WHO in Europe: does it have a role?

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This is the seventh in a series examining the role of the World Health Organisation, its current problems, and its future prospects

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WHO is under pressure from all sides to justify its existence. Donors want to know what they are getting for their money, and health professionals question the relevance of the organisation's work. The pressure to justify itself is perhaps strongest of all in Europe, where most member countries have fully fledged health infrastructures and high overall levels of health. Now there is the additional threat of encroachment into the field of public health by the European Union. The disintegration of the Soviet bloc has given WHO's regional office in Europe a new sense of purpose and led to a major shift in resources towards the countries of central and eastern Europe. But WHO's critics are calling for a different shift in the way its European office works: from its current concentration on broad based policy issues to the nitty-gritty of health care management and delivery.

Article 129 of the Maastricht treaty of 1993 gives the European Union "competence" in the field of public health. With the union already funding medical research and taking an interest in disease prevention and data collection, article 129 raises questions about the future of WHO. What, people ask, does WHO do in Europe? Does it need tbe regional office in Copenhagen? Could there not be a small office within the Geneva headquarters responsible for collecting data, setting normative standards, and producing reports? A recent critical analysis of WHO's budgetary priorities points out that the European office has been allocated $56·6m for 1994-5, compared with $36·6m allocated to programmes dealing with tropical disease.' The authors argue that European countries are competent to look after their own people and are already spending an average of $642 per person per year on health compared with about $9 in low income countries. Closing the European office would, they conclude, allow WHO to increase the country budgets in Africa by two thirds.

A new sense of purpose

Five years ago WHO might have found itself hard pressed to defend its European operation from these offensives. But conflict and economic decline in central and eastern Europe have given the European office a new sense of purpose. Before 1989 the office was concerned mainly with promulgating Health for All and promoting primary health care in the region's 32 member states. Since the disintegration of the Soviet bloc the region's membership has grown to 50. Twelve newly independent states and three Baltic states have joined the organisation, as have the warring states of the former Yugoslavia.

The region's new members have enormous health problems. In the newly independent and Baltic states, health care continues to rely on an inefficient, overstaffed service, and the collapse of the central command economy has brought severe shortages of drugs and medical equipment. The health of women and children is a major concern. In the absence of adequate contraception, abortion rates in 1990 were running at more than one for every live birth in many countries of the former USSR, compared with about one in five in western Europe. Poor socioeconomic conditions and the collapse of state run immunisation programmes have led to the re-emergence of diseases like diphtheria,

WHO

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the aftermath of nuclear tests in Kazakhstan, and the drying up of the Aral Sea constitute major environmental threats to-health.

Shifting resources away from the West

The office in Copenhagen has responded to these challenges by radically reallocating its resources. Two thirds of the region's biennial budget of $46m is now committed to the countries of central and eastern Europe. In 1992-3, 20 of the wealthiest countries in Europe each received $450000. These countries receive nothing in 1994-5. Whereas almost all staff had been based at the regional office in Copenhagen, more than a third of staff are now working in country offices or as liaison officers in the field. Staff still based in Copenhagen spend large amounts of time travelling. Dr Marc Danzon, director of country health development in central and eastern Europe and the newly independent states, estimates that more than two thirds of the region's human resources are now directly employed at country level, mainly in central and eastern Europe.

The European office has shown itself to be capable of rapid and radical restructuring in reponse to changing needs. What is not clear, however, is what the restructured office can achieve, given its limited overall resources. Even with two thirds of its budget directed activities there have so far been piecemeal. Lacking resources to set up permanent programme offices, WHO has relied on short term consultancies (box). Without funds to, back up its consultants' recommendations, so its reports invariably conclude with the suggestion that the government in question should seek funding from elsewhere. As Professor David Hunter, director of the Nuffield Institute for Health at the University of Leeds, told me, "WHO is trying to put its stamp *on things,* but it doesn't have the resources to do it properly."

Relations with other agencies

Other agencies have made a greater impact. The World Bank has undertaken in depth, structural reviews of countries' needs and followed them up with financial loans for implementation. Commentators talk of lack of communication between the two agencies, poor exchange of information, and much duplication of effort. The International Red Cross has five permanent programme offices in central and eastern Europe. Its role is largely to provide emergency relief, but as these countries are now in what one of its staff called "a chronic emergency" it is also gathering informanon and setting up longer term interventions. Its drug programme began as an attempt to supplement drug supplies from Moscow. The programme went on to

Glasgow-a healthy city?

The healthy cities project, launched by the European office in 1986, was designed to translate the principles of Health for All into practice at a local level. For the first time in its history, WHO bypassed national governments (with their consent) and worked directly with local governments.

Since 1986, the project has expanded from 11 to over 40 cities across Europe. Other independent healthy cities networks have been established involving nearly 400 European cities and towns, and new networks are now developing in Australia, Canada, and the United States. To join, cities must convince the European office of their commitment and ability to see the project through. In return, cities receive no funding, but the imprimatur of WHO helps *them* raise money from government and voluntary bodies. Project organisers meet twice a year to discuss progress and share experiences.

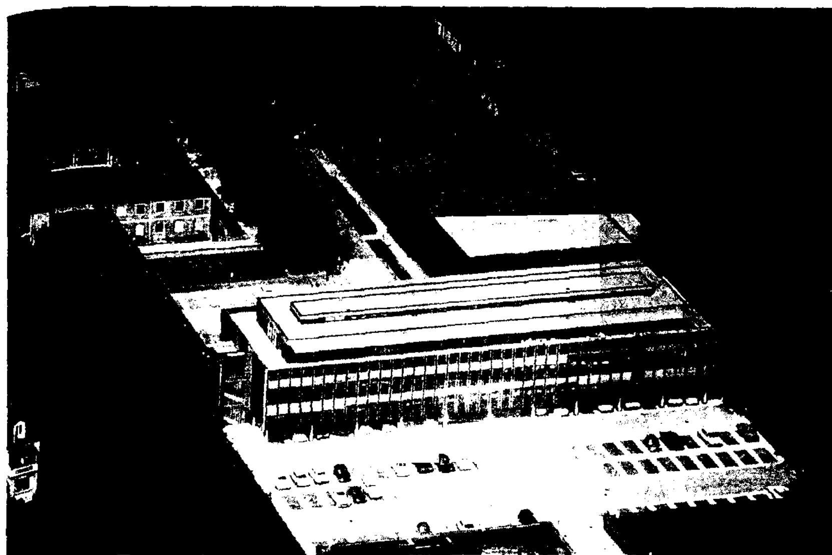
Glasgow joined WHO's healthy cities project in 1988. It brought with it a mortality in people under 65 that was 20% higher than the already high Scottish average, and a threefold variation in mortality across the city. Underlying the project's activities is the need to build up understanding of the causes of the city's poor health record and find out what health really means to Glaswegians.

Housing was an obvious place to start. The link between housing and health is well recognised and much of Glasgow's housing stock is poor. The project team has developed close links with the city's housing department, which has committed £25m over the next three years to developing a housing strategy that meets the needs of the city's most vulnerable groups. Realising that heating costs would preclude a quarter of tenants from living in renovated houses, the team set up Glasgow Action for Warm Homes. This aims to ensure that no hosuehold has to spend more than a tenth of its disposable income on fuel bills. One practical step is to persuade Scottish Power to arrange bulk metering in tenement buildings instead of each tenant having to pay the full standing charge. Other issues tackled by the team include establishing a policy for women's health, lobbying for a policy on food retailing, and setting up community support programmes across the city.

A pilot project in one of Glasgow's most deprived areas, Drumchapel, has set out to discover what local people feel are the **most important health issues. Life expectancy** among Drumchapel's 18 000 residents is 1 o years less than in the neighbouring suburb of Bearsden, and local people express most concern over traffic, housing, poor local amenities, and the poverty of the local environment. Their views are changing the way local services are provided, says Andrew Lyon, coordinator of Glasgow's healthy cities project. A survey of 700 sets of parents found that more than half of them kept their children away from local playgrounds and that nearly 200 had recently taken their children to hospital as a result of playground accidents. Armed with this information the team approached the city's parks and recreation department. The department has now put £35 000 towards mobile play equipment for the under 5s.

The team has now produced **a tool kit for local** activists, giving advice **on how to** identify local health issues, how to take action, and how to evaluate the effects. "We want people to have the confidence that their actions can make a difference and to encourage them to take part in civic life," he said. Overall, £5m-7m has now been made available for health related initiatives in Drumchapel over *the* next five years, and local people will decide how this money is allocated. Similar community based projects have now been set up in every deprived area of the city.

The Glasgow project's budget of about £3m a year comes almost entirely from local and central government As well as empowering **local** people it aims to influence senior decision makers and to keep them informed on Health for All initiatives, Andrew Lyon is convinced that it has changed the debate on health in Scotland, just as the Health for All initiative has changed the international health debate. When he joined the project in 1989, the then secretary of state for Scotland, Michael Forsythe, sent him a memo emphasising that the project should not concern itself with unemployment or housing. He and his team have worked hard since then to convince politicians in Scotland that these issues are central to health. Scotland now has its own version of Health of the Nation, *Scotland's health: a challenge for us* all, and although he finds the content of the report disappointing, Andrew Lyon its existence as a glimmer of hope. He is also encouraged by the recent James report on the Scottish diet. "For the first time Scotland has a national policy document that discusses poverty in some detail," he said. "Health for All definitely had a role in that."


DMS/WHO

The regional office in Copenhagen, viewed by many as a sleepy backwater, out of touch with the political mainstream

evaluate prescribing behaviour and set up a targeted training programme to encourage appropriate use of drugs.

Piece-meal activities

It is not WHO's role to provide emergency relief in central and eastern Europe. Its role is to coordinate the efforts of other agencies in the health field and to help countries rebuild their health systems. But medical staff from other agencies told me almost apologetically that they felt they knew far more than WHO about the health needs of the area because of their experience in the field. "The problem is that WHO is consultant based rather than programme based," explained Dr Jo Kreysler, medical officer for the Red Cross. "How can WHO coordinate other agencies' programmes when it doesn't have its own programmes in the field? You need to have people permanently out there. You cannot do this on a consultant basis."

Dr Kreysler emphasised that relations between the Red Cross and WHO's European office were good. WHO has taken an important initiative to coordinate vaccination programmes in eastern Europe. Last year at a meeting in Tokyo WHO pulled together a consortium of interested parties. But liaison between the agencies in the field was limited, he said, and tended to be focused on individual programmes rather than policy.

Others agree. "Countries in central and eastern Europe are waiting for guidance on health policy and implementation," said one medical aid worker. "The structure needs to be sorted out before individual programmes are set up. What's the point of increasing vaccination coverage of the under 5s if the programme then collapses because the management structure is not functioning?"

Dr Danzon in Copenhagen acknowledges the criticism that WHO's activities have been piecemeal. He hopes that, once the immediate needs of the emerging democracies have been met, there will be a move to develop long term programmes and priorities. To this end, the region is establishing liaison officers in each of the 26 countries in central and eastern Europe. These officers, with the help of an administrative assistant, will oversee a specific contract of assistance drawn up with each government.

The changes in central and eastern Europe may be WHO's chance to rediscover its role as a leading adviser on health policy. But commentators doubt whether governments will listen if advice is not backed up with practical assistance in the form of staffing or money. They point to the fact that several of the new member states are planning health systems baaed on health insurance, something that WHO does not advocate, while continuing to concentrate on hospital medicine rather than primary care.

Health for All in Europe

Promoting primary health care is a central element of the Health for All initiative, along with promoting equity and the rational use of resources. Ironically it is in Europe, the region with arguably the least pressing health needs, that Health for All has had its greatest impact. Dr Jo Asvall, the region's director, does not find this so surprising. Initially, countries in Europe considered Health for All irrelevant to them, he told me, and they resisted interference from WHO. "They signed on to it when it was passed at the World Health Assembly, but saw it as something for the Third World," he said. He and his colleagues believed, however, that it was vital to implement Health for All in Europe, both because of the genuine problems of inequity between and within its member countries and because failure to adopt the policy in Europe would have made it difficult to implement elsewhere in the world.

To show the need for change in Europe, in 1980 the staff at the regional office undertook a study of health status in the 32 member countries. They found that the lifespan of men in Europe had decreased since the 1960s. All countries in central and eastern Europe had seen a decline, but so too had some industrialised Western countries. "This presented a big challenge to those countries who had said that their way of doing things was fine," said Dr Asvall. "It opened up the debate." The study also found increasing rates of cardiovascular disease, cancer, accidents, and suicide. From this the European office went on to study lifestyle factors, about which no country at that time had a strategy. "Ministers of health did not see this as their responsibility," said Dr Asvall. They also identified other areas that governments were not dealing with, including the big differences in quality of care among countries and among institutions and poorly structured primary care networks.

As a result of the study, the regional office was asked by WHO's European member states to draw up a strategy for health dealing with problems of lifestyle, the environment, health services, and staff training. The strategy was accepted by all members, "even the lifestyle issues-that was a surprise," said Dr Asvall. Since then targets have been set and governments have provided data for regular monitoring. Dr Asvall believes that, by publishing data that show the geographical and socioeconomic inequities in health, WHO has shamed governments into action. Where governments fail to provide data, WHO publishes the results with blanks.

Getting countries in the region to sign on to Health for All and agree to a common policy and to health targets was, says Dr Asvall, a watershed. "The agreement did not come lightly," he said. "That politicians should stick their necks out, by clearly defining what leveis of improvemenr they would try to reach within a given time, was abhorent to those who felt that caution should always be paramount. After all, what would happen if a target was not reached-wouldn't someone be held accountable?"

The Health for All initiative has taken on new relevance since the collapse of the Soviet bloc, says Dr Asvall. "Before 1989 we had 32 countries with high levels of health," he kid. "But we knew very little about health in the Soviet Union. It presented us with a single façade." The newly available data revealed vast differences across Europe. While mortality in people under 65 has been falling steadily in western and

northern Europe, the countries that now make up the newly independent states have seen a steady rise since the mid-1970s. In central Europe, which has the highest death rates in the region, rates have been rising sharply since 1989.

Few commentators deny the role of Health for All in changing the way people in Europe think about health. Most agree that it has shifted the debate away from a narrow focus on individual behaviour to broader policy, environmental, and social issues. The British government's publication of *Health of the Nation, with* targets for health improvement, is seen as a direct result of Health for All.' Other governments in the region have produced similar documents.

Critics say, however, that Dr Asvall has concentrated almost exclusively on promoting the policy issues involved in the Health for All initiative while paying little attention to the organisation, financing, and delivery of health care services. "Health for all has been an extremely effective slogan," said one observer, "but the European office has failed to follow through in terms of how countries should implement the policies." But WHO's insistence that implementation is not its role does not mean that it can ignore the practical management issues surrounding implementation.

A few individuals in WHO are championing the cause of health services management, but critics say that the regional office has been slow to respond. At a time when many countries in Europe are undergoing major health reform, Copenhagen might have served as a clearing house for countries to share their experiences. But it has failed to take the lead. The result is that, despite the impact of Health of All, many in western Europe see the office in Copenhagen as a sleepy backwater, out of touch with the political mainstream.

Keeping out of politics

The question of whether WHO should involve itself in politics is hotly debated. WHO and many of the larger donor countries, including the United States, believe that it should not. But people outside the organisation insist that political action is essential to achieve change. Andrew Lyon, coordinator of WHO's healthy cities project in Glasgow, is one of those who would like to see WHO in Europe putting much more effort into lobbying national governments. 'WHO wants to provide technical assistance to cities. Cities don't need this. We need advocacy with national governments," he said. He believes that the healthy cities project could become an influential social movement if WHO would realise its political potential. '"With over 40 cities and therefore the possibility of over 100 national politicians committed to the project, WHO is in a strong position to influence policy in Europe," he said (box).

WHO disputes this view of the healthy cities project. Ilona Kickbusch, who initiated the project from within the Copenhagen office and now heads a new division of health promotion and education in Geneva, says that the project was never intended as an entry point to influence national governments. Its primary aim was to put health on the agenda within cities at all levels. In this, she says, it is already succeeding. 'We wanted to get decision makers within cities to take every possible opportunity to promote better health. At the start of the project many cities were spending their whole health budget on hospitals and nothing on prevention. For example, they couldn't tell us how many smokers there were in the city." She is certain that the project has raised awareness. In Vienna, for example, health policy makers now take pan in urban planning, and the health consequences of planning decisions are routinely discussed.

Threat from the European Union

While WHO's European office hesitates at the sidelines of the political game, the European Union is already on the' field, taking what one person in WHO called "an unhealthy interest in WHO's territory." Already funding medical research and training, the union is now looking to involve itself in disease prevention and public health. This introduces the possibility of conflict or at least duplication. Despite these threatened encroachments, Dr Asvall maintains that the two bodies have entirely different functions, WHO's being to give technical advice and support and to advocate Health for All, and the union's being to make policy decisions on behalf of its member states. But these distinctions are becoming blurred. Gathering and analysing health statistics, for example, is one of WHO's central functions in Europe as part of the Health for All initiative. But the European Union is now planning to set up its own statistical unit.

A recent report commissioned by the regional committee and chaired by Britain's chief medical officer, Dr Ken Calman, warns that there till need to be close liaison between the European Union, the Council of Europe, and WHO if duplication and waste of

Collaborating centres-a wasted resource

Many of WHO's external consultants come from "collaborating centres" like the Nuffield Institute for Health in Leeds. WHO has several hundred such centres throughout Europe, which offer technical expertise ranging from medical science to health care policy. Being a collaborating centre carries useful kudos and the right to use WHO's logo on headed paper, but it brings no financial reward. Many centres say that they subsidise WHO's activities, since the organisation is unable to pay competitive rates for consultancy work. In fatter days this was less of a problem. Now, with university departments being forced to generate their own income, centres are having to question the benefits of being involved with WHO.

Professor David Hunter, director of health policy management at the Nuffield Institute, believes that WHO is wasting a major resource. "If the centres were used as a coordinated network, perhaps with fewer centres used more effectively," he told me, "they could beef up WHO considerably without the need for lots of extra resources." The problem is that from the beginning WHO had no clear idea of how it wanted to use the centres, he said. At the momenr they are used for "hit and run advisory services." His staff may be asked by WHO to be on the platform at an inremational meeting or to do a five day visit to report on a country's health needs, "The request usually comes at the eleventh hour," he said. "They expect us just to down rools and go. It is all reactive and ad hoc There is no atrempr to develop a long term relationship with the centres or to encourage centres to collaborate with each other," Liaison between the centres and the European office is, he says, effective on a casual basis, but it could be greatly improved by the creation of more formal links.

Professor Hunter is also critical of the department of health in Britain for its failure to nurture the collaborating centres and for its lack of interest in WHO as a whole. The department's inremational relations unit sent a questionnaire to all centres in England and Wales in 1990, asking for their views on their links with WHO. "The results were never analysed," Professor Hunter told me, "or if they were, they were not made public or even fed back to the respondents." He believes that, despite a clear commitment to WHO on the part of the chief medical officer, Dr Ken Calman, the department itself has taken even less interest in the organisation over the past two years than it did before.

ROBERT HARDING

The healthy cities project, in Glasgow and elsewhere, aims to empower individuals and find out what their priorities are for health

resources are to be avoided. Dr Calman told me, "As the union expands, relations with WHO will have to get closer. It is important that the union takes account of public health bodies that already exist."

So far there has been little sign of mutual understanding. In December WHO hosted a meeting in Copenhagen, that was attended by representatives from the European Commission and the Council of Europe. Observers noted a definite coolness between the two sides. The problem for WHO is that, although it clearly has the edge in terms of technical knowledge and experience, it lacks the union's financial and political clout. "If the European Union wants to set up new programmes in public health, there's not much WHO can do about it," said one observer. Others have suggested that the threat from the European Union may be just what WHO needs. It may, they say, force the regional office to examine its role in western Europe, as it is doing in central and eastern Europe.

Relations with Geneva

When it comes to relations between the regional office and WHO's headquarters, Europe suffers or enjoys the same detachment as WHO's other regions. Health professionals in regular contact with WHO talk of poor communication between Copenhagen and Geneva and confusion as to which office takes responsibility for what. Being on the same continent has done nothing to improve cooperation, they say. It may even have made things worse. In the early days of the crisis in central and eastern Europe, Dr Asvall fought off a concerted bid by the director general, Dr Hiroshi Nakajima, for the Geneva office to take the lead in directing aid delivery and health policy. Since then the region's dislocation from headquarters has, according to observers, been aggravated by a growing coolness between the two leaders.

Conclusion

Through the Health for All initiative, WHO's European office has had a profound influence on the debate on health in Europe. The office has also shown itself able, within its limited resources, to respond to the enormous changes in its constituents and their needs over the past five years. But there are new threats on the horizon. If the European Union decides to involve itself in WHO's traditional territory of public health, it has the two important things WHO lacks: money and political power. WHO has to find a way to harness these external attributes, by wooing the union into cooperation, if it is to push forward its own agenda for Europe. There are now growing calls for WHO's European leaders to come down from the high plane of policy and get involved in the earthy and increasingly political complexities of health care delivery. Without more activity at this practical level, and with the European Union now on the scene, countries in Europe may yet decide that a separate European branch of WHO is a luxury they can do without.

1 Tollison RD, Wagner RE. *Who benefits from WHO? The decline of the World Health Organisation.* London: Social Affairs Unit, 1993. (Publication No 53.)

2 Secretary of State for Health. *The health of the nation: a strategy for health in England.* London: HMSO, 1992. (SM1986.)

WAY WITH WORDS

Problems with pronouns

In 1875 Robert Browning wrote: "We've still our stage where truth calls spade a spade." Not any more: 120 years on political correctness paradoxically dissembles truth. Good old Anglo-Saxon words are replaced by woolly circumlocutions: the old are chronologically challenged, the dead are (sic) non-living persons, and the fat differentially sized. And its effect on sex has been to mm the writer of English into a contortionist in order to avoid being charged with sexism.

The constant awareness of the need to address both sexes and yet to avoid the repetitive *he and she* leads to curious and inappropriate use of pronouns: "The individual was also impaired in their personal development" and "It is helpful if the counsellor appreciates that they can lean towards the client. This can encourage the client and make them feel more wanted." A simple solution if you don't want to get tied up with single (singular) sex is to use plurals for the subject-individuals, clients, patients-when *their* follows logically.

A similar problem arises with a collective noun like everyone. You don't say "Everyone were" so sentences like "Everyone was assumed to be Christians" and "Everyone should have the opportunity to express themselves in imaginative language" (from the Arts Council) are strictly speaking ungrammatical. But I gather the Times has given its imprimatur to plurals like *their* after a singular subject.

Confusion of a non-sexist kind is if anything worse when dealing with institutions, where singular and plural are mixed indiscriminately: 'While the town council was privatising anything it could lay their hands on," and "The Royal College of Psychiatrists have arranged its first Christmas lecture." The rule should be to treat such collective nouns as singular.

To get back to sex, I am always careful to be politically correct, as, for instance, in describing airline desks as "womanned by BA representatives." So I find it bizarre to read an academic survey of views of both sexes about living wills (by a man) addressed to the reader as she; and am surprise&by a woman doctor whose article was directed solely to *he* and his. Imagine the outcry if the author had been a man. But this was nothing compared with the shock produced by a picture of the successful England women's world cup cricket team, which included the woman who had been "declared man of the match."—ALEX PATON, refired *consultant physician, Oxfordshire*