

REVIEW ARTICLE

Ten years onwards: Comparison of the South Eastern European regional public health strategy 2004 and the South Eastern European 2020 strategy

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Abstract

Aim: Regional collaboration has continuously contributed to the development of public health in the South Eastern Europe (SEE) region since 2000 when the Public Health Collaboration in SEE (PH-SEE) was initiated. This article looks into two frameworks for regional collaboration in the area of public health: a framework developed in 2004 by a network of public health professionals and academics, and another one developed by the SEE Health Network as integral part of the SEE 2020 strategy on *Jobs and Prosperity in a European Perspective*, adopted in 2013. It compares the commonalities and differences of the two frameworks; considers what is still valid and relevant after ten years and which new features have emerged in the new strategy.

Methods: A literature review was carried out and a qualitative analysis was applied for the comparison of the two frameworks.

Results: Notwithstanding the time gap of nearly ten years, the commonalities between the two regional health strategies are significant. Major consistent goals include: improving equity in health; strengthening human resources for health; improving intersectoral cooperation and governance. The differences between the two regional strategies, including issues around social participation and regional health information systems, are partially due to their different development context. Cross-border policies and quality management have emerged as new or more pronounced topics in the SEE 2020 strategy's health dimension.

Conclusions: Many aspects addressed in the 2004 framework are pertinent with regard to the SEE 2020 health dimension and remain relevant in the current context. The integration of health as part of the economic SEE 2020 strategy reflects a significant paradigm shift and important step forward for public health.

Keywords: public health strategy, regional collaboration, socioeconomic development.

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Introduction

In November 2013, Ministers of Economy of seven South Eastern European (SEE) transition economies signed the SEE 2020 strategy on *Jobs and Prosperity in a European Perspective* (hereafter SEE 2020 strategy, or strategy). The SEE 2020 strategy aims at socio-economic growth and underlines the importance of the European Union (EU) perspective for the SEE region. It provides a framework for regional cooperation in specific political and economic areas with the purpose to assist governments in the achievement of common national goals. The development of the strategy has revealed a high level between regional and national agendas (1,2).

While the focus of the strategy is primarily on advancing the economic development of its members, health constitutes an integral part of this strategy. As highlighted by the SEE Health Network (SEEHN), this is an innovative aspect reflecting a paradigm shift in recognizing that health contributes to socioeconomic growth rather than constituting just a burdening cost factor (3,4). The SEEHN has been mandated to assist in the implementation of the health dimension of the SEE 2020 strategy (5).

In the context of another network, the Public Health Collaboration in SEE (PH-SEE), a Framework for a Regional Public Health Strategy had been developed and suggested as early as in 2004 (6).

This article looks into two frameworks for regional collaboration in the area of public health: one framework developed in 2004 by public health professionals and academics, and another one developed by the SEEHN as integral part of the SEE 2020 strategy. It compares the commonalities and differences of the two frameworks; considers what is still valid and relevant after ten years and which new features emerged in the new strategy. It is based on a literature review and applied qualitative analysis for the comparison.

Background information

During the past three decades, the SEE countries have experienced dramatic changes through the disintegration of the communist systems and the subsequent rapid transition to market-oriented economies. This shift had social and cultural implications for the societies, marked by increasing poverty, high unemployment, massive emigration, and financial downturn, further aggravated by a devastating war. As a consequence, the burden of disease in many SEE countries has been – and continues to be – higher than in Western European high-income countries despite varieties in the region (7-9).

The EU-initiated Stability Pact for the SEE (1999-2008)¹ included two major health programmes under the Social Cohesion pillar that resulted in two distinct public health networks, operating at political and professional levels:

- The SEE Health Network (SEEHN), established in 2001, brought together the Ministries of Health of nine SEE countries² and other experts, and has since acted as an intergovernmental forum and legal platform implementing regional collaboration on health systems and public health at political level. In 2010, the SEE Health Network took ownership for the regional collaboration on health and development under the Regional

¹The EU was the main initiator of the Stability Pact for the SEE. Over 60 partners provided funding for the activities and programmes under the Stability Pact, including the WB, EBRD, CEB, CoE, all UN Organizations and many bilateral donor countries. All health actions were financially and technically supported by ten bilateral donor countries, CoE, CEB and WHO Europe.

²Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the former Yugoslav Republic (FYR) of Macedonia (Republic of Macedonia), Republic of Moldova, Montenegro, Romania and the Republic of Serbia. Israel joined SEEHN in 2011 as the tenth Member Country.

Cooperation Council (10), the successor of the Stability Pact since 2008 (11). Its institutions include regional health development centres in each of its ten Member States and a network of over 300 experts, with a secretariat based in Skopje, FYR Macedonia (12). It is one of the over 60 SEE regional initiatives under the broad political framework of the SEE Regional Cooperation Process and the Regional Cooperation Council.

- At the academic and technical level, the Public Health Collaboration in SEE (PH-SEE), funded by the German Stability Pact (2000-2008), brought together universities and Institutes of Public Health of SEE countries and partner universities from European countries to develop Programmes for Training and Research in Public Health and assist in the establishment of Schools of Public Health. Following the end of the Stability Pact, in 2008, PH-SEE transformed into the Forum for Public Health in SEE (FPH-SEE), a non-governmental and non-profit consortium of public health institutions in the SEE region. As an affiliate of the European Public Health Association (EUPHA) it aims at exchange of experience, mutual support, and common activities for a New Public Health (13).

Both networks continue to be active; it is noteworthy that they share the vision and mission to promote peace, reconciliation, and health through regional collaboration in public health. As pointed out by Ruseva et al. (14), both networks together enhanced public health as a common denominator of both a political and an academic movement to improve the health and wellbeing of the SEE populations. The SEEHN achievements are numerous with significant impact on health policies, spanning the areas of mental health, non-communicable and communicable diseases, healthy aging, antibiotic resistance, organ donor and transplant medicine, blood safety, accreditation and quality improvement of health services, health workforce, and public health services. At the academic level, the PH-SEE by 2008 had produced six volumes of teaching materials (3500 pages), a shortlist of health indicators; organized more than 25 conferences and summer schools; and had assisted in the establishment of new schools of public health in Belgrade, Bucharest, Chisinau, Novi Sad, Pleven, Skopje, Sofia, Tirana, and Varna. As a lesson learnt from the SEEHN, Ruseva et al. conclude that a network approach constitutes an added value for the region with view to the small size of most of SEE countries. The regional collaboration network amplifies their influence and power at international levels, as they speak with one voice; moreover, collaboration between various stakeholders has enabled the countries to rapidly resort to their respective networks to mobilize assistance in emergency events, such as the floods in 2014 (14).

Development of a Regional Public Health Strategy Framework in 2004³

In 2004, the Public Health Collaboration in SEE Programme (PH-SEE) (13) brought together public health professionals from seven SEE countries and other European countries⁴ in a seminar that served as a forum for the development process of the regional strategy framework. The seminar built on previous work in the region and followed a participatory approach in several steps. Hence, based on the existing national health strategies at that time, the participants jointly elaborated a situation analysis with regard to public health in the SEE

³ This section draws on reference no. 6: Framework For a Common Regional Public Health Strategy of South Eastern Europe, in: Scintee SG and Galan A (eds.). *Public Health Strategies: A Tool for Regional Development – A Handbook for Teachers, Researchers and Public Health Professionals*. Lage: Hans Jacobs Publishing Company, 2005.

⁴ 36 public health experts from Albania; Bulgaria; Croatia; FYR Macedonia; Romania; Serbia and Montenegro; and Slovenia; five public health experts from Denmark, Germany, Switzerland and the UK.

region, selected priorities for a regional framework, formulated major goals and developed an operational action plan.

A methodological combination of the SWOT⁵ analysis and the nominal group technique was selected for the framework development. Both methods are recognized in supporting decision-making and problem solving processes, by applying heuristic reasoning for advancing analysis and decision-making. Being primarily intuitive and judgemental rather than mechanistic and measurable (15), these methods nevertheless follow rigorously disciplined regulations. In regional development as well as in strategic planning, the use of heuristic reasoning is well-established.

Situation analysis of public health in the SEE region in 2004

The situation analysis using the SWOT methodology aimed at describing the external and internal environment of public health in the SEE region and facilitating the choice of strategic options.

Strengths

The countries in the SEE region could build on a strong tradition and history in public health. Namely, the management of communicable diseases in conjunction with the sanitary control of water supplies and food safety had the potential for further development at regional level. The traditional system of family physicians and the focus on maternal and child health were highly relevant with regard to international trends in health. This was backed by already existing legislation and regulations like the laws on surveillance of communicable diseases, food safety and healthy nutrition, environmental health, occupational health, school children health, immunization and the like. Routine health data collection was maintained in most countries.

The existing public health infrastructure consisting of professionals, inspectorates and National Institutes of Public Health represented a solid base both at country and regional levels. In 2004, a core group of public health professionals with international training and connections provided quality input into projects and institutions. Nearly all countries in Central and Eastern Europe had mature education and training systems (15), although the SEE region could build only on a selected number of schools of public health, such as the Andrija Stampar School in Zagreb, Croatia with its long tradition. Professional associations and non-governmental organizations (NGO) reflected the continuing cooperation and communication and represented a means for empowerment of public health. National public health associations and schools of public health had been founded in Romania, Serbia, Moldova, FYR Macedonia, Bulgaria and Albania in recent years with the support of the Open Society Foundations and the German funded Stability Pact.

Weaknesses

Weaknesses within public health in SEE countries were observed in the areas of legislation, organization, financing, health promotion, health information system, human resources, education and training, and ethical issues.

The health sector reforms during the transition period brought about rapid changes of legislation. In addition, the unstable political situation often led to the disruption of development processes in public health, and as a consequence resulted in a lack of persistent vision and policy. At the same time, the slow transition from a centralized structure to

⁵ SWOT analysis is a structured planning process that assesses strengths, weaknesses, opportunities and threats with regard to the internal and external environment of a project or business.

decentralised systems reflected a form of inflexibility stemming from former systems. Additionally, poor vertical and horizontal communication impeded the advancement of new structures and initiatives. Community involvement in health development tended to be neglected.

Overall, the efficiency of the health information systems was questioned, as was the quality and the effective use of health information.

The health financing was perceived to be insufficient. Of concern were also the inappropriate allocation of funds and the low effectiveness in spending, enhanced by a lack of control mechanisms. Corruption was a significant worry, as it was contributing to increasing inequalities in health care.

Inappropriate salaries and lack of incentives were also weakening the delivery of public health services through demotivated health personnel. Furthermore, the lack of professional and social recognition and the missing formal inclusion in decision-making processes demotivated the public health professionals. At that time, a critical mass of well-trained public health professionals was not built yet and a clear shortage of management skills in public health was observed.

Opportunities

In contrast to the 1990s, in 2004, the SEE region was characterized by a climate of opening and cooperation between the countries. The Dubrovnik Pledge of 2001 (16) had marked a firm political commitment to regional health development. The political and technical cooperation had been institutionalised in the “SEE Health Network” as the main political body for providing leadership and sustaining ownership of the countries and implementing concerted action in defined areas of mutual interest.⁶ There was an enhanced trend to increased professional cooperation within and between the SEE countries, facilitated and sustained by the establishment of institutionalized structures, such as the SEEHN and the PH-SEE networks.

Political changes and increasing foreign investment targeting the socio-economic development in SEE countries also opened opportunities for public health initiatives.

A number of international agreements and regional declarations constituted important reference points for a regional public health strategy, including the United Nations (UN) Millennium Development Goals (MDGs) (17). The European public health policies provided a frame for harmonizing SEE approaches and alignment with the European standards, including the WHO Health 21 strategy (18); the Ljubljana Charter on Reforming Health Care, 1996 (19); and the EU public health programme (20-22). Other relevant international declarations were the WHO Ottawa Charter concerning health promotion and the Verona Initiative advocating for multi-sectoral investment in health (23).

The development of information technology (IT) offered new opportunities in terms of facilitating better access to the international body of knowledge in public health for professionals and politicians in the region, helping to exchange information and improving equal access to new databases, journals and other up-to-date information.

The emerging national public health strategies demonstrated the relevance of a regional approach as they provided evidence on the numerous common problems and challenges that

⁶ In 2004, the SEE Health Network consisted of over 200 members, including representatives of nine SEE beneficiary countries, ten donor and neighbour countries and representatives of international organizations, such as WHO Regional Office for Europe, the Council of Europe (CoE) and the Council of Europe Development Bank (CEB). The political body of representatives of the Ministers of Health, called the National Health Coordinators of the SEE countries, acted as the Steering Committee for implementing the Dubrovnik Pledge.

most SEE countries faced. For addressing those, a regional framework through setting of goals of mutual interest, joining forces through cooperation and information exchange was considered beneficial for advancing public health in the SEE region.

Threats

At the same time, political, security and socioeconomic instability in the region and at country level was perceived as a major constraint on the way forward. Particularly, the political instability was of concern as every electoral mandate came along with changes in governmental strategies, institutions and agencies with effects on legislation and financing mechanisms. The lack of continuity in management, legal framework and allocation of resources throughout and across different political cycles were challenging the development of sustainable public health strategies. Competing and conflicting interests of the different political groups also meant a threat to the thorough development of a long-term public health policy.

Despite the Stability Pact efforts in the follow-up of the Dubrovnik Pledge, the SEE countries at that time felt that the international community had paid limited attention to the reform of the health systems in SEE and health had been excluded as a regional priority in the frame of the EU CARDS Programme (24).

Primary concern among the consequences of the socioeconomic instability was the high turnover of health professionals. Furthermore, the lack of recognition of public health professionals compared to clinical medical staff, in terms of identity, social status and public image, hindered the evolution of public health within the health system.

Strategic choice and recommendations

The mapping of interactions between the external and the internal environment suggested the choice of the *comparative advantage strategy* that matched the strengths in the public health field in SEE with the external opportunities. Building on the potentials did not mean losing reality out of sight: maximising the strengths implied overcoming the weaknesses for a stronger position to take opportunities offered by the external environment.

In this understanding, a set of key messages and recommendations were formulated:

- A key priority in the SEE region was the reduction of health inequalities within and between the countries with a view to further socioeconomic stabilization of the region and a better use of external opportunities.
- Improved community involvement and social participation in the decision-making process in health activities would be important with a view to meeting the expectations of the population and making the public health strategy socially and culturally acceptable.
- Intersectoral collaboration (vertical and horizontal) would be indispensable for integrating public health in the agenda of all economic sectors and overall politics. It would also help to resolve competing interests in national coalitions and international partnerships.
- The willingness of joining the EU could be the engine for economical and social development. The public health field should take advantage of the requirements to adapt to EU standards and regulations in order to improve legislation, professional regulations and harmonize public health practices.
- Regional cooperation would contribute to improving the capability of attracting international funding for multi-national projects. Joining forces in obtaining international

investments in public health research, capacity building and improving infrastructure could help to mitigate the weak financing of public health in the region.

- The sustainable development of a public health workforce was necessary to strengthen public health aspects in health reform and health policies. Capacity building should include management of health systems and better use of existing resources.
- An improved status of public health professionals would enhance their active involvement in policy development and decision making processes, thus ensuring the integration of public health knowledge and the use of data for evidence based policy-making processes. This could be operationalized in strengthening or establishing national public health associations and forming a regional umbrella organization.
- Professional collaboration in the form of networks would help in capacity building across SEE countries through mutual exchange of information and experiences and the sharing of successful national projects throughout the region.

The results of the situation analysis and the recommendations informed the priority setting process for public health goals in the region. The final priorities were formulated as goals, framing the regional public health strategy. This framework of strategic goals was translated into an action plan by setting operational objectives, specifying activities, timeframe, deliverables, outcomes, indicators, and analysing potential partners, resources and risks.

The SEE regional public health strategy framework (2004)

Five strategic goals build the overall framework for action to address public health priorities at a regional level (Box 1). An initial five-year period for implementation was established (2005-2010). The regional strategy framework aims to complement the national public health strategies. In addition to the countries' strategies, it provides a framework for addressing common health challenges in the region, contributing to the harmonization of public health policies between the countries and the approximation to European standards.

Box 1. Overview of the strategic goals and objectives of the draft of SEE regional public health strategy framework (2004) [Source: Scintee SG and Galan A (eds.) (2005). *Public Health Strategies: A Tool for Regional Development*, page 629]

SEE regional public health strategy framework, 2005-2010	
Goals and objectives	
Goal 1	Improving equity in health
	1.1: Targeting vulnerable groups
	1.2: Ensuring adequate and safe living conditions
Goal 2	Strengthening social participation
	2.1: Mapping social participation opportunities and initiatives
	2.2: Awareness rising and empowerment of the public
	2.3: Developing mechanisms to involve civil society in decision making processes
Goal 3	Strengthening human resources in public health
	3.1: Ensuring sustainable development of human resources
	3.2: Enhancing regional professional collaboration
Goal 4	Improving regional public health information and knowledge
	4.1: Establishing a regional public health information system
	4.2: Developing mechanisms for reporting and analysis at regional level
	4.3: Improving the level of public health knowledge among three key groups: the professionals, the decision-makers and the public
Goal 5	Establishing intersectoral cooperation
	5.1: Establishing involvement in programmes of non-health sectors
	5.2: Introducing intersectoral research

SEE 2020 strategy – the health dimension (2013)

The SEE 2020 strategy pursues a holistic approach of development (1, page 4). It features health as integral part of the overall socioeconomic development. The strategy aims to achieve three overall economic targets⁷ building on a structure of five pillars (*Integrated Growth, Smart Growth, Sustainable Growth, Inclusive Growth and Governance for Growth*), with pillar specific targets and a set of 16 dimensions. Health and employment form the two priority dimensions under the pillar *Inclusive Growth* as they were identified as the most urgent topics to be addressed and there are expectations of significant return of efforts in terms of social development. The employment dimension appears more prominent compared to the health dimension, which may reflect on the importance of employment in the strategy, as well as the commitment to create one million new jobs in the SEE region by 2020. Yet, the inter-linkages of the employment and the health dimensions become apparent in two key goals of the strategy: fighting poverty through job creation and fighting health inequalities with a focus on low-income and vulnerable groups. The aim is to ensure that everybody benefits from growth through reduction of poverty, improved health and wellbeing, and greater social cohesion.

The SEE 2020 labour market policies focus on the flexicurity approach to be implemented through comprehensive lifelong learning strategies, effective active labour market policies and modern social security systems (1, pages 28 & 50). According to the European Commission, flexicurity is an integrated strategy that attempts to reconcile employers' needs for a flexible workforce (flexibility) with workers' needs for security (25). The SEE 2020 actions refer to the four components of flexicurity approaches: flexible and secure contractual arrangements and work organisations, both from the perspective of the employer and the employee; active labour market policies that help workers to cope with rapid changes, unemployment, reintegration and transitions to new jobs; lifelong learning systems to ensure the continuous adaptability and employability of all workers, and to enable firms to keep up productivity levels; and modern social security systems which provide adequate income support and facilitate labour market mobility (26).

Effective social security can be achieved through comprehensive social protection floors. This approach comprises an integrated set of social policies designed to guarantee income security and access to essential social services for all, with a focus on vulnerable groups and protecting and empowering people across the life cycle (27). Social protection floors, as defined by the International Labour Organization (ILO), are nationally defined sets of basic social security guarantees that ensure that all in need have, as a minimum, access to essential health care and to basic income security that together secure effective access to goods and social services. The concept is part of a two-dimensional strategy aimed at the rapid implementation of national social protection floors in line with the ILO Social Protection Floors Recommendation, 2012 (No. 202), and the progressive achievement of higher levels of protection within comprehensive social security systems according to the ILO Social Security (Minimum Standards) Convention, 1952 (No 102) (28). Robust social protection floors are important particularly with view to the demographic transition in the SEE region posing challenges for both the employment and the health dimension. Accelerated population aging has been observed in the region throughout the past six decades, with an increased median age, rising life expectancies and a simultaneous fall of fertility rates by more than half

⁷ Short version: (I) Increase SEE average GDP per capita relative to the EU average; (II) Boost total SEE trade in goods and services; (III) Reduce SEE trade deficit (1, page 5).

(from 3.55 children per childbearing woman in 1950 to 1.49 in 2010). The percentage of population aged 65 or older has doubled in the same period (from 7 to 14 per cent) as well as the old-age dependency ratio (from 10.6 to 20.9). The effect of the demographic transition on health systems consists of an increasing demand through more old-age related health care needs; the employment dimension will have to address the increasing gaps in labour, while social security systems have to struggle with the decrease of the potential support ratio. The countries in the SEE region will have to respond to these developments with complex and integrated socioeconomic and health policies (29).

The SEE Health Network has developed the health dimension for the SEE 2020 strategy (12). This section of the SEE 2020 strategy has been based on the SEEHN policies expressed in the Skopje (2005) and Banja Luka (2011) Pledges, the findings and recommendations of four SEEHN studies (3,4,30,31), the national health and health systems policies, strategies and action plans of all SEEHN member states and, finally, on their cross-country analysis. A brief description of the situation within the SEE 2020 acknowledges the significant progress in health care in the region while pointing to several challenges. Among the common health challenges identified in the region, inequalities within and between countries are a priority concern. Health systems in the region have been described as still being inefficient with common weaknesses including the lack of effective access to health services; inadequate financing of health systems, but also inefficient use of available resources; fragmentation of health services; deficiencies in quality of care; inefficient management; low capacities of the health workforce and significant internal and international migration. In terms of public health needs, the burden of non-communicable diseases also suggests a lack of effective health promotion policies and preventive health services (1, page 27).

In order to achieve the set objective of improving health and wellbeing of all people living in the SEE region, four key strategy actions have been set:

- i) Strengthen the delivery of universal and high-quality health-promoting services. Policies for improving the health status focus on low-income and vulnerable groups.
- ii) Strengthen and improve the intersectoral governance of the health sector at all levels, including the health information structure and enhancing regional information exchange.
- iii) Harmonise public health and public health services legislation, standards and procedures across countries in the region. This includes developing mutual recognition and trust to enable the creation of a Free Trade Area from a public health perspective.
- iv) Strengthen human resources in the health sector, harmonise qualifications of health professionals in the SEE region and monitor health workforce mobility.

Table 1 summarizes the objective, key strategy actions and activities, projects or instruments for implementation of the SEE 2020 health dimension.

The responsible actors for implementation of the Health Dimension consist of the Ministries of Health at national level and the SEE Health Network at regional level.

Table 1. Overview of the SEE 2020 Strategy, Dimension Health
(Source: Regional Cooperation Council. *SEE 2020 Strategy, pages 28-29 and 50-51*)

Objective: Improve health and wellbeing of all those living in the SEE region	Timeframe
<p>1. Strengthen the delivery of universal and high-quality health-promoting services at all levels of care</p> <ul style="list-style-type: none"> • Adopt and implement a regional model for delivery of universal and high-quality health, promoting services at all levels of care with an emphasis on a strong primary care sector for improving the health gain in the SEE region, with a particular focus on low-income and vulnerable groups; • Develop a baseline cross-country study on the efficiency of health systems and services; • Update current health service legislation and regulations related to health care, disease prevention, health promotion and patient safety; • Develop and implement quality improvement mechanisms; • Introduce efficient monitoring and evaluation mechanisms in the region's health systems to improve transparency and accountability. 	2015–16
<p>2. Strengthen and improve the intersectoral governance of the health sector at all regional levels. Adopt regional exchange mechanism for sharing experiences and good practices</p> <ul style="list-style-type: none"> • Strengthen health institutions and improve the intersectoral governance of the health sector at national, regional and community levels following the Health in All Policy (HiAP) approach; and including capacity building for health information infrastructure and introducing e-health; • Adopt a regional information exchange mechanism for sharing experiences and good practices in cross-border public health, health care and mobility of health workforce; • Review the current networks of health institutions and develop reform strategies; • Review and update the existing health legislation in order to introduce HiAP and HIA; • Implement best practice from EU countries when introducing mechanisms for the intersectoral governance of health; 	2015–16
<p>3. Harmonise the cross-border public health legislation and enable a Free Trade Area from a public health perspective</p> <ul style="list-style-type: none"> • Adopt multilateral and bilateral agreements to harmonise the cross-border public health and public health services legislation, standards, procedures and develop mutual recognition and trust to enable the creation of a Free Trade Area from a public health perspective; • Develop mutually agreed regional public health cross-border standards and procedures; • Develop and launch an SEE regional information database on cross-border public health issues and best practice. 	2020
<p>4. Adopt multilateral and bilateral agreements to strengthen human resources for health, harmonise and mutually recognize health professionals' qualifications</p> <ul style="list-style-type: none"> • Adopt multilateral and bilateral agreements to strengthen human resources for health, harmonise and mutually recognise health professionals' qualifications and monitor the human resources for health and their mobility; • Review the current situation on forecasting and planning in respect of the health workforce, as well as on harmonising and mutually recognising the qualifications and mobility of health professionals; • Establish a permanent SEE forum for health education institutions; • Establish a regional Masters programme for public health based on EU public health curricula. 	2016

Discussion

Notwithstanding the time gap of nearly ten years and the different context of their development histories, the commonalities between the two regional health strategies described above are significant. This may be owing to the common spirit in which they have been created with shared values of equity, social justice, and health as a human right as

underlying principles. Another reason emerges when comparing the two situation analyses pointing to a number of persisting common problems and weaknesses, including health inequalities within countries and across the region as a primary concern. The aim to address these problems being the basis for the selection of strategic goals and implementation action may explain some of the similarities between the two strategies.

In 2004, the experts of PH-SEE were convinced that a regional public health framework would underscore the critical role of public health for the socioeconomic development and its implementation would help enhancing social stability and peace in the region. While in 2004 it was acknowledged that the health of populations was an important factor in economic development (18,32), the potential of public health as active supporter remained underestimated. Similarly, in the context of SEE 2020, the SEEHN refers to health and wellbeing as a determinant as well as a contributor to peace and economic development (12). The integration of health as part of the economic growth strategy SEE 2020 reflects indeed an important paradigm shift towards the full recognition of health as a contributor to economic growth as highlighted by SEEHN (5).

Both regional strategies underline the commitment to EU and WHO Regional Office for Europe policies in the area of health as well as the intention to complement national health policies and support the collaboration between countries in the region to address issues of mutual interest in national health policies aiming for harmonization of policies and standards. Regardless the differences in structure and wording, both strategies are consistent in the majority of their goals and strategy actions. Major consistent objectives include:

- i) Improving equity in health with a focus on vulnerable and low-income groups, hence improving health for all;
- ii) Strengthening human resources for health and public health, respectively;
- iii) Strengthening and improving intersectoral cooperation and governance.

Within those consistent goals, partially different priorities and approaches reflect the time-gap and the variety of contexts.

i) Improving equity in health

In 2004, reducing inequalities in health and in access to quality health care within and between the countries in the region was a top priority. At that time, political changes, economic breakdowns and war had resulted in the deterioration of the overall population health status, affecting most the vulnerable groups. A special challenge for some SEE countries in that period was the situation of internally displaced persons and refugees; those living in conflict areas under the stress of insecurity and violent threats; and those considered as ethnic minorities. These groups were considered vulnerable in terms of social exclusion and deprivation from resources influencing health such as income, education and healthy living conditions. Despite the progress made to date, health inequalities within and between the countries remain of high concern; assisting governments in reducing poverty and health inequalities is the declared aim of the SEE 2020 Inclusive Growth pillar. The health objective in this regard is to ensure universal quality health services focusing on access for vulnerable groups.

ii) Strengthening the health workforce

The concern of insufficient numbers and capacities of the health workforce has been addressed in both strategies, regardless of different perspectives. The PH-SEE framework emphasized the strengthening of the public health workforce capacities and status within the overall health workforce. In 2004, the emergence of the holistic approach to public health

was not mirrored in the public health workforce in SEE. The existing body of knowledge, institutions and professionals focused on the bio-medical aspects of public health and was complemented by the existing expertise in social medicine; however, the need for integrative approaches and inter-professional collaboration was evident. In the context of SEE 2020, low capacities of the health workforce have been indicated as one of the persisting weaknesses. Under the objective of strengthening the health workforce, the cross-border aspect is emphasized. Mobility has been mentioned in the 2004 Framework Strategy, but the emphasis of this aspect in SEE 2020 reflects the current situation characterized by significant international migration of health workers. General trends of health professional mobility flows from Eastern to Western Europe have been persisting throughout the past decade with peaks following the EU enlargement, though at more moderate levels than expected, and with varying magnitude across countries depending on their health labour markets (33,34). On the one hand, health professional mobility is being facilitated in the context of EU policies, through harmonization and mutual recognition of qualifications; on the other hand, the intention is to improve the management of the mobility through monitoring and bilateral and multi-lateral agreements to mitigate adverse effects of outflows from vulnerable health systems that already experience workforce shortages as well as protecting migrant health workers. Both regional public health strategies commonly aim for enhancing the regional professional collaboration in the area of education through harmonisation of curricula and a common forum of health education institutions. SEE 2020 further aims at establishing a regional Public Health Masters programme based on the EU public health curricula. Here is certainly an opportunity for enhanced collaboration between the two networks FPH-SEE and SEEHN as most of the SEE countries have already implemented the three cycles of the Bologna process including master programmes in public health. Both strategies focus on the qualification and performance aspects regarding the health workforce while the importance of employment opportunities and decent working conditions in the health sector have been mentioned only marginally. Yet, health provider performance and quality of care are linked with enabling and supportive work environments (35). In the context of the SEE 2020 strategy, the health sector is also economically important in terms of its potential for employment creation, with a view to the increasing demand for health services in times of demographic transition.

iii) Improving intersectoral collaboration

The progress made in the past ten years is particularly evident in the aspect of achieving the integration of health across all sectors. Intersectoral collaboration has become more commonly accepted with the appearance of the health impact assessment in the context of the health promotion movement. While the 2004 Strategy Framework (modestly) aimed at establishing the involvement of public health in the programmes of non-health sectors, the SEE 2020 aims to implement the integrative approach of “Health in All Policies” (HiAP). In 2004, there was already recognition that most of the determinants of health were outside the sphere of influence of the health sector. However, at that time, the awareness of health impact of actions undertaken in other sectors was limited and neglected in practice in the SEE region. Regular and institutionalized mechanisms of intersectoral cooperation needed to be developed and established in the region in order to promote the protection of health. Such integrative and intersectoral approach, while recognized and promoted since the Alma Ata Declaration on Primary Health Care (in 1978) has only later been labelled as “Health in All Policies” (HiAP), more specifically in the EU during the second Finnish EU Presidency in 2006 (36). In parallel, methods of Health Impact Assessment (HIA) have been developed and

implemented. Furthermore, the WHO Europe framework health policy “Health 2020” develops and recommends the whole-of-government and whole-of-society approaches that were endorsed by all ten SEEHN Members States during the WHO Europe Regional Committee Session in 2012 in Malta (37). The SEE 2020 strategy takes advantage of these developments and includes in their objectives to “*review and update the existing legislation in order to introduce HiAP and HIA*” (Table 1, action 2). HiAP and HIA reflect the important influence of health within the policies of other sectors in the overall SEE 2020 strategy and offers new opportunities for public health intersectoral collaboration. SEEHN has been mandated to monitor the health impact of the SEE 2020 implementation and has ensured that health targets and indicators incorporate prevention and health promotion within the HiAP approach, social determinants of health and inequalities (5).

In addition to the obvious commonalities, there are also apparent differences between the two strategies that are reflected in a number of objectives and issues without matching counterparts. Nevertheless, some of those aspects can be found as elements or indirect intentions in the other strategy.

- ***Social participation***

The 2004 framework for a regional public health strategy emphasized the importance of strengthening social participation in public health and in decision-making processes. It referred to the Alma Ata Declaration on Primary Health Care (PHC; 1978) and the Health For All Strategy (HFA; 1981) policies promoting public participation in health policy development. It further pointed to the responsibility and accountability of all as a prerequisite for sustainable health development, which required the involvement of all stakeholders in health policy and action, including communities. The concept of social dialogue had been suggested as a means for inclusive development processes in the health sector (38). The emphasis of social participation in the 2004 Framework Strategy may be explained by the historical context and situation at that time, influenced by the aftermaths of a war and in light of the political and socioeconomic instabilities in transition countries. Developing trust between people and nations was seen as a priority at a time when SEE countries were perceived as fragile and the rapid changes involved socio-cultural incoherence. Nevertheless, while social or community participation is not explicitly mentioned in the SEE 2020 health dimension, it emphasizes Primary Health Care and seeks to improve transparency and accountability. Both aspects take into account the community level and population interface with the health service delivery, with the aim to build up resilient communities.

- ***Regional public health information***

Improving regional public health information and knowledge was one of the priorities and strategic goals in the 2004 framework strategy as well as one of the seven objectives of the SEEHN Dubrovnik Pledge. The health information systems at that time were considered inefficient and compounded by the ineffective use of the information in shaping health policies. The set objectives included establishing a regional public health information system and developing mechanisms for reporting and analysis at regional level with a view to improving the level of public health knowledge among professionals, decision-makers and the public. The objective referred to the Dubrovnik Pledge with its commitment to “*establish regional networks and systems for the collection and exchange of social and health information*” (16). Within the SEE 2020 health dimension, information systems appear less prominently and in a different way. A reference is found under the objective of cross-border harmonization where the “*development and launch of a SEE regional information database on cross-border public health issues and best practice*” is one of the planned activities (Table

1, action 3). While the establishment of health information systems in the SEE region has advanced following the commitment of the Dubrovnik Pledge, it is still “work in progress”. Thus, strengthening health information systems in the SEE region continues to be an important priority, as recognized by the Ad-hoc Meeting of the SEE Ministers of Health, 22 June 2015, in Belgrade, Serbia (39).

• **Cross – border public health**

The SEE 2020 strategy includes cross-border public health as a new aspect that is not reflected in the 2004 framework. The strategy action aims at harmonizing cross-border public health legislation and to enable a Free Trade Area from a public health perspective (Table 1, action 3). To this end, multilateral and bilateral agreements shall help in harmonizing standards and procedures and, moreover, in the development of mutual recognition and trust to enable a public health free trade area. In 2004, the idea of a SEE regional free trade area was not foreseen given the instable situation in the region at that time.

• **Quality improvement**

SEE 2020 explicitly addresses quality improvement of health services delivery. It aims at exploring the efficiency of health systems with a baseline study and establishing a sustainable quality management system. The aspect of quality management is missing in the 2004 strategy while it implicitly forms an underlying principle.

Conclusions

Despite the time lag of nearly ten years, the commonalities of the two strategies for regional public health collaboration are significant. Many aspects addressed in the 2004 framework are pertinent with regard to the SEE 2020 health dimension; therefore, the main parts of the 2004 framework strategy are still relevant in the current context. The differences between the two regional strategies are partially due to the different development context, not only in terms of the different situations in the SEE region in 2004 and 2013, respectively, but also in terms of different angles: the 2004 framework strategy was developed from within the health system perspective by public health professionals, whereas the SEE 2020 strategy has been developed at a political level and implies consequently a different perspective on the issues at hand.

Collaboration between the two networks FPH-SEE and SEEHN particularly in the area of public health education could be of mutual benefit, with a format still to be agreed upon though. Similarly, collaboration between the two networks could further strengthen the improvement of regional health information. The integration of health in the SEE 2020 strategy with the HiAP approach opens opportunities for health influencing socioeconomic development policies. This paradigm shift is an important step forward for public health.

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