

W.H.O. Remarks at the Regional Forum on Sustainable Development for the UN Economic Commission for Europe (UNECE) Region

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Excellency, honourable ministers, ladies and gentlemen, dear colleagues and friends,

On behalf of the WHO Regional Office for Europe, I am pleased to participate in this roundtable in the second year of implementing the 2030 Agenda for Sustainable Development and its Sustainable Development Goals (SDGs) in the WHO European Region. I would also like to thank the United Nations Economic Commission for Europe (UNECE) for organizing this event. It comes at the right time, just before the high-level panel where, among others, SDG 3 on health and well-being for all at all ages will be discussed.

We are here today to touch base on where we stand. Let me start by saying that health and well-being for all at all ages are outcomes, determinants and enablers of the SDGs. Good health and well-being is the primary focus of SDG 3, but health is a major contributor to other SDGs as well. Without health, many SDGs may not be achieved; at the same time, health benefits from progress towards other SDGs.

Across the SDGs there are approximately 25 health targets, which relate to almost all of the 17 SDGs. The European policy for health and well-being Health 2020 is fully aligned with and instrumental to the achievement of the SDGs in our Region. The SDGs are also critical to completing the unfinished agenda of the Millennium Development Goals (MDGs) – particularly those related to communicable diseases – and to widening the scope of our work to incorporate a health-in-all policies approach.

I am happy to say that many of our policies are working. In our Region we have seen great improvements, and yet challenges clearly remain. For example, life expectancy at birth increased from 73.9 years in 2000 to 77.5 years in 2014, though the last years of life are often unhealthy ones. All countries in the Region have reduced maternal mortality, though not equally for all. Under-five mortality rates are already level with or below SDG targets, though neonatal mortality continues to present a problem in several countries.

The Region was the first in the world to achieve interruption of indigenous malaria transmission, and Member States have passed significant milestones in the eradication of poliomyelitis. In terms of noncommunicable diseases (NCDs) such as diabetes, cardiovascular diseases, cancer and chronic respiratory diseases, we are observing a downward trend. However, this overall regional picture masks significant differences within and between countries and population groups.

Many conditions are also not detected early enough for effective treatment; 30–40% of cancers, for example, have already spread by the time they are diagnosed. Mental disorders, most commonly depression and anxiety, affect more than one third of the Region's population every year. In all countries, mental disorders tend to be more prevalent among the most disadvantaged groups.

It is also concerning to note that some MDG targets have not yet been achieved. Ours is the only region in the world where the number of newly diagnosed HIV cases continues to rise rapidly, and there are also significant gaps in testing and treatment. The Region's incidence rate of tuberculosis has been declining by 4.5% annually, but its rate of drug-resistant tuberculosis is the highest globally.

Progress has been stalled or delayed in many areas. For example, interpersonal violence is the third leading cause of death in the Region, accounting for 15 000 homicides annually. Of particular concern is gender-based violence: nearly 25% of women are affected by intimate partner violence. If progress on deaths from road traffic injuries continues at the current rate, the Region will fall short of the global target of a 50% reduction in road traffic-related fatalities by 2020.

Additionally, the influx of refugees, asylum seekers and migrants into the Region presents an ongoing challenge to European countries, one with medium- and longer-term security, economic and health implications.

Risk factors and health-damaging lifestyles are also slowing down development. The Region ranks highest in the world for per capita alcohol consumption, and illicit drug use ranks as the Region's ninth most important cause of lost disability-adjusted life years (DALYs). Unhealthy food consumption, lack of physical activity and many additional factors are contributing to the obesity epidemic we are observing in our countries.

Currently, 21% of men and 24% of women over 18 years of age are obese, and obesity rates are rising among children. We estimate that the Region will fail to halt the rise in obesity unless action accelerates. We also estimate that we will fall short of the global goal of reducing tobacco use, which increases the urgency of scaling up implementation of the WHO Framework Convention on Tobacco Control.

Economic, social and environmental determinants must be addressed across the whole of government and the whole of society. We face a significant unfinished agenda for addressing environmental risk factors: in the Region alone, 1.4 million deaths – equivalent to 16% of all deaths – are caused by environmental factors that could be avoided or eliminated. The major health impact of environmental determinants in the Region is related to NCDs, disabilities, chronic conditions and unintentional injuries.

Large health inequities also prevail. For example, women's healthy life expectancy differs across the Region by up to 15 years. The causes of these inequities include the range of social, economic and environmental determinants of women's health and well-being, as well as health system responses to women's needs. Gender inequalities, discrimination and gender stereotypes are important underlying factors influencing behaviour and practices that affect women's health throughout the life-course.

The economic costs of health inequities are significant. Health inequity accounts for 15% of the costs of social security systems and 20% of the costs of health care systems in middle- and high-income countries. Health inequities are avoidable, and policy interventions to reduce them must go hand-in-hand with interventions to tackle social, gender, environmental and economic inequities. The SDGs focus on breaking the cycle of poor health, poverty and exclusion, and on preventing the transmission of intergenerational inequities from parent to child.

Going forward, what can we do more, better or different – and how?

1. We can make a societal effort to tackle the determinants of health.

Many countries have established governance structures for inter- and multisectoral action, especially in areas for which evidence and business cases are well established and supported by social norms. Nevertheless, additional multisectoral action is required to tackle the burden of disease from environmental pollution, climate change and unsustainable food systems; to address NCD risk factors through behavioural change; to address communicable diseases, health security and antimicrobial resistance; and to strengthen the factors that promote social protection and empower people through education and training.

Examples of such action include investing in environmental protection and healthy settings; prioritizing legal and regulatory frameworks in sectors other than health that tackle shared risk factors and unhealthy commodities (such as alcohol, drugs and tobacco) or that ensure consumer environments support healthy choices; and addressing regulation on health-impairing investment and trading activities through fiscal, taxation and financial policy tools.

2. We can focus on young people – and people of all ages – and leave no one behind.

Many of those who will die in 2030 from preventable causes are young adults today. As many of these causes take several years to manifest, actions taken now will determine whether countries succeed in achieving related targets. This requires a focus to our young generations.

At the same time, our population is ageing. Women now make up 70% of the 14 million people currently over 85, and this population group will grow in years to come. For many women, however, later years are characterized by illness or disability: on average, women in Europe live 10 years in poor health.

With the adoption of the 2030 Agenda for Sustainable Development and its SDGs, governments reaffirmed human rights, gender equality and women's empowerment as crucial to our future achievements. This means that reaching the targets of SDG 3 on health and well-being will be enabled by progress on other SDGs – particularly SDG 5 on achieving gender equality and SDG 10 on reducing inequalities within and between countries.

To this end, all 53 Member States adopted the new Strategy on women's health and well-being in the WHO European Region in September 2016. The Strategy is designed to help health planners work towards improving the health and well-being of women and girls beyond maternal and child health, ensuring that policies and health systems are gender-responsive and based on a life-course approach.

3. We can establish healthy places and communities where people live, eat, work, play and age.

Work to achieve the SDGs has attracted new allies and actors involved in the long-standing healthy settings approach, which involves promoting health in schools, hospitals, workplaces and cities. These new allies include municipalities and mayors. Together, we must do the following: promote measures for creating spaces that are supportive to all ages and all levels of ability, and engage communities and public agencies in the process; empower populations to develop health-promoting behaviours; and prioritize city policies that create co-benefits among health and well-being and other social, economic and environmental goals.

4. We can strengthen health systems to work towards universal health coverage.

Most countries in the Region provide universal or near-universal health coverage, but large differences remain in health services delivery, health financing and health workforce capacity. Financial hardship is often heavily concentrated among poor households and pensioners, and is largely driven by out-of-pocket payments for outpatient medicines. Weak financial protection leads to more widespread and increased poverty. We must break this cycle by further strengthening health systems and ensuring that they are equitable.

5. We can increase health security.

The majority of countries in the Region are parties to the International Health Regulations (IHR). In several countries, however, increased cross-sectoral commitment and operational relevance are required to fully implement the IHR.

Cross-border health is a burning public health issue, especially now and especially in our Region given the ongoing refugee and migrant crisis. This crisis confronts countries with the urgent and growing health needs of these people, and with the associated burden on national health systems and often-scarce resources. The access of refugees and migrants to quality essential health services is paramount to rights-based health systems, to global health security and to public efforts aimed at reducing the health divide. With this in mind, Member States endorsed the Strategy and action plan for refugee and migrant health in the WHO European Region in September 2016.

As requested by Member States and with their support, WHO also set up the new Health Emergencies Programme to strengthen its operational capabilities in traditional technical and standard-setting roles. WHO supports countries to build core competencies as mandated by the IHR, and updates IHR reporting mechanisms including joint external evaluations and hands-on simulation exercises.

6. We can carry out monitoring and evaluation.

Health information systems in the Region must harmonize, standardize and improve traditional information sources, but they must also add tools and standards that can describe and measure subjective well-being and incorporate more qualitative and value-based concepts, such as community resilience and empowerment.

We have committed ourselves to pursuing these goals through, for example, an action plan to strengthen the use of evidence, information and research for policy-making under the European Health Information Initiative; prioritizing and regionalizing the indicators and performance objectives for the health-related SDG targets; and developing through further consultation with Member States a joint framework for monitoring and evaluating health policy in the Region.

In conclusion, it is clear that the 2030 Agenda for Sustainable Development defines our work and priorities for the years to come. Health is a political choice, and WHO continuously supports Member States to place health high in their development agendas through high-level policy dialogues, partnerships, cross-sector involvement and comprehensive technical support. Today, when so many public health issues traverse national boundaries, if one country fails to meet the basic health needs of its population it is our common failure. As we work towards achieving the SDGs, we will leave no one behind – and we truly mean it. With this, I wish all of us a day of productive discussion.

Thank you.