THE EUROPEAN ACTION PLAN FOR STRENGTHENING PUBLIC HEALTH CAPACITIES AND SERVICES

Report of the First Subregional Consultation in Helsinki, Finland

31 January – 01 February 2012
ABSTRACT

The First Subregional Technical Consultation on the EAP/PHS was organized in partnership with the Ministry of Social Affairs and Health of Finland and took place in Helsinki, Finland, 31 January – 01 February 2012. The aim of the consultation was to collect feedback from senior public health experts on what actions need to be included in the EAP/PHS, as well as to review the essential public health operations. The main recommendations from the meeting were that the structure of the EAP/PHS be revised to mirror the EPHOs more closely, and that the EPHOs be further revised to ensure that they were representative of the state of the art in current thinking on public health and explicitly addressed cross-cutting issues such as the social determinants of health and Health in all Policies.

Keywords

PUBLIC HEALTH
HEALTH PLANNING
HEALTH POLICY
HEALTH SERVICES
DELIVERY OF HEALTH CARE
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Acknowledgements

The WHO Regional Office for Europe would like to acknowledge the support provided by the Ministry of Social Affairs and Health of Finland. The dedication and professionalism of the staff of the Ministry, working under tight deadlines and time pressure, as well as the generous financial support provided by the Ministry, were instrumental to the success of the meeting. Professor David Hunter and Ms Linda Marks of Durham University are also to be commended for their patience and perseverance in preparing successive drafts of the EAP/PHS, also working under tight deadlines and time pressure.

The organizers also express their appreciation for the efforts of the meeting participants during the meeting and in the follow-up.
Abbreviations

<table>
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<th>Abbreviation</th>
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<tr>
<td>EAP/PHS</td>
<td>European action plan for strengthening public health capacities and services</td>
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<td>EPHO</td>
<td>Essential Public Health Operation</td>
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<td>HIV/AIDS</td>
<td>Human immunodeficiency virus/Acquired immune deficiency syndrome</td>
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<td>HiAP</td>
<td>Health in all policies</td>
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<td>MS</td>
<td>Member State</td>
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<td>Noncommunicable disease</td>
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<td>RC</td>
<td>Regional Committee</td>
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<td>SDH</td>
<td>Social Determinants of Health</td>
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Introduction

1. The WHO Regional Committee for Europe Resolution EUR/RC61/R2 on “Strengthening public health capacities and services in Europe: a framework for action” endorsed the development of a European action plan for strengthening public health capacities and services (EAP/PHS). The plan is to be submitted to the Sixty second session of the WHO Europe Regional Committee in September 2012, together with the new European health policy, Health 2020.

2. The renewed commitment to strengthening public health capacity, operations and services calls for a comprehensive European action plan for PH, with the aim of integrating the essential public health operations (EPOHs) into national health systems, and strengthening human resource capacities in public health. The action plan will provide an opportunity to renew the Regional Office’s commitment to public health; integrate interrelated policy areas in a coherent way; and offer an opportunity to further clarify the strategic linkages between public health and health care services, in particular primary health care, as foreseen in the holistic approach to health systems articulated in the Tallinn Charter: Health Systems for Health and Wealth.

3. The WHO Regional Committee for Europe has endorsed the eight avenues identified in EUR/RC61/R2, as a basis for the Regional Office’s proposal to formulate a European action plan. RC61 requested that prior to consideration of the final action plan by RC62 there should be a further process of examining and developing the essential public health operations, to ensure full consistency with Health 2020, particularly in relation to that draft policy’s “whole of government” approach to health system development.

4. The WHO Regional Office for Europe is determined to develop the European Action Plan for Strengthening Public Health Services and Capacities through a broad participatory and consultative process involving all 53 WHO/Europe Members States and main international partners. This will be done through subregional technical consultations with senior public health officials, experts and partners as well as through an official written consultation at the political level with all 53 Ministries of Health.

5. The written consultation with health ministries is the only official and decisive consultation with Member States on the EAP/PHS. The subregional technical consultations taking place in parallel are intended to raise awareness, promote mutual understanding and generate momentum, for all parties (key actors in the MSs, the Secretariat, and the Partner organizations). This in view of invigorating the process of developing the EAP/PHS, but also the process of implementing it.

6. While it is hoped that the increased awareness, understanding and momentum will work to facilitate and enrich the official written consultation, it is fully understood that it is strictly the feedback provided in the context of the official written consultation that can be considered as the official expression of the views of Member States.

7. The First Subregional Technical Consultation on the EAP/PHS was organized in partnership with the Ministry of Social Affairs and Health of Finland. The meeting took place in Helsinki, Finland, 31 January – 01 February 2012.

8. The aim of the consultation was to:
• Collect the ideas and opinions of senior public health experts on what actions need to be included in the EAP/PHS in order for it to contribute to strengthening public health at all levels: international, national, subnational and local.
• Review the essential public health operations (EPHOs) in order to ensure full consistency with Health 2020.

9. The consultation was attended by senior public health experts, nominated by the respective countries, members of the Northern Dimension Partnership for Public Health and Social Wellbeing (Estonia, Finland, Germany, Iceland, Latvia, Lithuania, Norway, Poland, the Russian Federation and Sweden), Belarus, Kazakhstan, Ukraine and international partners.

Summary of proceedings

10. With regards to the structure of EAP/PHS, it is confusing that the 10 EPHOs are at the heart of the EAP, but the EAP is structured according to the 8 avenues. The structure should be revised to mirror the EPHOs more closely. In order to remain faithful to the text of Resolution EUR/RC61/R2, the avenues could be stated in the guiding principles, and considered implicit to the remainder of the EAP/PHS.

11. It was explained by the Secretariat that the EPHOs were considered the “ends”, and the avenues were considered as the “means” through which to achieve the “ends”.

12. It was noted that at the Jerusalem high level meeting of officials at the end of November 2011 the discussion of the EAP had suggested highlighting the link between the Avenues and EPHOs more effectively and visually, as was the case in the current version of the document.

13. To provide clarity in respect of how the various work streams fit together, it was suggested that the “What” was Health 2020, the “How” was the EPHOs, and aligning the eight avenues were the means of aligning the two.

14. The contents of the section of the EAP/PHS, under the heading “Current state of public health capacities and services in Europe” had to be revised in order to present a summary of the latest evidence on the current state of PH capacities. As it stands, the text simply refers to the studies that have been completed, without reporting any of the conclusions.

15. The introductory part should make more visible the links to other WHO Europe policy initiatives. Similarly, the core values of Health2020, such as the focus on the social determinants of health, health equity and sustainability, should be emphasized in the introductory part.

16. New subsections should be added to the EAP/PHS to address each of the following topics:
• Statement identifying the Partner Organizations and Networks that will contribute to implementing the EAP/PHS
• Statement outlining the timeframe envisaged for implementing the EAP/PHS
• Statement explaining the measures that will be taken to monitor and evaluate the implementation of the EAP/PHS

17. The actions included for the WHO Secretariat and Partner Organizations should be prioritized, and more detail should be provided (who, what, when?). A Partners meeting should be convened to agree on this.

18. The actions for Member States should not be prioritized in the EAP/PHS, as this prioritization would vary from country to country, and would be informed by the national assessment of the EPHOs.

19. Particular attention should be paid to the quality of the Russian translation of the EAP/PHS and similar documents in principle. The vocabulary employed in the draft EAP/PHS that had been circulated was considered inaccessible, outdated and complicated for decision-makers to read.

20. A common glossary of terms in the four official languages should be developed for the EAP/PHS and Health2020.

21. A proposed revised outline for the EAP/PHS, reflecting many of the points made above, is included in Annex 1 to this report.

22. The EPHOs need to be further revised and possibly restructured, in order to ensure that they are forward looking and reflect state of the art in contemporary Public Health thinking. This is in line with the text of Resolution EUR/RC61/R2, which states that the Regional Committee:

   “Endorses a further process of examining and developing the essential public health operations described in the reports as a basis for the Regional Office’s proposal to formulate a European action plan embedded in the vision of the Regional Director”

23. General views on the EPHOs, as expressed by several countries, were as follows:

   • The logic of the divisions between the EPHOs was unclear as there was often too much overlap between them.
   • The EPHOs and their categorization and structure were not up-to-date. The specific example given to illustrate this point related to EPHO 5 on prevention – it was too biased towards a biomedical approach and did not reflect current thinking around prevention centred on a social model.
   • The EPHOs should indicate how investment and interventions would impact on different socio-economic groups thereby giving attention to the social gradient approach that was consistent with Health 2020 and the Marmot review of health inequalities in Europe
   • The link between each EPHO and key cross-cutting issues (e.g. health inequities, HiAP) should be made more explicit in the description of the individual EPHOs.
   • The format and style with which each EPHO was described should be consistent throughout.
24. The question was raised as to whether the EPHOs were all of equal importance, or whether different values or priorities were attached to all 10 of them? The checklist was extensive and it would take between 10 and 20 years to implement. Hence the need for each country to specify its priorities. An action plan would need to be developed in each country with quantitative targets to enable progress to be monitored.

25. The self-assessment tool was considered helpful in identifying weaknesses and priorities. It was sufficiently flexible to enable this to be done in a variety of different national contexts.

26. Some detailed comments on the text of the EAP/PHS and the EPHOs were collected. These are presented in Annexe 2.
Annex 1

PROPOSED REVISED OUTLINE FOR EAP/PHS

European Action Plan for Strengthening Public Health Capacities and Services

- CONTENTS -

Background ................................................................. X
Goal............................................................................. X
Objective...................................................................... X
Guiding Principles....................................................... X
Links to other WHO Europe policy initiatives ..................... X
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Priority actions: Assessment, delivery and continuous monitoring of Essential Public Health Operations .......................................... X
Action by Member States
Action by WHO Europe and Partners

Supportive Actions
Surveillance of diseases and assessment of the population’s health and well-being........................................ X
Action by Member States
Action by WHO Europe and Partners

Identification of priority health problems and health hazards in the community.................................................. X
Action by Member States
Action by WHO Europe and Partners

Preparedness for and planning for public health emergencies.......................................................... X
Action by Member States
Action by WHO Europe and Partners

Health protection operations ........................................X
Action by Member States
Action by WHO Europe and Partners

Disease prevention ....................................................X
Action by Member States
Action by WHO Europe and Partners

Health promotion .....................................................X
Action by Member States
Action by WHO Europe and Partners

Assuring a competent public health and personal health care workforce.................................................................X
Action by Member States
Action by WHO Europe and Partners

Core governance, financing and quality assurance for public health.................................................................X
Action by Member States
Action by WHO Europe and Partners

Core communication for public health ................................X
Action by Member States
Action by WHO Europe and Partners

Health-related research ..............................................X
Action by Member States
Action by WHO Europe and Partners

Monitoring and evaluation of the EAP/PHS.................................X

Next steps .................................................................X

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Bibliography.............................................................X

Glossary .................................................................X
Annex 2

PROCEEDINGS

Plenary Session One

Ms Aino-Inkeri Hansson, Director-General, Department for Promotion of Welfare and Health, Ministry of Social Affairs and Health, Finland

Public health challenges change and there’s a need to review the capacity of the health system to respond. In Finland there is a lively political debate in progress on the reform of the public sector to make it more efficient. The municipalities are responsible for health and social care which is good for, and benefits, public health. However, this also poses some challenges: there are 350 municipalities for a population of 5 million, with one quarter of the municipalities being populated by only 800 – 1,000 people. As elsewhere, demographic changes are resulting in a growing aging population. The nature of health problems has also changed with the growing burden of noncommunicable diseases (NCD) and mental health problems.

Ms Liisa Ollila, Chairperson, Northern Dimension Partnership in Public Health and Social Well-being

The EAP/PHS is welcomed and is attracting ownership of key stakeholders. The 2 priorities facing Finland are controlling and preventing NCDs. Promoting healthy lifestyles is a cornerstone of public health.

Infectious diseases – HIV/AIDS – remain a problem, as does resistance to antibiotic treatments.

The actions in the EAP/PHS are co-related with the goals of the partners of the Northern Dimension Partnership in Public Health and Social Well-being (NDPHS).

Health is a human right and a precondition for economic growth. This is not widely recognized. Health promotion is one avenue for action.

The EAP/PHS provides an opportunity to reinforce the whole of government approach. Finland is completing the self-assessment tool and the results will be fed into the EAP/PHS.

Dr Agis Tsouros, WHO Regional Office for Europe

Health 2020 and the EAP/PHS go hand-in-hand. Public health has had its ups and downs and has not always been a great focus of the Region which has placed too much emphasis on health care and services rather than on public health and a population approach. Public health has been seen as the poor relation despite it being an exciting area.

There have been lots of strategies and action plans over the years which have largely remained unimplemented. The reason has been a lack of capacity in Member States. The importance of local government for public health cannot be overstressed.
Health 2020 is a framework to connect with activity. There was Health for All in the 1980s, Health 21 in the 1990s, and now Health 2020. These policy initiatives have evolved along with the evidence base on public health and the social determinants of health (SDH). In the new context we are in, the importance of governance is a factor because of the multi-levelled nature of public health. A strong public health capacity is essential to achieve Health 2020. Nice words are not enough.

At a time of financial crisis, the key question policy-makers ask is where is the best investment going to occur? It is a big challenge and it will be necessary to dispel the persistent myths surrounding public health. On the issue of behaviour, individual behaviour change is important but it is not sufficient to guarantee that change will happen. We need to understand complexity and uncertainty. The right to health is not enough although the commitment remains.

Dr Hans Kluge, WHO Regional Office for Europe

WHO has renewed its commitment to public health and to strengthening this component of the Tallinn Charter.

The North Karelea experiment demonstrated that NCD can be prevented and coronary heart disease rates reduced.

A web-based self-assessment tool has been developed for evaluating capacity and practice in relation to implementing EPHOs. To date, it has been tested in 17 eastern European countries with positive feedback on its relevance, and the tool is also to be tested in western Europe in order to get comprehensive feedback on its relevance across the European Region. Ireland, Finland, Portugal, Spain and the Russian Federation will all be using the tool. In addition to these applications of the EPHO approach, assessments of public health capacities are available for Austria and Switzerland. Furthermore, the European Commission has commissioned an assessment of public health capacities in the 27 EU countries, the results of which are forthcoming.

We need to identify and understand the barriers and facilitating/enabling factors underlying the effective development of public health capacities. This insight will underpin the EAP/PHS. To this ends, three other pieces of work have been commissioned by WHO/Europe and are expected by June 2012:

- Review of policy instrument for public health (Professor Pereira, NIPH, Lisbon)
- Rapid assessment of organizational models for delivering PHS (Professor McKee, LSHTM, London)
- Summary of WHO country assessments of public health capacities and services.

In addition, a working group on human resources for public health has been established and is chaired by Professor Lennart Kohler of the Nordic School of Public Health.

The EAP/PHS contains ambitious priorities for which strengthened alliances and cooperation will be required if these priorities are to be achieved.

Progress with the EAP/PHS will be reviewed in 3 – 5 years.
Dr Maria Ruseva, WHO Regional Office for Europe

To face the public health challenges, it is important to set out clear and measurable goals and to agree on basic definitions, boundaries and concepts.

The definition of public health proposed by Sir Donald Acheson in 1988 was adopted by Member States at RC 61 in Baku:

“Public health is the science and art of preventing disease, prolonging life and promoting health through organized efforts of society.”

The definition of Health Systems being used in the European Region was that approved by WHO Member States in the Tallinn Charter of 2008:

“The ensemble of all public and private organizations, institutions and resources mandated to improve or restore health. Health systems encompass both personal and population services as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health.”

Through Health 2020, the WHO Regional Office for Europe advocates a whole of society and whole of government approach to population health. This strategy must encompass all sectors that can potentially affect population health, including housing, the environment, transport, tourism, education and industry. At the same time, public health is an integral part of the health system. It is linked to health care, and the first and most important public health practitioners are often primary health care physicians and nurses themselves, who have an essential role in health education, health promotion, disease prevention and health protection, in addition to their role in curative medicine. Thus, closer linkage between public health and health care within the health system will be a vital component of any successful strategy to strengthen public health services and capacities.

To reflect this dual role and responsibility, government must ensure certain essential core public health functions are effectively carried out, however these may be organized at a local or national level. We have adapted the experiences gathered across other regions worldwide to the EURO context, formulating 10 essential public health operations. These are a vital component of the wider health system within society, giving expression to health across the whole political and administrative spectrum of policy-making.

The delivery of these 10 EPHOs by the health system is a role and responsibility of all its levels and parts, and not only of the Public Health Institutes. Primary health care and hospitals have to deliver a substantial number of primary and secondary preventive individual health care services related to the EPHOs, and successful service delivery will depend on the close cooperation of the different levels of the health system and even integration of disease preventing and health promoting services at the level of primary health care.
Plenary Session Two

Chair: Ms Taru Koivisto, Director, Ministry of Social Affairs and Health, Finland
Facilitator: Professor David Hunter, WHO Temporary Adviser

The session took the form of a group discussion of a series of questions prepared by the Secretariat, as follows:

1. **Completeness:** Are there any important action proposals that you think are missing from the plan? If so, please specify which.

2. **Feasibility:** An aim is for the EAP/PHS to be ambitious, while still being realistic. Please comment on the extent to which the actions proposed could realistically be implemented in your country, given the current political and economic context. If there are any of the proposed actions that you think should be withdrawn, please specify which.

3. **Prioritization:** Are the proposed actions listed sufficiently prioritized, such that they clearly indicate to Member States, WHO Europe and Partners which actions should be taken most urgently?

4. **Consensus building:** An important aim for the actions proposed for WHO Europe and Partners is that they should contribute to the emergence of a consensus on key issues, thereby contributing to build alliances to support the implementation of this and subsequent action plans. Do you think the actions proposed for WHO Europe and Partners will achieve this? Are there other actions you would suggest in view of building consensus and strengthening alliances?

5. **Structure of the document:** Is the current structure of the document useful, including:
   a. Is the format easy to use and apply?
   b. Should the eight avenues be explicit in the structure of the document (as is currently the case)? Or should these avenues simply be stated in the introductory part of the document, and main body structured differently?
   c. Please suggest other formats/examples of action plans for structuring the document differently?

There was discussion around public health and what it was. For some, there is no such thing as public health but rather improving the health of individuals, through which the health of the population is improved. The language is important as well as the definitions of terms which could mean different things in different countries, e.g. the distinction between public health and the public health system.

The Russian translation of the document had posed problems. The ambiguity in the terminology might have far reaching implications as it risked jeopardizing much of the positive heritage from the Semashko system, by undermining the mandate of certain institutions of professions to deliver public health services. A glossary of terms would be useful. The definition of the EPHOs needed attention since for some countries, especially those coming from a Semashko heritage, the background was different. Health services were sometimes regarded as public health. It was not possible to draw a clear dividing line between public health and the health system.

The core values for Health 2020 were a focus on the SDH and health equity. They needed to be stressed in the EAP accordingly. The health promotion section might be the place to do this.
Sustainability, including the economy and environment, was also a key guiding underlying principle for Health 2020.

There was some confusion over the timelines for the EAP with a suggestion that the EAP should be for 3-5 years with a more detailed plan for 2 years. Was the EAP for 4 years or for 2 years?

In respect of the EPHOs, the question was raised as to whether they were equal or whether different values or priorities were attached to all 10 of them? The checklist was extensive and it would take between 10 and 20 years to implement. Hence the need for each country to specify its priorities. An action plan would need to be developed in each country with quantitative targets to enable progress to be monitored.

The self-assessment tool was helpful in identifying weaknesses and priorities. It was sufficiently flexible to enable this to be done.

In terms of the priorities for actions set out in the EAP/PHS, those actions directed at WHO should be set out more concretely with specific deadlines, such that MSs would know what could be expected from WHO by when. Advice would be welcomed by MSs as to what the top priorities were.

Actions need not be prioritized for MSs, but they should be for WHO. The priorities for MSs would be revealed by the assessment of the EPHOs. There were no priorities proposed for the WHO at this stage.

In terms of the EAP and EPHOs, there was confusion since it was not easy to distinguish between the 2 documents – they were neither sufficiently overlapping, nor significantly different from each other. Greater clarity between the 8 Avenues and 10 EPHOs was needed. In Baku the two lists had not been discussed. In particular, the Avenues had not been discussed alongside the EPHOs. Hence the confusion that had arisen subsequently. There was a need to revisit the necessity of retaining the Avenues. The suggestion was to work on the 10 EPHOs and drop the 8 Avenues.

It was explained by the Secretariat that the EPHOs were considered the “ends”, and the avenues were considered as the “means” through which to achieve the “ends”.

It was noted that at the Jerusalem high level meeting of officials at the end of November 2011 the discussion of the EAP had suggested highlighting the link between the Avenues and EPHOs more effectively and visually, as was the case in the current version of the document.

To provide clarity in respect of how the various work streams fit together, it was suggested that the “What” was Health 2020, the “How” was the EPHOs, and aligning the eight avenues were the means of aligning the two.

In these sessions, the EAP/PHS was reviewed line by line to solicit comments from the participants.

The detailed comments received are listed below, grouped according to the relevant paragraph number in the EAP/PHS.

Para 1-3 or 6-11: Reference should be made to other important WHO policy initiatives, such as the Framework Convention on Tobacco Control, the Moscow and UNGA declarations on NCDs, etc…

Para 4.
- Inequalities in the SDH should come first, followed by health.
- Bullet 6 specifies “in particular primary health care”, but no particular attention is paid to PHS in the rest of the doc.

Para 5.
- The details about the process (e.g. broad and participatory) are not part of the objective per say.
- Monitoring and evaluation is not sufficiently addressed in the EAP/PHS for it to be stated as part of the objectives here.
- Keep monitoring and evaluation in the document, but beef it up.

Para 6. “Sustainability” should be expanded on.

Para 7. Reference should be made to Winslow (1920) in attributing the definition of Public Health.

Para 9. Should read “… (led by the Ministries involved in health)…”

Para 10.
- Is it useful to organize the EPHOs into ten categories? A holistic approach may suggest otherwise. Mainly the categorization of EPHOs 4, 5 and 6 should be reconsidered. There may also be overlaps between 1 and 2.
- It is useful to categorize the EPHOs, but the question is how? Also, the entire subsection on “Guiding Principles” (Paras 6-11) should refer more explicitly to the important role of other sectors in generating health – the theme of intersectorality should become more prominent and sharp in the text.
- Compare the list of EPHOs to the EC approach to evaluating candidate countries in view of protecting the acquis, to ensure compatibility and exploit potential synergies in reporting requirements.

Paras 12-14.
- The paras of this subsection should summarize the actual factual information on the state of PH in the Region, not simply refer to the studies that do so.
- Be careful however that the section does not become too long.
Para 13. The reference to “public health focal points” is ambiguous. EST does not have one. Do other MSs?

Para 14. Insert a footnote to indicate who is performing these studies, and when the results will be available. If the results are not expected to become available prior to the SCRC where the EAP/PHS will be approved for submission to the RC, then it will not be possible for the development of the EAP/PHS to be underpinned by these results, and the wording of para 14 should be changed accordingly.

Para 15. 7 or 8 avenues? The text refers to 7, but there are 8.

Para 16.
- It is not clear why patient organizations are singled out here.
- Public Health Institutes are a key instrument to overcoming the implementation gap and deserve to be mentioned here.
- Paras 15, 19 and 23: The wording in these paras needs to be harmonized. The wording in para 19 should be strengthened to emphasize the importance of the EPHOs, e.g. “a vital” could read “the vital”. Yet, in para 23, the EPHOs are described as “merely” a resource. Consistency in the strength of the qualifiers is required.

Para 19. Delete the bullet point on “key conditions” and “pre-conditions”, as these are not referred to elsewhere in the document.

Paras 19-21. Strengthen the wording on the need to strengthen the institutional basis for implementing the EPHOs.

General comment on avenues: The partners that will contribute to implementing the actions should be specified, as should be the timeframe anticipated.

Para 25.
- International health regulations have been negotiated by MSs – wording should be adjusted.
- The FCTC is a powerful tool for addressing other issues than tobacco, e.g. inequalities, obesity and harmful use of alcohol.

Paras 25-27: Add the necessity for governments to create healthy lifestyles and motivate populations to maintain a healthy lifestyle.

Paras 30-43. The way in which health protection, health promotion and disease prevention are defined and distinguished from one another is not reflective of current thinking. Prevention is used in a very narrow sense and Promotion is very vague. Reference was made to the UNGA Resolution on Prevention and Control of Noncommunicable Diseases as an illustration of this point.

Para 29. “relevant” partners, not “all” partners.

Para 30, 36, 40.
• Remove the word “outcomes” from the title here, as well as in other titles.
• OK, but then specify “public” health.

Para 34. Clarify/specify the mechanisms referred to in bullet 2.

Para 36.
• Mental health should be considered an NCD.
• Specify screening for what. Important to call for evidence of successful implementation, success being understood as implementation in accordance with international guidelines for screening programmes, such as those published by IARC and the EU

Para 38.
• Tertiary health care does usually not deliver preventive services.
• Bullets 3 and 7 seem redundant
• Why is maternal and child health singled out here?

Para 40.
• Very strong WHO strategies such as those on NCDs, alcohol and tobacco should be referred to here.
• SDH needs to be made more explicit here.

Para 44. What about professionals outside the health sector? Link to last bullet under para 46.

Para 46.
• This Para should make reference to EU training programs. ECDC can provide text.
• Public health institutes have a role in continuing education

Para 47
• Is WHO the Partner best placed to do bullet 1?
• How relevant is the Global Code for PH Professionals?
• Last bullet: the terms “systems thinking”, “complexity science” and “transformational change” should be un-packed, or dropped.

Para 50.
• MSs should ensure funding, align funding with health ministry needs, and ensure research is taken up.
• emphasize the role of PH institutes

Para 54.
• Last bullets, specify/enumerate “enabling conditions”, or refer to another piece of work that explains this in more detail.
• : Keep the reference to these enabling conditions, it is valuable.

Para 56.
• Bullet 2, no standards and indicators have been proposed…?
• Conclusion should reflect what is agreed in the EAP/PHS, not introduce new material/ideas
need to strengthen what is proposed for monitoring and evaluating the implementation of the EAP/PHS
Emphasize the importance of prioritizing of PH, there is currently a crisis in PH capacities.

- How will success be assessed?
- Indicators can be tricky

Working Group Sessions on the Essential Public Health Operations for Europe

In these sessions, the EHPOs were reviewed line by line to solicit comments from the participants.

Working Group 1

General views on the EPHOs, as expressed by several countries, were as follows:

- the logic of the divisions between the EPHOs was unclear as there was often too much overlap between them
- the EPHOs and their categorization and structure were not up-to-date; the specific example given related to EPHO 5 on prevention – it was too biased towards a biomedical approach and did not reflect current thinking around prevention centred on a social model
- the EPHOs needed to be more forward looking in respect of the state of play in public health and the contemporary challenges it faced
- the EPHOs should indicate how investment and interventions would impact on different socio-economic groups thereby giving attention to the social gradient approach that was consistent with Health 2020 and the Marmot review of health inequalities in Europe
- there were issues with cross-cutting concerns, notably how to handle the social determinants of health (SDH) and intersectoral action; these could be dealt with in a separate section at the start setting out generic issues that affected all or most of the EPHOs, or they could be integrated with each EPHO, or a solution could involve doing both; the issue was not a technical matter but a communications/presentation one – the points were already made in the EPHOs but were often buried or not emphasized enough (e.g. SDH in last bullet point in section 1.8, p.2) or in a way that made most sense or had most impact from a communications point of view
- the EPHOs needed revision at the highest level if they were to be seen as relevant to Member States – this would be a task for MS
- The format and style with which each EPHO was defined/described should be consistent throughout.
- Detailed written comments on the EPHOs were promised by some countries within the next 2 weeks.

Specific comments from the sessions on the EPHOs included:

- EPHOs 1 (surveillance) and 2 (priority health problems and health hazards) overlapped and it didn’t make sense to separate them – it was artificial; they could be integrated into a single EPHO
- EPHO 1
specify that data should be stratified by socio-economic group and sex
make SDH more explicit, consider establishing an EPHO on SDH
in 1.3, why single out Roma: “minorities”

- EPHOs 2 and 4 overlap
- EPHO 2: Not all risk factors are listed; title wording “priority health problems” is misleading. This part of the title could be deleted.
- EPHOs 4, 5, 6 and especially 5 and 6 gave rise to odd distinctions that no longer seemed up-to-date or to reflect current concerns in public health
- EPHO 4: the contents of this EPHO are incomplete. Should include food safety, treats related to climate change, chemical biological and nuclear threats.
- EPHO 5 (prevention) was seen as too biomedically focused and as giving too little attention to NCDs, lifestyle illnesses and socio-economic drivers of health problems
- EPHO 6 (promotion)
  - was too focused on individual behaviour and not enough on collective action as set out in the Ottawa Charter and elsewhere – it was too narrow and ignored intersectoral action which was more important; on section A, p.11 there was nothing on injury prevention
  - Perhaps injury prevention could go in 6A
- EPHO 7 (PH workforce)
  - needed to make more reference to the wider public health workforce and for basic PH training or awareness-raising to be available to a range of practitioners who may not always see themselves as ‘doing’ public health;
  - there should be reference to epidemiological training opportunities available in Europe;
  - the needs for trained staff etc should be mapped against the socio-economic characteristics of local areas and regions to see where skills might be most needed but also in short supply, i.e. the inverse prevention law
- EPHO 8 (governance) needed to align with the Health 2020 governance work and be consistent with it; section 8.A.3, p.18, HIA needed to apply to all levels – national, regional, local; section 8.A.5, p.18 was not clear or even accurate since the EU did not have a competence for health services – this should either be amended or omitted; it was also better to avoid specific references to the EU but rather refer to alliances in general; in section 8.A.7, p.19, last bullet point – who was supposed to undertake the supervision of governmental and NGO PH entities was not clear – was it to be the health ministry in MS or somebody else? It might in any case vary across MS; 8.A.8, p.19, there was no mention of health equity; section 8.B.7, p.21, use of best practices might be included but should go mention HTA to include other interventions. Remove the word “Core” from the title.
- EPHO 9 (communication),
  - Section 9.3, p.22 – mention was made of HiAP but this point was an important theme throughout the EPHOs as part of the intersectoral, cross-government approach which underpinned all EPHOs. Health literacy of politicians and general public also needs to be improved
  - Change title to “Informing the population in the interest of Public Health”.
- EPHO 10 (health research), section 10.1, p.23, 4th bullet point – not every country would be able to appoint a chief scientist in the health ministry or consider this to be an appropriate action to take – the wording should be changed to make the point that a research programme in PH should be established with adequate funding and that the
results of such funded research should inform policy and practice where appropriate; the EPHO might also be updated to reflect current thinking about knowledge translation, exchange, brokerage and the co-production of knowledge and evidence. Specify “Public” in title (i.e. not just health, public health).

In the final plenary session, working group 2 (the Russian group) made the following specific points on the EPHOs although some of these may be the result of poor translation which was a major cause for concern:

- EPHO 4 was not complete in respect of the challenges facing public health, notably climate change, energy security
- EPHO 7 should say something about the competences of the public health workforce
- EPHO 9 should be shorter.

**Plenary Session Three**

The final plenary session took the form of a debriefing and report back from the two working groups and conclusions and recommendations.

The new structure proposed for the EAP focusing on the 10 EPHOs was welcomed.

There was some discussion over whether the term ‘supportive actions’ was the right title or whether they should perhaps be called ‘follow up actions’.

The EAP would be a medium term plan over a 2-3 year period. Follow up actions should be completed in the medium term. Full implementation was not possible but a follow up EAP in 3 years time to revise the position should be forthcoming.

There was a huge difference in translation between the Russian and English versions of the EAP. Again, the desire for a Glossary of terms was mentioned. Shorter definitions were also needed in the Russian version but an improved translation would achieve this.

**Dr Hans Kluge**

In bringing the meeting to an end, the next steps were listed: (a) to produce a consultation report that would be a compendium of the comments received on the EAP/PHS; (b) to receive any further written comments over the next 2 weeks – these to be sent to Maria; (c) to bring together and streamline the comments from the consultation – Helsinki and Brussels; (d) to ensure that the comments from the subregional consultations should be reflected in Ministers’ comments on the draft EAP/PHS; (e) to convene a meeting of WHO partners to discuss the EAP and the supportive actions to be adopted by the partners.

Hans Kluge thanked everyone for participating in the consultation and for a productive and frank discussion which had achieved its purpose of getting engagement and buy-in to the process of producing a EAP which MSs would be able to endorse and act upon. Some clear messages had been received and these would be helpful in enabling a revised EAP/PHS to be produced.