, a nongovernmental organization founded to give more power to citizens, was invited to organize the events, which were designed to ensure that speakers of French, Dutch and German could all take part. There were 120 participants. The organizers readily acknowledged that it was probably impossible to secure a group of people that was truly representative, but the process nevertheless allowed people to be able directly to speak with their own voice with others and have their views noted in a way that seldom is possible (Fig. 2) (5).

The topics discussed were the three main topics of the conference: equity, the participatory approach and human resources for health. Specially prepared moderators encouraged full engagement by all participants, using a technique called Theme-centred Interaction. Their views on the three topics are cited later, but they also generated some overall conclusions (see Box 1).

Box 1. Messages from the citizen summits

Citizens are not other people – they are us. We are all citizens. We have our feelings and self-respect. We have our expertise and creativity. We want to be engaged, we do not want to be ordered about.

We have this one earth and so the United Nations Sustainable Development Goals (SDGs) are logical and vital.

Given that context:

- corporate social responsibility is vital – companies should conduct their business in a way that takes account of their social, economic and environmental impact, and of human rights;
- Positive Health is a powerful way of thinking about who we are and how we are treated (see below, section 4.3);
- people should be involved at all levels in developing and influencing policies that influence their life;
- cross-border regions that ignore boundaries serve people better;
- strong, simple language is essential to win support for vital ideas such as sustainable development and equity; and
- services should help people to help themselves.



2.3 MANY INITIATIVES

The host region and euPrevent also put considerable effort into preparing a so-called Vademecum, a 96-page report documenting much of the best practice in health in the EMR. Some examples of the huge range of local initiatives across EMR and its member regions were presented during the conference, with an opportunity for those attending to discover more about them. Box 2 gives a flavour of these, with more information in the Vademecum. The full Vademecum is available on the meeting website (Fig. 2) (6).

Box 2. Examples of health initiatives across the Euregio Meuse-Rhine region

- HELPADOS (Province of Liège) aims to develop and use an interactive digital tool to help and guide professionals in better assessment of the seriousness of high-risk behaviour among 9–24-year-olds.
- BReIN (Dutch Limburg with Maastricht University) aims to create a data infrastructure capable of using big data in health care, both improving health and generating new economic possibilities.
- Gezonde Gemeente (Flemish Limburg) is helping local authorities gradually to develop more sustainable local preventative health policy and support them in communicating the policy more effectively.
- Kaleido (east Belgium) aims to provide a variety of free activities for children and their families, the goal being to make children, adolescents and adults aware of issues around a healthy diet, dental care and physical activity.
- euPrevent Senior Friendly Communities (EMR) aims to ensure all senior citizens can continue to participate in daily life for as long as possible.
- Data in the EMR is working to compare data across the EMR and support its use in projects across the region.
- In de Zorg – uit de zorgen¹ (Flemish Limburg) aims to help guide refugees to a job or internship in the health-care sector, helping them settle in and also solve a shortage of nursing and other staff.
- Patient as a Person (Dutch Limburg) aspires to offer people-oriented care through people-oriented education of future care professionals.
- School and community setting (Maastricht/Kerkrade and Aachen/Heinsberg regions) aims to compare health promotion activities in Germany and the Netherlands to find out what factors are important in setting up such activities and contributing to their success and sustainability.

¹ This means something like, “*End your worries by becoming a nurse*”.

Fig. 2. The citizen summit report and the Vademecum



Source: euPrevent (5,6).

2.4 HEALTH DIFFERENCES IN THE EUREGIO

The local area overall generally has good health, with a vibrant and developing economy and a safe environment, but there are also problems, including ageing, unemployment and budget pressures. These might yet be overcome, especially where there is a positive, collaborative mentality.

A study presented at the meeting looked at health across the different component parts of the Euregio to identify what might be learned from the best (7). Differences in data collected by the component regions means that general comparisons are difficult, so just seven indicators have been chosen for review in what is intended to be a 10-year study: age, sex, education level, unemployment, life expectancy, cause of death and overweight.

The average life expectancy across the Euregio is about 81, but there are differences. The figure for women in Belgian Limburg is 84.6, while for men in French-speaking Belgium it is only 77.1, a gap of 7.5 years. To explore the possible reasons behind the differences and potential opportunities to narrow the gaps, interviews were held with people from across the Euregio.

Possible influences on the health situation include changing economic patterns, with weakening of the coal-mining, pottery and textile industries causing out-migration, and the ease of access to new, alternative sources of stable employment. The future role of education was also stressed. The study will continue as an example of good cross-border collaboration.



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3. How to keep people at the centre in tackling health inequities

3.1 PROVIDING HEALTHY, PROSPEROUS LIVES FOR EVERYONE

There have always been differences in people's health. In recent years, however, it has become increasingly recognized that many differences are avoidable, unfair and caused by the way society is ordered. To describe this situation, the term health inequity has been used.



The recent 2019 High-level Conference on Health Equity, hosted by Slovenia, brought representatives from WHO Member States, international organizations and society more broadly to identify and discuss ways to accelerate progress in achieving health equity (8).

The WHO European Health Equity Status Report initiative (HESRi) can potentially contribute greatly to reducing inequities. The RHN has long had an explicit commitment to reducing health inequalities within member regions and beyond and was involved in piloting some of the tools developed for HESRi. It had given public support to the Ljubljana Statement at the recent High-level Conference on Health Equity (9).

HESRi has four main aims – to:

- set a baseline for monitoring health status and policy progress in Europe;
- create easy-to use tools and guidance to drive forward equity in health;
- strengthen arguments and action in support of health equity at every level; and
- increase public and state attention, support and accountability for health equity nationally and locally.

The fundamental aim of HESRi is to incentivize political and policy action in support of a healthy and prosperous life for everyone, removing the obstacles that stand in the way of good health and a decent life. This means supporting a decisive shift from describing and analysing problems to taking action to solve those problems.

The biggest obstacle is a sense of hopelessness among both people who are “left behind” and among policy-makers. Tackling health inequities can seem too hard, too complex, when inequalities are seen as just the way society is. Countering this means developing clear and convincing answers to some tough questions.

Is there any point at all in trying?

- OK, what then do you do, and what needs to be done first?
- How do you do it?
- How do you measure progress?
- Who needs to be involved?
- How can you influence and sustain action?

The measurement issue is fundamental, so attention has been focused on defining and capturing three types of indicators needed to measure and drive action in support of health equity:

- health and self-reported well-being;
- the underlying conditions and circumstances that influence whether people will be able to live a healthy prosperous life, looking at how they vary over time and place and how they affect people differently; and
- policies which strong evidence suggests will improve health equity and address the underlying conditions of health inequity, and which could work in the WHO European Region.

An alliance of 30 scientific institutions has been put together to support the work, led by the WHO Venice Office. The WHO Collaborating Centre for Policy Research on Determinants of Health Equity in Liverpool, United Kingdom (10) has led work on creating a big data set to support the process, and 109 indicators are being tracked.

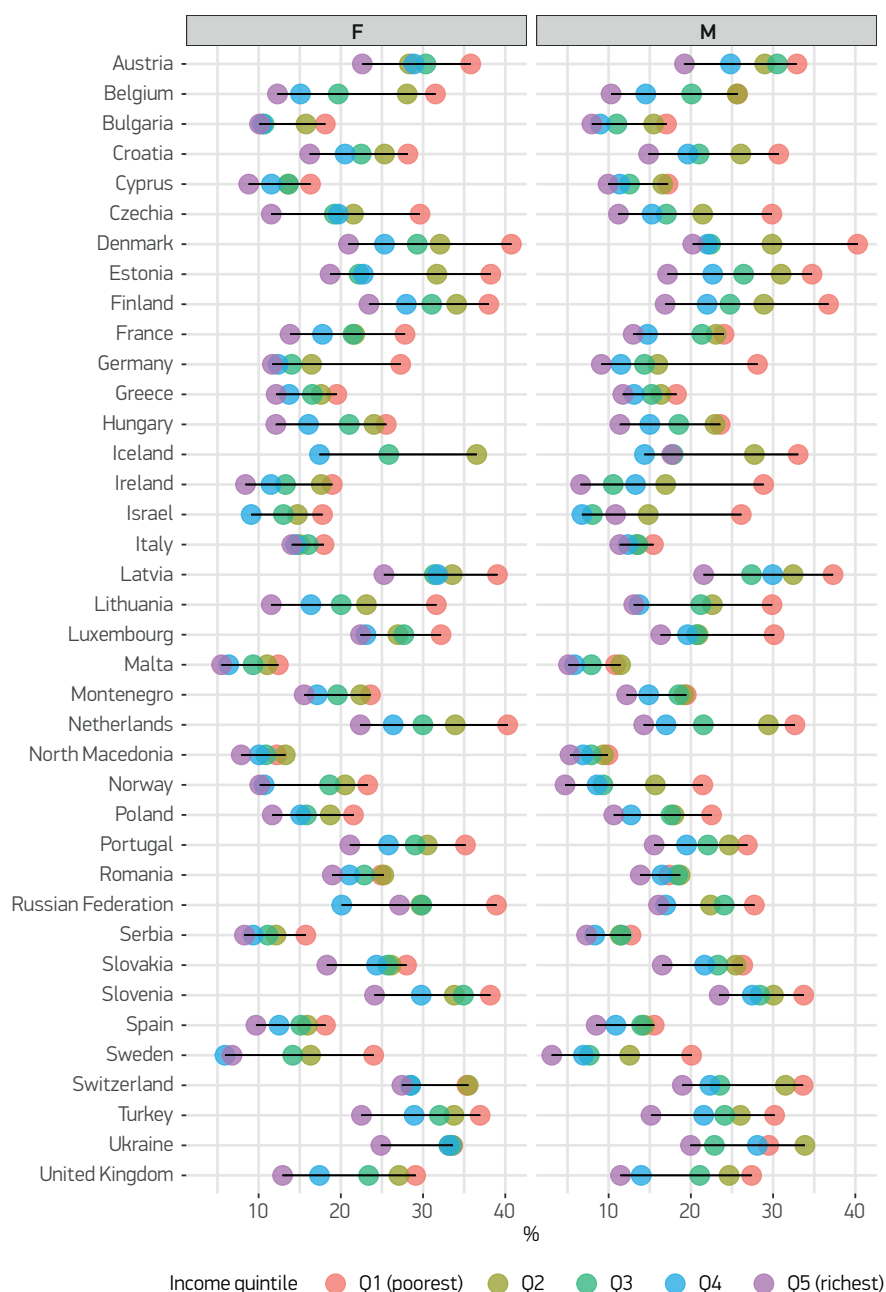
Early findings show that the gap between women with the best and worst life expectancy in the WHO European Region is 7.4 years, and that for men is 15.5 years. In addition, there are marked differences in people's chances of getting a health problem that significantly limits their ability to live life normally; in the case of women, the gap here has actually increased in some cases.



Data showing limiting illness across countries are available. As Fig. 3 shows, when the data are tabulated on a comparative basis, analysing the population across five groups based on income level (income quintiles), there are marked differences both within and across countries in the European Region.

This is an important indicator, because those affected by such illnesses are likely to face poverty, sudden falls in household income, social exclusion and a lack of security. Further effects include reduced economic activity and tax revenue, and higher social welfare costs at local, regional and national levels.

Fig. 3. Limiting illnesses by income quintile in the WHO European Region



Source: WHO (11).

Left unchecked, inequity grows over the life-course. A 6% gap among girls reporting poor health between the highest and lowest income quintiles during childhood rises to 19% for women during working years and reaches 22% during later life. For men, the figures are similar at 5%, 17% and 22%.

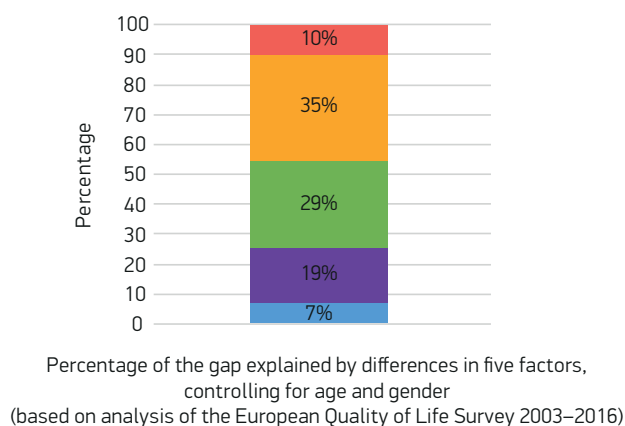
What is vital is to understand why all this is happening, and what to do about it. Analysis of data over the period 2003–2016 identified five broad areas found to be statistically significant in explaining the gaps. It looked at how different factors affected the occurrence of mental health problems, life-limiting illness and self-reported health issues in countries, looking at the experiences of people within five income quintiles. The five broad areas are:

- inequity in access to health care, and in its quality
- financial insecurity (*“not being able to make ends meet”*)

- poor-quality living conditions in homes and within neighbourhoods
- higher levels of social exclusion
- a lack of decent work and poor working conditions.

Fig. 4 shows the estimate of their relative importance.

Fig. 4. Analysis of the gap in health status between poorest and richest income quintiles over 36 European countries



Source: WHO (11).

Each of the five factors has been further analysed, showing for example that in the case of health services, 79% of the reason for differences in health between groups stems from differences in the quality of services provided, 12% is due to affordability and 9% to the absence of a service when needed.

For living conditions, the biggest element is housing deprivation, followed (in order of magnitude) by fuel deprivation, lack of green space, an unsafe neighbourhood, overcrowding, low air quality and, shockingly, food deprivation. These factors underline the point that a house is more than just a residence; it also means a place of shelter, safety and belonging.

The analysis relating to social and human capital shows a marked difference in how trust within society varies across Europe. This underlines the importance of communal attitudes and public policy. Sadly, there has been disinvestment in major policy areas in recent years. Over half of the countries surveyed had reduced spending on housing and community amenities.



In tackling both equity challenges and sustainable development, it is vital to engage with the individuals and communities who currently are not able to prosper and thrive, as they best understand the issues and are essential partners to design solutions for a better life.

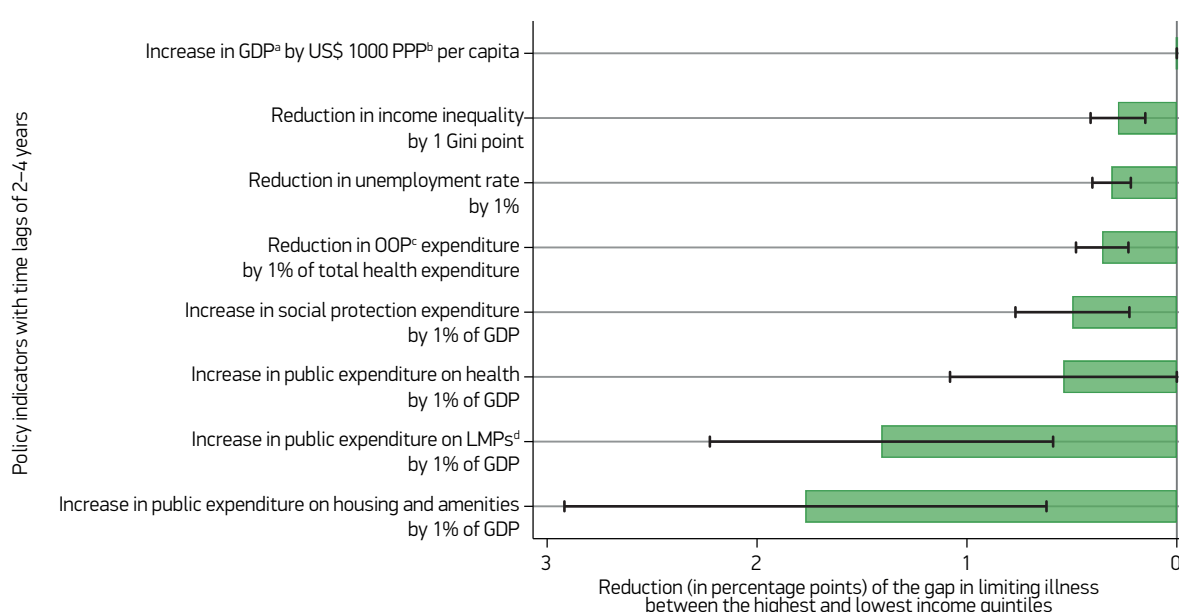
Change is possible even in the short term. Action in six policy areas has been shown to be statistically significant in reducing inequities in limiting illness between the top and bottom quintiles in the population over 2–4 years. These are increasing investment in:

- improving housing and public amenities
- labour-market policies

- increased social protection in a non-stigmatizing way
- cutting out-of-pocket expenses for health
- reducing unemployment
- reducing income inequity.

These are the same policies statistically shown to deliver inclusive growth. The impact is shown in Fig. 5 – the longer the bar, the greater the impact. It is noticeable that the increasing per capita national income alone is not significant. While not a causal analysis or predictive model, this shows what is realistic in terms of policy impact looking to the future, and who needs to be engaged if the aim is to narrow inequities.

Fig. 5. The potential for eight macroeconomic policies on reducing inequities in limiting illness among adults with a time lag of 2–4 years in 24 countries



^a GDP: gross domestic product.

^b PPP: purchasing-power parity.

^c OOP: out-of-pocket (expenditure).

^d LMPs: labour-market policies.

Source: WHO (11).

But is there any chance of securing political support for this, even if it can be shown to work? A strong case can indeed be put to politicians. There is:

- a financial argument – a 50% reduction in gaps in life expectancy would provide cash benefits to countries ranging from 0.3% to 4.3% of gross domestic product;
- public support – evidence that the public see the value of health and want to see reductions in inequalities; and
- symmetry with the European Union’s strategic agenda for 2019–2024.

Action on inequalities ticks boxes with voters, on economic growth and in relation to international responsibilities.



The evidence shows that no single policy on its own can make the necessary impact. But a basket of policies proportionate to need benefits everyone's health and accelerates improvement of those at risk or already left behind. As part of the HESRi, WHO has produced a number of documents showing what can be part of that basket (12). Interventions that improve social capital, such as civic participation, reducing crime and generating social connections, have positive impacts on health and well-being.

Case topic 1. Using public sector spending to improve prosperity and reduce inequities

The health sector and public sector in regions and countries across Europe spend huge amounts on supplies and services. It is possible to use this money to strengthen the local economy by procuring locally; one study in the United Kingdom (England) showed a shift of 13% in a period of six years in the amount spent locally (13).

European competition requirements have changed in recent years, and the European Union is encouraging local procurement to support local economies. It is easier to consider shifting services (such as cleaning and waste disposal) to local providers than to find local sources of more sophisticated goods, such as medical supplies.

Discussion was directed to what the health system might do to improve prosperity and reduce inequality.

There was little evidence that this was already being done in regions at the meeting. Health care was more generally seen as a cost, not an investment. The benefits of the system were recognized, but in terms of impact on health, not in any wider sense. It was suggested that if the economic benefits were to be examined, employment by the health sector was another potentially fruitful area for examination. A recent report on the economic and social impacts and benefits of health systems offers arguments to help make this case (14).

Improving local procurement was seen as being neither simple nor straightforward. Local sources might be more expensive than those from further away and not of as high quality. European competition requirements were noted as an issue (though they may be more supportive than is sometimes thought), and it was felt that in some places and circumstances a more closed, local system might be vulnerable to corruption.

Potential actions to secure further benefits were to:

- look for advocates who could develop the arguments and gather evidence to support a shift in opinion;
- encourage the health sector to work with local government to show what might be done and explain to the public the potential benefits of this approach; and
- engage politicians to explore whether legislation could be helpful.

So, the necessary components to reverse health inequity have been identified:

- identifying and acting upon the conditions that would allow everyone to live a healthy life means it is now possible with a high degree of certainty to **ACHIEVE** improvement;
- shifting from fragmented and short-term interventions to a comprehensive and coherent basket of solutions means it is possible to **ACCELERATE** improvement; and
- creating new partnerships and instruments to show convincingly how health equity matters and so **INFLUENCE** action at all levels can put health equity at the centre of sustainable development and inclusive economies.



3.2 ACTION AT ALL LEVELS TO REDUCE INEQUITIES

Those with expertise in trying to reduce inequities and improve access to services gave examples, including:

- the cross-border mammography screening service in EMR;
- the development of healthy life centres in Busk in Norway for people who need support in health behaviour change and in coping with health problems and chronic disease (15);
- development of the fourth health plan of Andalusia, Spain, the latest in a sequence of planning rounds over several decades in which a commitment to reduce health inequities has been maintained despite political changes in the region (16);
- the work of the EPECS foundation, which recognizes that to ensure people get the best from services, they too need to be part of conversations about design and evaluation and have an expertise ignored only at a cost (17); and
- the TipTop scheme in Wallonia, which takes health advice out to where people live (18).

Invited to comment on what might usefully be done to reduce inequity, speakers suggested:

- to improve collaboration, there must be a defined framework for working together and a strong focus on getting to know all about your partners;
- to combat the growing problem of loneliness and isolation among older people, the obvious should not be overlooked – for example, people can be stranded at home simply because there are no public toilets and no seats at bus stops;
- politicians' involvement is essential, and they must be approached, involved and convinced; and
- the public also must be involved, and on a continuing basis.

3.3 COMMENTS FROM THE CITIZEN SUMMITS ON REDUCING INEQUITIES

Those attending the summits did not readily understand the meaning and use of the word “inequity”, but after reflection saw its importance. Their main insights were that equity requires that:

- everyone must be able to have access to services – that is fundamental;
- to achieve this, community initiatives should be encouraged and nourished;
- equity requires not just equal access but, over time, development of approaches focusing more precisely on the individual person concerned; and
- communication – the language and languages used – has to be addressed to foster equity, especially if cross-border care is to be a reality.

Equity, then, means being treated equally, not in a sense of receiving the same standard package as everyone else, but being given equal attention as an individual person, with individual needs and concerns addressed: *“When equity has been put into place, you feel heard, you are a person”*.

3.4 COMMENTS FROM THE REGIONS ON REDUCING INEQUITIES

There was discussion among those at the meeting on their local experience. Some could point to valuable successes in reducing inequities in areas as varied as reducing frailty, improving health literacy and mental health, and creating new programmes in schools and family centres.

There was strong support for creating a participatory approach, which gives lay people a strong voice in dealing with the system rather than being forced to engage with separate organizations.

Potential actions to move forward include:

- avoiding targeting small groups, but encouraging the view that equity matters to everyone;
- taking existing official priorities and working out how they can be moulded to target inequalities;
- using community settings and thinking how to create a powerful chain of interlocking links through connecting efforts in different settings;
- using numbers, examples and simple, direct language to give clear explanations of what is wrong and what needs to be done, and how to enthuse people; and
- bringing people together, enabling them to hear different voices, including their own, and developing sharper insight through personal contacts.



4. How to keep people at the heart of sustainable development

4.1 THE 2030 AGENDA FOR SUSTAINABLE DEVELOPMENT: FROM GLOBAL TO LOCAL THROUGH PARTICIPATORY APPROACHES

The vehicle for taking forward sustainable development at global level is the 2030 Agenda. In September 2015, representatives of all United Nations Member States voted to adopt *Transforming our world: the 2030 Agenda for Sustainable Development* (2030 Agenda) and to work towards achieving its 17 SDGs, also known as the Global Goals (19).

Case topic 2. Tackling gender inequality

Improving long-term care services for our older population is a matter of human rights protection and promotion, and of gender equality. At service level, long-term care provision is usually a profession of low prestige and salary. Most of the paid long-term-care workforce and unpaid volunteers are women.

Unequal distribution of unpaid caregiving affects women's health, economic chances and quality of life, particularly in older age. Social expectations based on gender norms and roles and inadequate formal health services are underlying factors.

A specific SDG target (SDG 5.4) recognizes the importance of unpaid care work through the provision of public services and policies, and a more gender-equal sharing of unpaid care.

The WHO European Region has recognized this in developing two gender-based strategies (20,21). The WHO Regional Office for Europe is also in the process of developing a policy brief on gender and long-term care as part of support to countries in strengthening integrated people-centred long-term-care services.

Discussion at the meeting focused on three issues – raising the status of care for older people, improving the status of unpaid care work, and making the case for investing in long-term care, all from a gender equality perspective. These were seen as issues with deep roots, requiring a strategic response looking right across society.

There were arguments for a wider conversation to open the matter up with the public and politicians, claiming the whole issue of gender needs to be better understood – including definitions and the impact of existing norms and stereotypes. Points needing to be explored include diversity, education about what caring means, quality of life, and how patterns of living and expectations change through life, as well as the way people are paid, the nature of the gender pay gap and how equal rights can be undermined in practice. Reliance on immigrant care workers was also mentioned.

Some countries already had taken legislative action, for example to assist carers, granting parental and caregiving leave and respite care, and mandating children to support parents. One suggestion was to re-examine the relationship between the economy and society in a radically different way (22).

Potential actions to secure further benefits were to:

- review potential tools to change attitudes, behaviour and expectations, including education, structural and legal interventions, planning and targeting of resources;
- promote family-friendly employers, better pension rights, rewards to volunteers, and flexibility in men's employment and caring opportunities;
- empower carers through networking, advocacy, peer support and training in negotiation; and
- promote specialist accommodation for older people and hospices and community centres.

There is general agreement that success in achieving the SDGs is vital to the future of the planet and the people who live on it. Keeping people at the heart of this agenda means not only allowing, but actually facilitating, the participation of everyone and engagement in partnerships to achieve the goals.

The main health-related goal is SDG 3 (good health and well-being), which comprises 13 targets. Efforts to achieve this goal, however, will contribute to and benefit from efforts to achieve other SDGs.

Progress is mixed. For example, there is improvement on reducing maternal mortality and noncommunicable diseases (though not among all groups), and opportunities to accelerate actions to reduce alcohol and tobacco misuse and obesity and, in some countries, to improve vaccination coverage, remain. Much more needs to be done to address the socioeconomic and commercial factors influencing health. In some areas, such as violence against women and traffic accidents, there is no sign of a breakthrough. Too little attention is being paid to future challenges, such as the expected increase in deaths from neurological causes, and the threats of antimicrobial resistance, environmental pollution and climate change (23).

Faster progress demands wider participation. The goals and action to achieve them affect everyone and require integrated, intergenerational effort. The important role of the regional level within countries is clear. The United Nations Sustainable Development Solutions Network has concluded that *“65% of the 169 targets that form the base for the 17 SDGs can only be reached if coordination with and inclusion of local and regional governments is assured”* (24).

Action at regional level is therefore vital to success on the SDGs. This requires that all the levers available, such as planning, mobilizing the public and other agencies, and close engagement with national governments within a well-defined coherent framework, are used. Adequate funding is essential and there needs to be clear accountability for meeting objectives.

To help guide and support action, WHO developed its *Roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020* (the SDG Roadmap), formally adopted in 2016 (25) (Fig. 6). As there is high diversity in the way countries and regions go about policy development and implementation to achieve the SDGs, the Regional Office is promoting the 4As framework (Fig. 7) as an integrated and universally applicable approach.

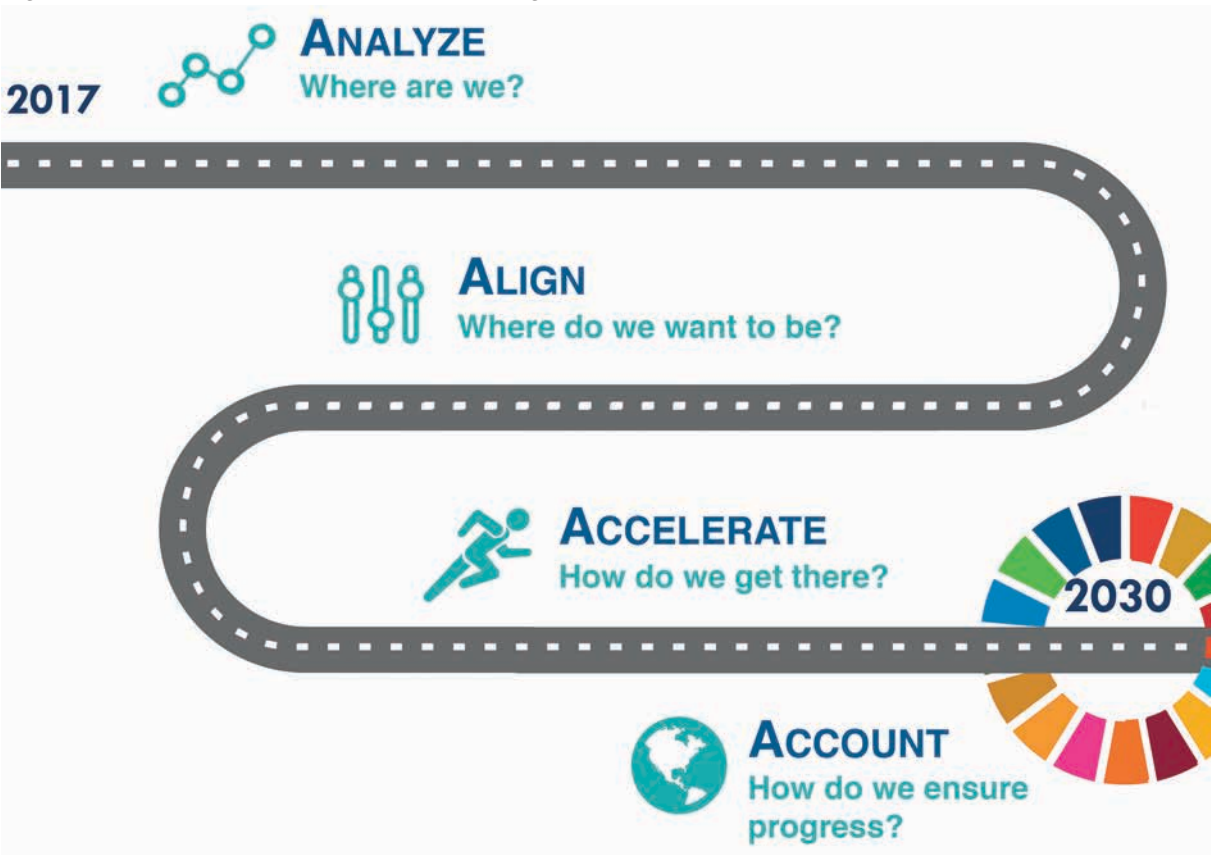


Fig. 6 .The components of the Roadmap



Source: WHO (25).

Fig. 7. The Roadmap to implement the 2030 Agenda: the 4As



Source: WHO (25).

At global level, the High-level Political Forum is the formal reporting mechanism on progress, with 42 European countries now doing so, providing a great deal of information on progress. This mechanism is grounded in national accountability arrangements. Indeed, the great majority of countries of the

WHO European Region reported engagement down through regional, provincial and municipal levels. Regions should feed into this reporting system and use it to strengthen discussions with other levels on how best to use resources to make progress.

Good practice includes formally linking national and regional actions through people from sitting round the same table. In the Netherlands, it appears that some 3000 initiatives are linked to the SDGs. In North Rhine Westphalia in Germany, an umbrella organization called Landesarbeitsgemeinschaft Agenda 21 (LAG 21) (26) provides a link across public bodies and nongovernment agencies (27).

Partnerships cross borders. Utrecht in the Netherlands, for example, is working with Ghent (Belgium), Bonn (Germany) and Malmö (Sweden) (27). A number of examples of good practice in smaller administrative areas has been reported on behalf of the countries working in the WHO Small Countries Initiative (28).

The vital lessons are that:

- regions matter
- coherence matters within regions and countries
- systematic action matters, with the 4As framework there to help.

4.2 ACTION AT ALL LEVELS TO SUPPORT THE SDGs

The WHO Regional Office for Europe sees countries as having the direct responsibility for deciding how to meet the goals; its role is to support them. WHO at global and European level is changing to align with that aim, adapting the ways it works, developing new tools and using its networks and partnerships to promote action.

The **European Commission** has prepared a reflection paper on action (29). It has important opportunities to promote the goals through developing policy and legislation and also through monitoring implementation. The challenge is that countries and regions are so very different from each other. The advantage the Commission has is that it works as one across all its policy areas.

The **Committee of the Regions** is supporting multi-level working within countries to meet the goals and action across society. The aim is to explain in each region what is needed and encourage participation in action to achieve the goals, especially among younger people. The Committee has prepared an opinion in response to the Commission's reflection paper (30). There is a need to ensure that the goals are reflected across the ways in which regions exercise their powers in, for example, planning.

The **euPrevent** initiative, which is working across the host region, also has advantages and challenges. Because it includes regions from different countries, it has to cope with differences in culture, language and law, but the fact that problems often exist on either side of formal borders helps in developing common solutions. Many initiatives are documented in the Vademecum of best practice prepared for the conference (6).

The **European Public Health Association** is using a simple prompt and challenge approach to try to keep the international public health community focused on the goals. *The Lancet* published an article on progress and future prospects relating to the SDGs for 195 countries (31). Each member country

has been asked by the Association to consider its own reported situation and explain its response, thereby challenging each to focus clearly on its own position. Because the professional public health community is small, the next proposed step is to work out from that group how to engage, on the one hand, people like town planners and, on the other, clinical professionals.

Future opportunities to promote wider understanding of the issues and of opportunities to take action were identified at the meeting. There are seminars in Brussels in the European Week of Regions and Cities in October 2019. At global level, the most recent United Nations High-level Political Forum on Sustainable Development – also known as the SDG Summit – was held in July 2019.

4.3 IMPLEMENTING THE SDGs AT REGIONAL LEVEL

Examples were given of a number of ways in which regions have responded to the challenge of implementing the SDGs.

Wales (United Kingdom) has for years had a formal commitment to supporting sustainable development and has now introduced legislation in the form of the Well-being of Future Generations (Wales) Act, which came into effect in April 2016 (32). This binds 44 public bodies to assess the impact of major decisions they take on the future, with a view to making Wales a prosperous, resilient, healthier, more equal and globally responsible country with cohesive communities, a vibrant culture and a thriving Welsh language.

Public involvement helped shape the legislation, with over 7000 people taking part. This influenced the title for the legislation and the inclusion of goals on global responsibility and Welsh culture. A public service board serves in each local government area to ensure agencies work together on this agenda and a Future Generations Commissioner holds the system to account. The recent Public Health (Wales) Act (33) also requires public bodies to undertake health impact assessments of major decisions.

The Friuli Venezia Giulia region in Italy has developed an inclusive approach to engaging local people in planning and implementation. It has introduced micro-areas as a way of improving life in some of its vulnerable districts. The aim is to improve the quality of life in specific areas by encouraging people from the area and volunteers from outside to work with the communities and individuals living there. This makes the community stronger, improves interagency working, reduces inequities and combats isolation and exclusion; it also improves people's engagement with services and reduces hospital use. The scheme is important in addressing issues that residents themselves feel are important.

The region funds the scheme, which has expanded from an initial five to a current 17 micro-areas. Two universities – one local to the region and one from outside – are involved in the work, and it is now being used in several other countries (34).

Burgerkracht (which can be translated as **citizen power**) is working in Limburg in the Netherlands to ensure that public services better serve the public by meeting their needs (35). The Netherlands has high-quality education and health services, but they are under pressure, and not everyone benefits in the same way. The aim is to start from what people need, understanding that a community functions at a number of levels that need to work together to get things right, and recognizing also that individuals' circumstances vary. The public are partners in achieving this. It is an engaging and evolving approach that will only achieve its full impact over a number of years.

The Positive Health programme is an example of how health services can be transformed to increase patients' acceptability and participation in making decisions for their health. Positive Health is a vision and a strategy to change attitudes and services. The Limburg region has for three years been working through its ambition to become the first **Positive Health region** in the Netherlands (36).

Consideration of how best to understand health in practical terms led to the development of the view of health as *"the ability to adapt and to self manage, in the face of social, physical and emotional challenges"* (37) and of a practical tool for plotting on a so-called spider's web individual experience against six dimensions – bodily functions, daily functioning, participation, mental well-being, meaningfulness and quality of life – that can help individuals assess and communicate how they feel and be used to chart changes over time. Experience to date has indicated that this approach can help professionals and the public to better discuss at individual level what needs to be done to promote health and measure progress.

4.4 COMMENTS FROM THE CITIZEN SUMMITS ON ACHIEVING THE SDGs



Those attending the summits were not accustomed to the idea of being invited to participate in policy-making, but liked the idea. They thought organizations and policy-makers should indeed actively ask citizens for their know-how through some systematic method. Universities might help, and laws might be used to require participation. It should be a requirement for every organization at every level. Actually listening to those who used services and acting on what they said could and should transform services.

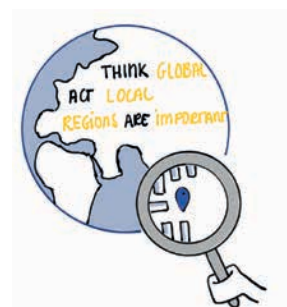
After all, citizens are the people who are directly affected by sustainable development policies: *"Citizens are experts as well: use it!"*



4.5 COMMENTS FROM THE REGIONS ON ACHIEVING THE SDGs

Regions briefly discussed their own current contributions to achieving the SDGs. Actions differed from place to place, and people were working at different levels.

One spoke of a strong commitment at national level, with interministerial, interinstitutional and interdepartmental working groups. Another cited efforts in the region to engage with the public through organized meetings.



Challenges have been experienced. The SDGs include a huge range of topics, and trying to integrate cross-sectoral working, sometimes for the first time, presented problems. The SDGs still are not well understood in places, and there is a danger that those heading implementation might themselves be seen as occupying a new silo.

The usual problems with working across boundaries remains – lack of previous experience of working together, uncertain evidence of what best to do, misunderstandings about others' purposes and financial barriers.

Case topic 3. Taking action on environmental health issues to reduce inequalities

Societal structures and processes often generate inequalities. A recent report from WHO reviewed inequalities in environmental exposure and injuries across the WHO European Region. It updated previous work and showed that inequalities in environmental exposure within countries persist or, in some cases, have even increased. Nineteen indicators were examined (38).

Regions at the meeting reported that they made some use of environmental data to analyse health inequalities. Public health legislation had helped strengthen the availability of data.

Contributors said that data had helpfully clarified inequalities regarding access to green and blue spaces, housing, work and noise. Older people faced challenges in some countries and there were specific urban/rural differences, with water pollution due to agriculture in one case and heat islands in towns and air pollution due to overcrowding in others.

The main issues seemed to be that while data were plentiful, they were not always easy to use, and methodological challenges exist. Capacity to analyse and collate the data, and to better understand deprivation, spatial issues and the way the economy operated, was needed. Even with a growing understanding of the issues, however, politicians often had little interest in this area.

Potential actions to secure further benefits were to:

- look for advocates who could develop the arguments and gather evidence;
- explore the value of a scorecard to measure and monitor the impact of local factors; and
- develop a common language that those dealing with health and environmental issues could use together and to raise awareness among politicians and the public.

People nevertheless could identify factors that helped progress. These included explicitly identifying the importance and urgency of action for the lives of ordinary people and future generations, and challenging individuals to consider their own behaviour and beliefs.

Again, the tested approaches of intersectoral working were relevant – developing effective partnerships, using champions, generating agreement around common ambitions, and helping different sectors feel they would see concrete benefits. In Norway, the SDGs were being used to manage regional reform.

Potential actions to secure greater participation regarding sustainable development included:

- making it personal;
- sharing successes;
- using inclusive, simple, welcoming language;
- emphasizing that this is our responsibility;
- making it seem one common effort;
- using managers to help organize the work and training professionals to encourage and manage participation;
- putting money behind it; and
- starting in schools.



5. How to keep focused on people when creating a future health workforce

5.1 PLANNING THE FUTURE WORKFORCE

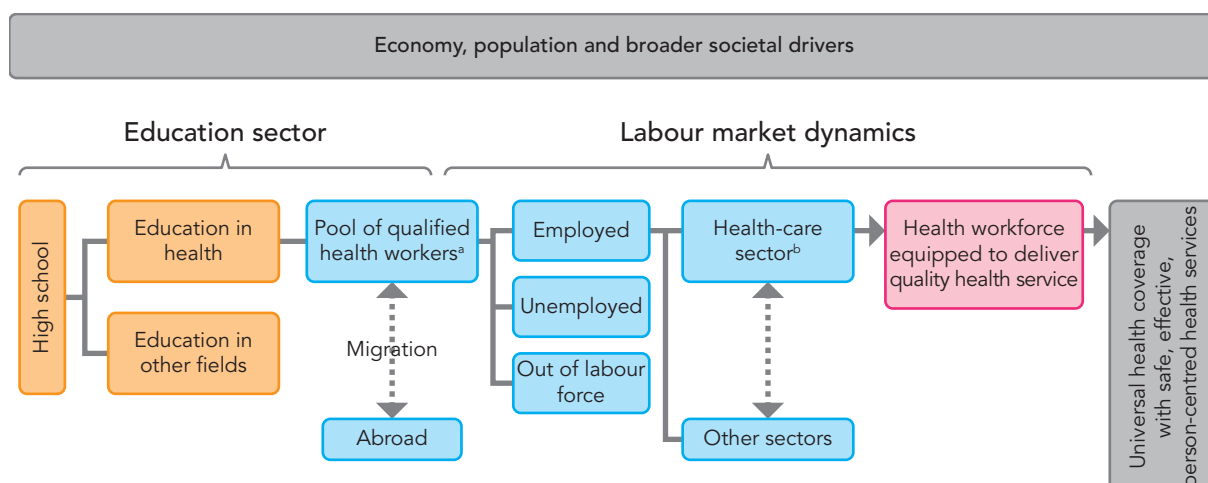
As WHO's Workforce 2030 initiative acknowledges, “*Health systems can only function with health workers*” (39). Health care depends almost completely on trained, committed professionals and volunteers. The WHO Regional Office for Europe is looking very carefully at how it will be possible in coming years to secure the right number of people with the right attitudes and qualifications to meet people's health needs. The problem is that there is a worldwide shortage of health workers and this is projected to increase – in the case of Europe, to 1.4 million by 2010 (40).

The workforce must be seen as stretching far beyond the traditional core professions – doctors, nurses, midwives, pharmacists and dentists. It includes many other clinical professions and also those in the supply chain, support workers and social care staff.

This is a huge and complex network of people and careful analysis will be required to ensure that there will be sufficient staff, with the right training and motivation, for the future. A functioning health labour market framework consists of two major components – one looking at education, the other at labour market dynamics (Fig. 8).

The education element needs to lay the ground for influencing the flow of people into the health-care system. It needs to cover the structure and effectiveness of education and the availability of staff and other resources at every stage. The labour market part needs to help ensure that staff are retained and deployed well, including matters such as the levels of supply and demand, the distribution of staff across countries and flexible recruitment. The whole requires attention to people's attitudes and aspirations through life and what affects decisions and opportunities at critical points.

Fig. 8. The health labour market framework



^a Supply of health workers: pool of qualified health workers willing to work in the health-care sector.

^b Demand of health workers: public and private institutions that constitute the health-care sector.

Source: WHO (39).

Health is affected by factors far outside the boundaries of traditional health care, and those working in other areas – police, education and housing, for instance – are also indirectly part of the health workforce. How workforce planning for the health sector can also address these sectors requires more

study; Ireland is currently looking carefully at how workforce planning across the whole public sector might be improved.

5.2 ACTION AT ALL LEVELS TO SECURE A NEW WORKFORCE

A project looked into **the factors that support successful intersectoral partnerships** in four cities in Canada (41,42). Important elements were:

- a vision that all sides could understand and aspire to;
- careful use of language, avoiding technical public health jargon;
- recognizing that a person with a high-level post may not be the right person to drive things forward, but also making sure that those people who have power to make things happen are involved; and
- avoiding any development of a gap between high-level leaders and those actually doing the front-line work.



Intersectoral working is important. The right things need to be in place to make it happen. Students need to be taught why it matters and how to do it. It is not enough just to assume organizations will find new ways of working together. Some new factor may be needed – for example, employing a town planner in a public health department to sensitize it to other ways of thinking and to act as a bridge to outside groups.

The first Maison Verte was founded in Paris in 1979 as a place where mothers and very young children could meet and mix (43). Recently, a similar venture has been introduced in Varna on Bulgaria's Black Sea coast through **ambitious, purposeful leadership** that combined the creativity of public health professionals, the generosity of a local property owner and the enthusiasm of local volunteers. The result is a new neighbourhood asset that benefits mothers and children and brings the local community together (44,45).



It is necessary to think about the health system as a whole, as if it was a business. The situation is very different across countries and is constantly changing, so it is essential to **remain alert and flexible** and be attuned to cultural issues. Traditional qualifications and professional boundaries have been dominant for years, but they and expectations can change. For example, in some parts of Europe, attitudes towards being a general practitioner (GP) have become positive again after a period of great reluctance, with general practice now being seen as an attractive career choice.

From a citizen perspective, the need is for a **workforce that is effective and responsive to individual patient needs**. While patients may in the future get more support from IT-based solutions, human interaction will remain hugely important; in an analysis of jobs vulnerable to being replaced through computerization, seven of the 10 least likely to be replaced were in the health field (46).

In general, there are strong arguments to **reduce the impact of boundaries within and around the health-care sector**. More might be done to lessen the sometimes sharp divide between physical and mental health and the separation of institutional and community services.

There might also be further attention to:

- recruiting migrants into the workforce, while being careful not to trap them in lower-paid positions;
- re-engineering the role of health professionals, systematically removing activities that add low value; and
- giving new thought to the chasm between, on the one hand, health professionals and, on the other, members of the public; expert patient approaches and improving people's understanding of health issues may do this to some extent, but an all-embracing approach based on the idea of co-production might prove valuable in making services more sensitive, sustainable and effective in the long term (47).

A handwritten-style graphic with the text "how Radical do we dare to be?". The word "Radical" is written in a larger, bold, yellow font and is underlined. The words "how" and "do we dare to be?" are in a smaller, black, cursive font.

5.3 COMMENTS FROM THE CITIZEN SUMMITS REGARDING A NEW WORKFORCE

The citizen summits naturally acknowledged the crucial importance of the health-care workforce. They saw it, however, less in terms of recruitment and retention, and more in relation to personal contact with patients and the experience of being employed within the workforce. On the second point, being treated as fully equal and given secure conditions are vital issues. Patients want to be acknowledged as equals, and the whole health system should understand the profound importance of how staff deal with patients and aim to ensure the highest quality of human contact within health care.

The summits encapsulated important ideas in some sharp, challenging words to health professionals and health system managers.

- Do you see me as a human being when helping me?
- Do you think of me when planning health care?
- I would love to share my story and my experiences; will you give me that opportunity?

5.4 COMMENTS FROM THE REGIONS REGARDING A NEW WORKFORCE

In discussion, there was a readiness to accept that, for society to tackle deep-rooted health problems, the relevance of other, non-clinical professions must be better acknowledged. This must include those who affect the conditions of daily life, like town planners, financial planners, quality and risk analysts and those who design services. In addition, the importance of teachers, communications specialists, journalists, economists and anyone else who can influence how people think and behave needs to be recognized.

There then needs to be a more systematic effort to get people from different backgrounds to work together more effectively. This would require new skills, or at least a willingness to apply existing skills differently. Health professionals need to have a deeper understanding of the humanities and social sciences. Data could be used to encourage more open conversations and collaboration. Professionals at all levels and all stages need to be more comfortable with working on equal terms with other agencies, other professions and local communities, and this may mean changes in the way they are educated.

Potential actions to shift thinking and practice included:

- focusing training more on working in teams, across professional and organizational boundaries, in mixed groups of all sorts, and in the community;
- adapting training to ensure skills change to match changes in society through life;
- creating ways in which professionals are open to new influences and ideas and can move more easily outside their narrow professional training;
- planning with and around communities and patients; and
- giving lay people confidence and opportunities to make their views matter.



6. The RHN in action

6.1 INTRODUCTION

This meeting, the 25th annual meeting, was a celebratory event, but at the same time was not greatly different in many ways to earlier meetings. It mixed serious business with networking, exchanging ideas and enjoyment. After more than a quarter of a century, there is a pattern in the work of the Network, learning together, planning joint activities and catching up on and reacting to developments in WHO and other parts of Europe.

From time to time, the overall direction of the work needs to be reassessed, and that has been going on in the light of the recently adopted WHO 13th General Programme of Work. The new Programme sets the agenda for WHO and its partners globally for the years 2019–2023 and establishes a mission for WHO to “*promote health, keep the world safe, serve the vulnerable*” in that period (Box 3) (48).

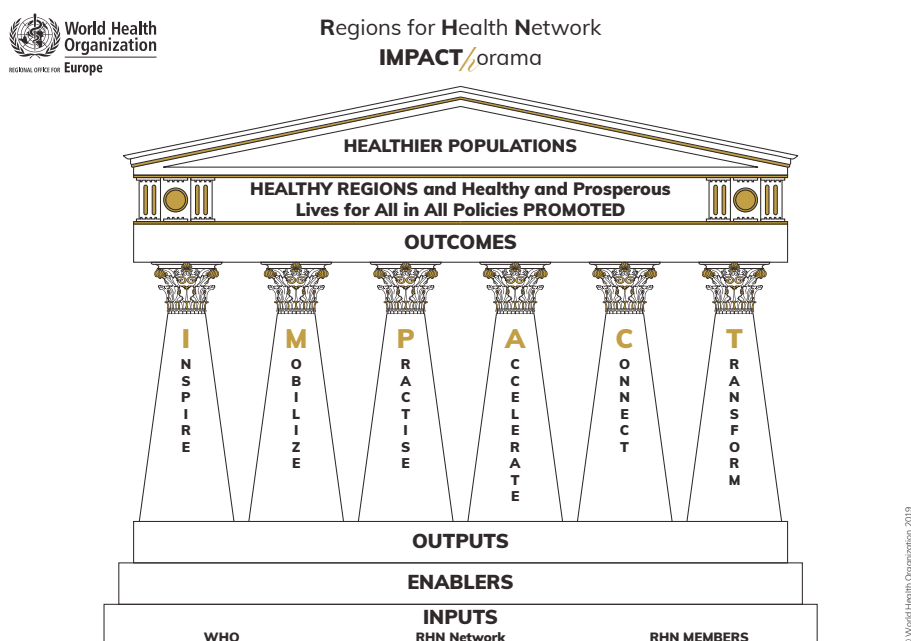
Box 3. Strategic priorities and goals of WHO’s 13th General Programme of Work, 2019–2023

Ensuring healthy lives and promoting well-being for all ages by:

- *achieving universal health coverage – 1 billion more people benefitting from universal health coverage*
- *addressing health emergencies – 1 billion more people better protected from health emergencies*
- *promoting healthier populations – 1 billion more people enjoying better health and well-being* (48).

In the context of needing to demonstrate that its activities have an impact, the Network has developed a visual means of describing and analysing how its different strands of work affect health (Fig. 9).

Fig. 9. A tool to gauge the impact of the RHN



As in previous years, there have been high levels of interaction across the Network, including the project on universities and public health described below. The Network Steering Group is itself an example of international collaboration, and in 2019 the Autonomous Province of Trento (Italy) left

the group and was replaced by Østfold (Norway). The other Group members are Flanders (Belgium), Wales (United Kingdom), Pomurje (Slovenia) and Västra Götaland (Sweden).

Since 2009, as WHO Collaborating Centre for Cross-sectoral Approaches to Health and Development, the Centre for Health and Development at Murska Sobota in Pomurje, Slovenia, one of the RHN regions, has been organizing public health schools and short training courses to enhance understanding of health inequalities and the social determinants of health in central, eastern and south-eastern Europe. Veneto, Varna, Flanders, Catalonia and Wales participated in the Spring School in April 2018 (49). The next event is in September 2019.

In November 2018, 42 representatives of 13 regions visited Andalusia, Spain, to study the region's fourth health plan, which is based on the health-in-all-policies principle (50). The Flanders reform, presented below, also drew on experience in other regions and countries and WHO publications.

Other examples of sharing expertise and raising awareness and skill-levels included:

- webinars organized with the WHO European Centre for Environment and Health in Bonn, Germany to share techniques on managing environmental problems such as air pollution, in one of the biggest examples of such a group arranged by WHO (51); spin-offs include YouTube videos of some of the material and a newly planned set of webinars on health and equity;
- a workshop on air pollution in Europe and ways to tackle it, in collaboration with the WHO European Centre for Environment and Health at the European Public Health Conference in November 2018; and
- RHN and the Healthy Cities Network agreeing to work more closely with each other, including attending each other's events, and together giving public support to the Ljubljana Statement at the recent High-level Conference on Health Equity (9).

More detail on communications within the Network and recent improvements are given below.

6.2 COMMUNICATION ACTIVITIES AND PUBLICATIONS

A well-developed set of communication activities was now in place linked to the work of the Network and the interests of its members. These included the involvement of:

- 3700 people on Facebook
- 4500 people on Twitter¹
- 250 subscribers to the weekly update
- 2500 subscribers to the newsletter.

The newsletter is a source of information on new developments, events and publications, while the weekly update provides brief items of news and current affairs of interest to members from a number of sources. The website is continually updated and there is a steady flow of new publications. A revised version of the Catalogue of Regions is being prepared. This document provides a quick overview of

¹ @WHO_Europe_RHN; official hashtag: #RHN.

each region/area, including their strengths, challenges and aspirations. A new simple information leaflet has been designed and a new RHN YouTube channel has been opened.

A report on primary care reform in Flanders was published in 2019 and two new publications are under development. One will offer an in-depth analysis of the health impact assessment implementation process in Andalusia, with a focus on elements of success, challenges, windows of opportunity and lessons learnt (52). The second, to be led by Wales, on empowering nurses and midwives and, especially, supporting their health workforce leadership role, will be published to coincide with 2020 as the Year of the Nurse and the Midwife.

6.3 PARTNERSHIPS FOR IMPROVING POPULATION HEALTH BETWEEN REGIONAL UNIVERSITIES AND GOVERNMENTS

A recent study has examined how regional universities and governments work together to improve the health of their local population and how their collaboration might be made more effective. The project was an initiative of the Østfold region and was run by Norwegian academics in connection with the WHO Venice Office.

Partnerships are seen as necessary and important factors, especially within governance and for solving complex so-called wicked problems. Health inequities and the SDGs clearly are complex problems, and partnerships have been recognized as an important tool in achieving the goals and creating sustainability.

Within regions, academic institutions have local knowledge and can potentially be valuable partners in helping regional governments make solid progress by providing additional resources and adding rigour in defining and evaluating interventions. Regional authorities and universities, however, inhabit two very different intellectual worlds (Table 1), and their differences may obstruct efforts to work productively together.

Table 1. The two cultures – the university and daily reality in the region

The world of research	The world of administration
Theory-orientated	Context-oriented
Solving research questions	Solving practical issues
Scientific publishing	Participative approaches
Long time frames	Now!
Loyalty to scientific methods	Loyalty to political decisions
Academic freedom	Hierarchy
Accountability and transparency	Reputation management and marketing

The study engaged 31 RHN member regions through an electronic questionnaire (a 72% response rate) and subsequently four group interviews were held with four best-practice areas: Østfold in Norway, Varna in Bulgaria, Utrecht in the Netherlands and Saskatoon in Canada.

The review found that over half the respondents had a formal regional partnership with regional academic institutions, and another third either informal links at that level or a formal link with national institutions. Only 7% had no links. There were other important links, particularly with health-care entities (over 80%) but also with many other bodies.

The regions benefited in many ways, including access to expert advice in areas such as policy, help in communication with the public, and technical support with matters such as evaluation and health impact assessment. Universities secured support through, for example, funding, data access and help with teaching and publishing. Some 70% of those involved saw benefits in terms of substantial achievements and benefits to the public.

Analysis of how best to achieve success suggested important factors were:

- being willing to be patient and put time aside for the partnership
- building personal relations, trust and a sense of a common identity
- building a sustainable partnership organization, with some dedicated staff
- accepting that both sides needed to understand how the other side is different
- starting small and capitalizing on early successes.

A substantial achievement that both sides could celebrate could create long-lasting momentum.

The study demonstrated that successful, sustainable partnerships can be established between regional governments and universities for addressing public health challenges to the satisfaction of both partners, and that the factors that support success remain the same irrespective of geography, subject matter or sociodemographic differences.

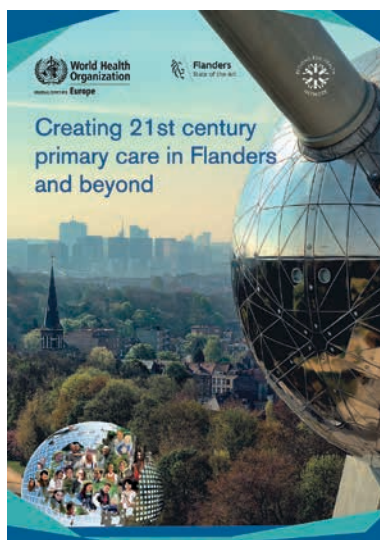


6.4 PRIMARY CARE REFORM IN FLANDERS

The RHN took the opportunity of the meeting to launch its latest publication (Fig. 10), which focuses on primary care reform, specifically the important changes in Flanders, but also includes brief references to recent developments in Utrecht in the Netherlands, Boto ani in Romania, Catalonia in Spain and Slovenia (53). An authoritative account of the process of change in Flanders was given at the meeting.

Flanders is located in the north of Belgium and has 6.5 million inhabitants. In the early 21st century, there was a perception that the primary care system was fragmented, with GPs feeling isolated and poor relations with hospitals and with social care. In some areas, such as mental health and chronic disease, health was deteriorating and the system was failing to keep up.

Fig. 10. The RHN's latest publication



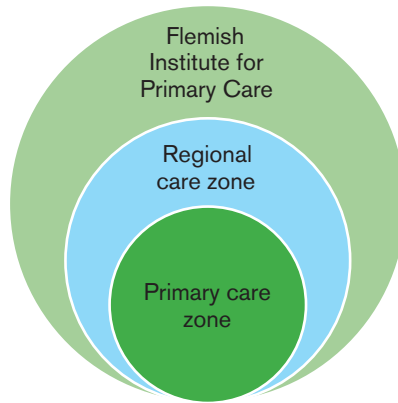
It initially was decided to hold a very broad-based conference to discuss the issues to try to secure agreement that change was needed. A year was spent on careful, thorough preparation. The meeting, at the end of 2010, was a great success, with the minister unusually receiving a standing ovation, opening the way to serious discussions on what should be done.

Federal reform in Belgium then led to a major transfer of competence in primary care and other matters to Flanders, creating an unprecedented opportunity to radically improve the system. A further large meeting in 2017 completed a second round of consensus-building, which then ensured political support for a primary care decree approved unanimously in 2019. The reform reflects the quadruple aim of combining improvements in patient experience, population health, efficiency and the well-being of the care team, and a conscious effort was made to reflect principles such as transparency, accountability, participation, integrity and capacity for change in the process of reform.

As a result, new institutional arrangements at three levels have been established, simplifying and strengthening the existing range of organizations (Fig. 11).

The 60 primary care zones (PCZs) each have a population of 75 000–100 000, with a prime responsibility for integrating primary care for local residents. Their tasks include assessing population needs and developing community care, integrating care for older people and helping create systems to allow people easily to find the way to the care they need. Each PCZ is administered through a care council, with membership drawn from four sectors – local government, health-care providers, the well-being sector and representatives of those who need services.

Fig. 11. New primary care structures in Flanders



The regional care zones each cover a group of PCZs with a population of 300 000–400 000. Their prime role is strategic planning for the population, ensuring there is an adequate supply of services and improving alignment with the hospital sector. Overseeing the system, acting as a central reference point and a partner for national bodies, there is a new Flemish Institute for Primary Care. More detail on the development and links to sources of further information are available in the report.



7. Conclusion

The conference ended with some simple but important messages.

- Services will be better and policies more effective if citizens are genuinely recognized as partners. This was captured in the statement “*what you do for us without us is not for us*”.
- The final venue, a former factory and current business centre, offered a model for all attending to think about as they left. Everyone working in the health field needs to be open to new ways of thinking in a world of cutting-edge ideas, research and innovation, and new start-ups that might turn out to change the world; what there is now is not the only possibility. **Radical reimagination is not just for the think-tanks and specialist centres – it is everyone’s job.**



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Annex 1. Programme

Wednesday 26 June 2019

18:15

Moderator

Mr Nicolas Decker (Kohll-Decker ruling)

Board member, European Patients Empowerment for Customised Solutions (EPECS), The Netherlands

Aachen, Aachen Town Hall (“Krönungssaal”)

Session 1. Welcoming remarks

Mr Marcel Philipp

Mayor, Aachen

Ms Gisela Walsken

President, Euregio Meuse-Rhine (EMR)

Mr Karl-Heinz Lambertz

President, European Committee of the Regions

Mr Francesco Zambon

Coordinator, Department of Investment for Health and Development in Healthy Settings, WHO Regional Office for Europe

18:45

Session 2. Reducing health inequities in Europe: what can regions do?

Moderators

Mr Francesco Zambon

Coordinator, Department of Investment for Health and Development in Healthy Settings, WHO Regional Office for Europe

Ms Brigitte van der Zanden

Director, euPrevent|EMR, The Netherlands

Keynote speaker

Ms Chris Brown

Head, WHO European Office for Investment for Health and Development, WHO Regional Office for Europe

Panel discussion

Ms Hildegard Schneider

Director, Department of Public Health, Medical and Pharmaceutical Affairs, Social Services and Hospital Finances, Regional Government of Cologne, Germany

Mr Nick Batey

Chairman, European Regional and Local Health Authorities (EUREGHA)

Ms Ana Maria Carriazo

Senior Advisor, Regional Ministry of Health and Families, Andalusia, Spain

Ms Silke Tamm-Kanj
Board member, European Patients Empowerment for Customized Solutions
(EPECS), Germany

Thursday 27 June 2019

Moderator

Mr Nicolas Decker (Kohll-Decker ruling)
Board member, European Patients Empowerment for Customised Solutions
(EPECS), The Netherlands

Maastricht – Provincial House (Statenzaal)

09:00–09:15

Welcome by Mr Theo Bovens

Governor, Province of Limburg, The Netherlands

09:15–10:15

Session 3. The 2030 Agenda for Sustainable Development: from global to local through participatory approaches

Moderators

Mr Francesco Zambon

Coordinator, Department of Investment for Health and Development in
Healthy Settings, WHO Regional Office for Europe

Ms Brigitte van der Zanden

Director, euPrevent|EMR, The Netherlands

Keynote speaker

Ms Bettina Menne

Coordinator, Health and Sustainable Development (SDG), Denmark

Panel discussion

Ms Piroska Östlin

Director, Division of Policy and Governance for Health and Well-being, WHO
Regional Office for Europe

Ms Birgitta Sacrédeus

Member, European Committee of the Regions, and Chairwoman, Interregional
Group on Health and Well-being, Sweden

Ms Isabel de la Mata

Principal Adviser, Health and Crisis Management, DG Santé, European
Commission

Mr Nanne de Vries

Board member, euPrevent|EMR, The Netherlands

Ms Natasha Muscat

President-elect, European Public Health Association (EUPHA)

10:15–10:30	<p>Session 4. Feedback from the Citizen Summit: citizens’ views on equity, sustainable development and participatory approaches, human resources for health</p> <p><i>Mr Jo Maes</i> Chairman, EPECS, The Netherlands</p>
11:00–12:00	<p>Session 5. Sustainable Development Goals: how to make them goals for everyone</p> <p>Moderators <i>Mr Francesco Zambon</i> Coordinator, Department of Investment for Health and Development in Healthy Settings, WHO Regional Office for Europe</p> <p><i>Ms Brigitte van der Zanden</i> Director, euPrevent EMR, The Netherlands</p> <p>Panel discussion <i>Ms Gianna Zamaro</i> Chief, social policies sector, Friuli Venezia Giulia, Italy</p> <p><i>Ms Sumina Azam</i> Lead, Public Health Policies Division, Public Health Wales, United Kingdom</p> <p><i>Mr Han von den Hoff</i> Director, citizen organization Limburg, The Netherlands</p> <p><i>Ms Machteld Huber</i> Director, Institute for Positive Health, The Netherlands</p>
12:00–12:10	Family picture – in the Statenzaal
12:10–12:30	Boarding the ship (<i>going along the River Maas from Maastricht to Liège</i>)
	Maastricht/Liège
13:00–14:00	<p>Sessions 6 and 7. Interaction Market and World Cafe-style discussion</p> <p>During this hour, participants are split in two main groups. One group starts at Deck 1 while the other starts at Deck 2. After the break, the groups swop decks.</p> <p><u>Group 1 on Deck 2 of the ship: Interaction Market</u></p> <p>During the Interaction Market, participants can interact with each other to discuss best practices from the EMR:</p> <p>School and community setting <i>Ms Christine Graf</i>, Professor, Institute of Movement and Neuroscience, Region Aachen, Germany</p>

HELPADOS

Mr Christophe Mairesse, Project Leader, Department of Social Affairs, Province de Liège, Belgium

BReIN

Mr Jos Kleinjans, Professor, Environmental Health Science, Maastricht University, The Netherlands

Gezonde Gemeente (Healthy Community)

Ms Sara Reekmans, Coordinator, Logo Limburg vzw, Belgium

Kaleido

Mr Manfred Kohlen, Director, Kaleido, Belgium

euPrevent Senior Friendly Community

Mr Frans Verhey, Professor, Maastricht University, The Netherlands

Data in the EMR

Ms Nicole Curvers, Policy Advisor, Public Health Authority South Limburg, The Netherlands

In de Zorg – uit de zorgen (Workforce and Social Inclusion)**People-Orientated Care and Education**Group 2 on Deck 1 of the ship: **World Cafe-style session**

Group discussions around:

Equity – economic and social impact of regional health systems

Ms Tammy Boyce

Consultant, WHO Regional Office for Europe

Environment and health

Mr Matthias Braubach

Technical Officer, Urban Health Equity, WHO European Centre for Environment and Health (ECEH), Division of Policy and Governance for Health and Well-being, WHO Regional Office for Europe

Gender and human rights

Ms Åsa Nihlén

Technical Officer, Gender and Human Rights, Division of Policy and Governance for Health and Well-being, WHO Regional Office for Europe

14:30–15:30

Group 2 on Deck 2 of the ship: **Interaction Market**

See the description above

Group 1 on Deck 1 of the ship: **World Cafe-style session**

See the description above

	Liège
15:30–16:00	Transfer by bus from boat to Cité Miroir, Liège
16:00–16:30	Welcome by <i>Mr Philippe Snoeck</i> Director Observatoire de la Santé, Province of Liège Santé et Qualité de vie, Belgium
16:30–17:30	Session 8. Improving population health: best practices from the regions Perspective of the Province of Liège <i>Mr Philippe Snoeck</i> Director Observatoire de la Santé, Province of Liège Santé et Qualité de vie, Belgium Health status of citizens in the EMR <i>Ms Maria Jansen</i> Programme Manager, Public Health Academy, GGD South Limburg, The Netherlands Partnerships for Health, RHN <i>Ms Camilla Ihlebæk</i> Professor, Public Health Faculty, Norwegian University of Life Sciences, Norway Primary health care in Flanders, Belgium <i>Mr Dirk Dewolf</i> General Administrator, Flanders Agency for Care and Health, Belgium <i>Ms Solvejg Wallyn</i> Policy Officer, Flanders Agency for Care and Health, Belgium
17:30–17:45	Wrap up of the day <i>Mr Nicolas Decker</i> Board member, EPECS, The Netherlands

	Moderator <i>Mr Nicolas Decker</i> (Kohll-Decker ruling) Board member, European Patients Empowerment for Customised Solutions (EPECS), The Netherlands
	Hasselt
09:30–09:45	Welcome by <i>Mr Herman Reynders</i> Governor, Province of Limburg, Belgium
09:45–11:00	Session 9. The new health workforce: going beyond the health sector Moderators <i>Mr Francesco Zambon</i> Coordinator, Department of Investment for Health and Development in Healthy Settings, WHO Regional Office for Europe <i>Ms Brigitte van der Zanden</i> Director, euPrevent EMR, The Netherlands Keynote speaker <i>Ms Gabrielle Jacob</i> Programme Manager, Human Resources for Health, WHO Regional Office for Europe Panel discussion <i>Mr Cory Neudorf</i> Chief Medical Health Officer, University of Saskatchewan, Canada <i>Ms Klara Dokova</i> Vice Dean, Faculty of Public Health, Varna Medical University, Bulgaria <i>Mr Jean-Luc Vanraes</i> Member, European Committee of the Regions, Belgium <i>Mr Henrik Basche</i> Citizen, Germany <i>Mr John Vanacker</i> Director Public Psychiatric Care Centre OPZC Rekem, Belgium
11:30–12:30	Session 10. Group discussion on equity, sustainable development and participatory approaches, and human resources for health

12:30–12:45	<p>Closing remarks by the moderators</p> <p><i>Mr Nicolas Decker</i> Board member, EPECS, The Netherlands</p> <p><i>Mr Francesco Zambon</i> Coordinator, Department of Investment for Health and Development in Healthy Settings, WHO Regional Office for Europe</p> <p><i>Ms Brigitte van der Zanden</i> Director, euPrevent EMR, The Netherlands</p>
13:30–15:00	<p>Parallel sessions</p> <p>EUREGHA meeting Keynote and panel discussion on cross-border cooperation <i>Mr Karsten Uno Petersen</i>, Member, European Committee of the Regions, Belgium Moderated by: <i>Mr Nick Batey</i>, Chairman, EUREGHA</p> <p>RHN business meeting – for RHN members only</p>

Annex 2. Participants

Austria, Lower Austria

Ms Julia Winkler
Project Manager
Initiative Healthacross
julia.winkler@healthacross.at

Belgium, Flanders

Ms Solvejg Wallyn
Policy Officer, Flemish Agency Care and Health
Flemish Ministry of Welfare, Public Health and Family Affairs
solvejg.wallyn@zorg-en-gezondheid.be

Dr Dirk Dewolf

General Administrator, Flemish Agency for Care and Health
Flemish Ministry of Welfare, Public Health and Family Affairs
dirk.dewolf@zorg-en-gezondheid.be

Bulgaria, Varna

Professor Klara Dokova
Faculty of Public Health
Varna Medical University
klaradokova@gmail.com

Mrs Anastasia Georgieva
Director, Health Directorate
Municipality of Varna
ageorgieva@varna.bg

Mrs Galina Arnaudova
Senior Expert, Programmes and Projects, Health Directorate
Municipality of Varna
garnaudova@varna.bg

Canada, Saskatoon Health Region

Dr Cory Neudorf
Chief Medical Health Officer
University of Saskatchewan
Cory.Neudorf@saskatoonhealthregion.ca

Croatia

Mr Zvonimir Repać
Member of the Supervisory Board
Croatian National Pensioners Association
zvonimir.repac@gmail.com

Estonia

Mr Vootele Veldre
Chief Specialist
Health Systems Development Department
Vootele.Veldre@sm.ee

Germany, Baden-Württemberg

Dr Layla Distler
Head of Integrated Health Solutions
Ministry of Social Affairs and Integration
Department for Health Policy, Prevention, Public Health Service
Layla.Distler@sm.bwl.de

Mr Joel Girard

Attaché for Health, Social Affairs and Integration
Representation of the State of Baden-Württemberg to the European Union
Joel.Girard@sm.bwl.de

Germany, Lower Saxony

Ms Janine Sterner
Aide to the CEO
Association for Health Promotion in Lower Saxony (LVG & AFS)
janine.sterner@gesundheits.nds.de

Germany, North Rhine-Westphalia

Dr Odile Mekel
Institute of Public Health
Odile.Mekel@lwg.gc.nrw.de

Dr Thomas Claßen

Senior Researcher for Health and Planning
NRW Centre for Health, Health Assessments and Forecasting Department
Thomas.Classen@lwg.nrw.de

Hungary

Mrs Petra Fadgyas-Freyler
Head of Unit
National Institute for Health Insurance Fund Administration
freyler.p@neak.gov.hu

Hungary, DKMT

Ms Eszter Csókási
DKMT Euroregional Development Agency
office@dkmt.net

Israel, Zfat District, Northern Region

Dr Haim Rothbart
Medical Health Officer
Ministry of Health in the Northern District
haim.rotbart@zafon.health.gov.il

Italy, Apulia

Dr Prisco Piscitelli

Prevention expert

Technical Officer, Apulia European working group

supportoprogetti.ambiente@regione.puglia.it

Professor Alessandro Miani

Environment and Health expert

Apulia European working group

alessandro.miani@gmail.com

Italy, Autonomous Province of Trento

Dr Pirous Fateh-Moghadam

Health Observatory

Department of Health and Social Solidarity

pirous.fatehmoghadam@provincia.tn.it

Ms Federica Rottaris

Health Observatory

Department of Health and Social Solidarity

Federica.Rottaris@provincia.tn.it

Italy, Emilia-Romagna

Dr Luca Barbieri

Head of the Primary Health Care Service

Regional Direction of Health and Welfare

luca.barbieri@regione.emilia-romagna.it

Dr Luigi Palestini

Social Innovation Area

Health and Social Agency

luigi.palestini@regione.emilia-romagna.it

Dr Vanessa Vivoli

Social Innovation Area

Health and Social Agency

vanessa.vivoli@regione.emilia-romagna.it

Italy, Friuli Venezia Giulia Autonomous Region

Dr Gianna Zamaro

Chief, Social Policies Sector

gianna.zamaro@regione.fvg.it

Dr Luana Sandrin

Technical Officer

Health Prevention and Promotion Department

luana.sandrin@regione.fvg.it

Italy, Lombardy

Dr Nadia Vimercati

Technical Officer

European projects

nvimercati@ats-milano.it

Italy, Veneto

Dr Federica Michieletto
Technical Officer
Hygiene and Public Health Promotion
Federica.Michieletto@regione.veneto.it

Dr Elizabeth Tamang
Technical Officer
Hygiene and Public Health Promotion
Elizabeth.Tamang@regione.veneto.it

Dr Mirko Claus
Resident Physician in Public Health
University of Padua
clausmirko@msn.com

Italy – other entities

Dr Maria Chiara Corti
Director of Research and International Activities
AGENAS (Italian National Agency for Regional Health-care Services)
corti@agenas.it

Dr Aldo Rosano
Senior Researcher
AGENAS (Italian National Agency for Regional Health-care Services)
rosano@agenas.it

Dr Maurizia Rolli
Managing Director
Rizzoli Institute
maurizia.rolli@ior.it

Kazakhstan, Kyzylorda

Ms Zhanar Kalmakov
Director
Kyzylorda Oblast Youth Health Centre
Coordinator for RHN in Kyzylorda
Zha_Kalmakova@mail.ru

Mr Olzhas Iskakov
Deputy Head
Kyzylorda Oblast Health Department
o.iskakov@korda.gov.kz

Dr Tolegen Bauyrzhan
Director
Kyzylorda Hospital
tbt1984@mail.ru

Euregio Meuse-Rhine

Ms Brigitte Van der Zanden
Director
euPrevent/EMR
vanderzanden@euprevent.eu

Lithuania, Kaunas

Professor Irena Miseviciene
Vice-chairperson
Advisory Board
misirute@yahoo.com

Lithuania, Klaipeda

Professor Arturas Razbadauskas
Dean
Klaipeda University
rektorius@ku.lt

Netherlands, City of Utrecht

Dr Miriam Weber
Senior Policy Advisor
Healthy Cities Coordinator
City of Utrecht
m.weber@utrecht.nl

Netherlands, Utrecht province

Ms Liesbeth van Holten
Programme Manager
Healthy Urban Living
Department of Physical Environment
Liesbeth.van.Holten@provincie-utrecht.nl

Ms Joanne Swets
European Union Representative
swets@nl-prov.eu

Dr Lennard Kosterman
Officer
lennard.kosterman@provincie-utrecht.nl

Norway, Akershus

Mrs Inger Johanne Strand
Public Health Advisor
Department of Culture and Sport
Akershus County Council
Inger.Johanne.Strand@akershus-fk.no

Ms Mari Kristin Martinsen
Public Health Advisor
Mari.Kristin.Martinsen@afk.no

Norway, Østfold

Mrs Ylva Lohne
Public Health Analyst
Public Health Programme
ylvakl@ostfoldfk.no

Professor Camilla Ihlebæk
Public Health
Norwegian University of Life Sciences
camilla.ihlebak@nmbu.no

Portugal, Autonomous Region of Madeira

Dr Miguel Pestana
Chief of Cabinet
Madeira Regional Secretariat
miguelpestana@gov-madeira.pt

Dr Herberto Jesus
President of the Regional Institute of Health Administration
Herberto.Jesus@iasaude.madeira.gov.pt

Portugal, Centro region

Ms Claudia Costa
Technical Officer
Centre of Studies in Geography and Spatial Planning
University of Coimbra
claudiampcosta@gmail.com

Dr Lúcio Meneses-de-Almeida
Public Health Physician/Senior Medical Officer (NHS)
Regional Health Administration of Central Portugal/Ministry of Health
LTAAlmeida@arscentro.min-saude.pt

Republic of Moldova

Mrs Daniela Demiscan
Head
Public Health Policy Division
Ministry of Health, Labour and Social Protection
daniela.demiscan@msmps.gov.md

Mrs Svetlana Bruma
Head
Public Health Centre of Cahul
sbruma@mail.ru

Mr Alexandru Calendari
State Sanitary Inspector
Public Health Centre of Cahul
alexandru.calendari@ansp.md

Romania, Botosani County

Dr Livia Mihalache

Director

Botosani County Hospital

livia_mihalache@hotmail.com

Dr Balan Viorel

Medical Director

Botosani County Hospital

balanviorel1976@yahoo.com

Russian Federation, Moscow Metropolitan area

Dr Natalia Mogosova

Leading Analyst

GPBU Mosecomonitoring

mogosovann@eco.mos.ru

Dr Irina Shiryeva

Head

Environmental Policy Unit

Department of Environmental Management and Environmental Protection

i.a.shiryaeva@yandex.ru

San Marino

Dr Elena Sacchini

Technical Officer, Statistics

Health Authority

elena.sacchini.authority@pa.sm

Dr Micaela Santini

Technical Officer

Health Authority

micaela.santini@iss.sm

Slovakia, Zilina region

Dr Silvia Pekarčíkova

Head of Department

Silvia.Pekarcikova@zilinskazupa.sk

Slovenia, Pomurje

Mr Peter Beznec

Director

Centre for Health and Development in Murska Sobota

peter.beznec@czr.si

Dr Tadej Pirc

Officer

Centre for Health and Development in Murska Sobota

tadej.pirc@rcms.si

Spain, Andalusia

Dr Ana Maria Carriazo

Senior Advisor

Regional Ministry of Health and Families, Andalusia

anam.carriazo@juntadeandalucia.es

Spain, Canary Islands

Professor Sara Darias-Curvo

Research Centre of Social Inequality and Governance

University of La Laguna

Sweden, Västra Götaland

Ms Elisabeth Bengtsson

Regional Development Officer

elisabeth.m.bengtsson@vgregion.se

Switzerland, Ticino

Dr Martine Bouvier Gallacchi

Health Promotion and Evaluation Office

Martine.BouvierGallacchi@ti.ch

Dr Giorgio Merlani

Chief Medical Officer

Giorgio.Merlani@ti.ch

United Kingdom of Great Britain and Northern Ireland, Wales

Dr Sumina Azam

Lead

Public Health Policy Division

Public Health Wales

Sumina.Azam@wales.nhs.uk

Temporary advisors and consultants

Mr Christopher Riley

Rapporteur

Temporary Adviser WHO Regional Office for Europe

cdgriley@yahoo.co.uk

Dr Natasha Azzopardi Muscat

Co-head

WHO Collaborating Centre on Health Systems and Policies in Small States University of Malta

natasha.muscat@gov.mt

World Health Organization Regional Office for Europe

Dr Pirooska Östlin

Director

Division of Policy and Governance for Health and Well-being

ostlinp@who.int

Ms Chris Brown
Head
WHO European Office for Investment for Health and Development
Division of Policy and Governance for Health and Well-being
brownch@who.int

Ms Åsa Nihlen
Technical Officer, Gender and Human Rights
Division of Policy and Governance for Health and Well-being
nihlena@who.int

Mrs Gabrielle Jacob
Programme Manager, Human Resources for Health
Division of Health Systems and Public Health
jacobbg@who.int

Dr Ledia Lazeri
WHO Representative
Country Office, Hungary
lazeril@who.int

Dr Francesco Zambon
Coordinator, Healthy Settings
WHO European Office for Investment for Health and Development
Division of Policy and Governance for Health and Well-being
zambonf@who.int

Dr Bettina Maria Menne
Coordinator, Sustainable Development and Health (SDG)
Division of Policy and Governance for Health and Well-being
menneb@who.int

Dr Emilia Aragon de Leon
Technical Officer, Health and Development (SDG)
Division of Policy and Governance for Health and Well-being
aragondeleonm@who.int

Dr Matthias Braubach
Technical Officer, Urban Health Equity
WHO European Centre for Environment and Health (ECEH)
Division of Policy and Governance for Health and Well-being
braubachm@who.int

Dr Tammy Boyce
Consultant, Footprint initiative
WHO European Office for Investment for Health and Development
Division of Policy and Governance for Health and Well-being
boycet@who.int

Ms Cristina Da Rold
Consultant, Social Media
WHO European Office for Investment for Health and Development
Division of Policy and Governance for Health and Well-being
dac@who.int

Dr Laura Utemisova
Consultant
WHO Country Office, Kazakhstan
utemisoval@who.int

Ms Annalisa Buoro
Secretary
WHO European Office for Investment for Health and Development
Division of Policy and Governance for Health and Well-being
buoroa@who.int



The WHO Regional Office for Europe

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World Health Organization Regional Office for Europe
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
E-mail: eurocontact@who.int