
Measurement of and target-setting for well-being: an initiative by the WHO Regional Office for Europe

Second meeting of the expert group
Paris, France, 25–26 June 2012





**World Health
Organization**

REGIONAL OFFICE FOR **Europe**

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ABSTRACT

A second expert meeting on measurement and target-setting for well-being was held in Paris, France in June 2012. Its overarching aim was to provide advice for the WHO Regional Director for Europe on how to assist in setting targets on well-being, which is one of the overarching targets of the European Health 2020 policy. The meeting reviewed previously commissioned work on measuring well-being and on its definitions, concepts and domains; advised WHO on the definition and concept of well-being to be used in the context of Health 2020; and determined what work was required to develop well-being indicators and targets. The meeting also agreed a working definition: 'Well-being exists in two dimensions, subjective and objective. It comprises an individual's experience of their life as well as a comparison of life circumstances with social norms and values'.

Keywords

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Executive summary

The second expert meeting on measurement and target-setting for well-being was convened by the World Health Organization Regional Office for Europe, and hosted by the Organisation for Economic Co-operation and Development, Paris, France, 25–26 June. Building on the first expert group meeting held in Copenhagen, 8–9 February 2012, it provided further advice to WHO on developing a common concept and approach to well-being that allows for effective measurement and potential regional targets for the Regional Office for Europe’s Health 2020 policy and the next European health report.

The meeting reviewed previously commissioned work on measuring well-being and on its definitions, concepts and domains. There were many different ways of seeing well-being, founded on incompatible ideas about the basic nature of well-being, and with different ideas of how knowledge about them could be gained. The first issue was to clarify these concepts and their underlying assumptions. Although discussion on well-being has increased in recent years, there is no consensus on what indicators to use.

The group considered which conceptual approaches to adopt, how to address the related measurement issues, and what definition of well-being to use. The following areas of agreement were reached.

- Well-being is multidimensional.
- Health contributes to well-being and well-being contributes to health.
- Well-being can be seen as a concept and entity in itself (with health as both a determinant and an outcome), and as a composite of various elements.
- General well-being includes objective and subjective elements.
- For the explicit purpose of setting targets, the WHO Regional Office for Europe should describe well-being using both elements.
- The Regional Office for Europe needs to consider reporting subjective well-being, and countries should begin to collect such information.

The meeting then proposed a definition of well-being for use by WHO: *Well-being exists in two dimensions, subjective and objective. It comprises an individual’s experience of their life as well as a comparison of life circumstances with social norms and values.*

The experts agreed 13 measurement or indicator principles, in agreement with the principles proposed for European health indicator definitions. Finally, it produced a roadmap for action. Some issues were identified that needed addressing: formulating a conceptual and operational framework; thinking about how to present well-being outcomes; formulating what differentiates this well-being concept from health-related quality of life; and encouraging the interest of Member States in the dimensions of well-being.

Next steps were also agreed for the measurement of well-being. They included continuing to map instruments, indicators and practices for measurement of well-being. Work should be commissioned to understand various strands better, including the links between health and well-being, and the use of other terminology (e.g. health-related quality of life). Stakeholders and policy uses of indicators for well-being should be identified, including policy levers for ministries of health.

Based on the results of these actions, an operational framework should be proposed to measure and set targets for well-being, including options to support Member States with different data and measurement starting points. These elements should be synthesized and interim guidance sought from Member States. The work would ideally be finalized for submission to the sixty-third session of the WHO Regional Committee for Europe in 2013.

Introduction

The second expert meeting on measurement and target-setting for well-being was convened by the World Health Organization Regional Office for Europe. Participants (listed in Annex 1) were welcomed by Dr Claudia Stein, Director of the Division of Information, Evidence, Research and Innovation, on behalf of the Regional Director. Dr Peter Achterberg was confirmed as chair of the meeting and for the remainder of the initiative, and Dr Coen van Gool was elected meeting rapporteur. The meeting agenda and programme were adopted unchanged (Annex 2). No conflicts of interest were declared.

The OECD Statistics Directorate hosted the meeting. Its director Dr Martine Durand welcomed participants, and explained its interest in how well-being trends and averages, and deviations between countries and population groups, could provide input to policy-making by countries. The OECD Better Life Initiative (1) focuses on people rather than economies, and on outcomes such as health rather than spending.

The aims of the meeting were to:

- review previously commissioned work on measuring well-being and on its definitions, concepts and domains;
- advise WHO on the definition and concept of well-being to be used in the context of Health 2020;
- agree the work required to develop well-being indicators and targets, mindful of the work already done by the expert group on indicators for Health 2020.

It was expected that the outcomes of the meeting would assist in setting targets on well-being. To ‘enhance well-being of European populations’ is one of the overarching targets of the European Health 2020 policy for health and well-being (2). This focuses on health and well-being, the right to health and access to care, and the determinants of health. It is people-centred and combines a whole-society approach with a whole-government approach. Its targets will be measured using indicators, and the work on selecting them is nearly complete. Assuming the policy was adopted by the 2012 WHO Regional Committee for Europe, indicator development would start immediately afterwards.

Outcomes of the first expert group meeting

Participants were reminded of the outcomes of the first meeting of the expert group held in Copenhagen, Denmark, 8–9 February 2012 (3). This concluded the following.

- Any definition of well-being should be conceptually sound; draw on existing work such as the models developed by the OECD and the Australian Unity Well-being Surveys; and aim for maximum coherence with other approaches at international level.
- WHO should focus on its central mandate of health, while being clear about how this fitted into the wider concept of well-being. Thus it should concentrate on advances in measurement of the health and health-related aspects of well-being, and how this information was useful to policy-makers and health professionals.
- Linked to this, the overall approach to health and well-being should take account of the two-way relationship: health influences overall well-being, but well-being also influences future health.

The expert group's work highlighted the importance of the various approaches to well-being, and their differences. Some objectivity in the definition of well-being was needed, to assist political leverage that would prompt governments to action.

Defining and contextualizing well-being

Follow-up work had been requested to clarify concepts, definitions and measurement of well-being. Mr Nick Fahy presented an overview of the issues, for discussion and agreement on how to conduct more detailed work. His paper (4) was based on the meeting inputs; a literature review on the measurement of well-being; and literature collected by the National Institute for Public Health and the Environment, The Netherlands, in its overview of measurement of well-being in Europe. A summary of the paper follows here.

Concepts of well-being

The Oxford English dictionary defines well-being as 'the state of being comfortable, healthy, or happy'. Despite the lack of a more precise definition, the term is often used in the academic literature, frequently in a way that echoes the WHO definition of health as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'. It has the sense of reflecting something about a person's overall state of being, beyond more narrow or specific measures. It is sometimes specifically linked to mental/psychological health, though the general usage is in the sense of a broader concept.

Not only are there many different ways of seeing well-being, but these approaches are founded on incompatible ideas about the basic nature of 'well-being' (its ontology), with different ideas of how knowledge about them can be gained (epistemology). The first issue in defining well-being is to clarify these different concepts and their underlying assumptions.

One approach is to see well-being as a composite or collection of different building blocks. This approach is taken in current work that has developed from more traditional measures such as income or gross domestic product. It typically draws on an objective epistemology, using measurement tools and indicators such as income, educational level and mortality rates. Health is seen as a component of the overall composite of well-being.

The other main approach is to see well-being as a concept in itself. This ontological approach is typically linked to a subjective epistemology, with knowledge about well-being gained through people's own perceptions. This combination of ontology and epistemology is often referred to as 'subjective well-being'. In this approach health is seen as a determinant of well-being; low subjective well-being is linked to certain aspects of health and illness.

Measurement issues

Each of these approaches leads to different measurement methods, each with its own issues to consider. When well-being is seen as an objectively measured construct, for example by OECD and the United Kingdom, it requires an overall approach using a combination of different measures of health and other factors such as income, education and family life. This may mean devising new measures, or more simply reusing existing measures. Although discussion on well-being has increased in recent years, there is no consensus on what indicators to use.

How health is measured in this approach depends on what health indicators are included in the overall composite of well-being; the overall approach; and practical data availability. As with well-being in general, there is no consensus on which health measures to use, and a multitude of different options. Pursuing this option would need substantial technical work.

How can a relevant composite be defined for WHO? Assessing what exactly to include (and if weighted, how to weight it) is technically a complex process, and politically sensitive. If such a composite focuses only on health, it will not reflect evidence on a much broader range of factors affecting well-being. If it ranges widely beyond health, it may be difficult to defend why it is specifically the concern of WHO. It is also not clear how to set targets in this approach.

The approach that regards well-being as a subjective concept in practice means asking people about their perceptions of well-being. There are three established ways of doing this.

1. Ask a single question about life satisfaction.
2. The Satisfaction with Life Scale (5) takes a similar approach but asks five questions and sums the responses. These questions do not relate to different domains, but attempt to overcome the risks of over-specific understandings of an individual question.
3. The Personal Wellbeing Index (6) is based on questions about eight different areas of life. Its advantage is that it provides data on how different dimensions of life affect well-being.

This approach does not require specific measures of health to support it. Existing health measures can be used alongside it to create an overall picture. Yet it is not straightforward either. If well-being is separate from health, why should this be a concern for WHO?

There are also technical issues, as follows.

- As to *adaptation and habituation*, there is evidence that people's subjective well-being can adapt to their circumstances; for example, objectively poor conditions do not necessarily show up as low subjective well-being. This is particularly relevant for long-term health conditions. Hence it is important to consider well-being alongside objective health measures.
- There is *variation between countries*. There is evidence that people's responses on subjective scales may be systematically different in different cultures. There is also evidence that subjective well-being linked to particular health conditions (e.g. obesity) may be mediated by different social norms linked to those conditions. The extent to which between-country comparisons can be made using such indicators therefore needs further investigation.
- There is *variation between income groups*. There may be systematic variations in subjective well-being between income groups, with subjective well-being perhaps mediated by social expectations.

This approach likewise raises challenges about how to set regional targets for well-being.

Then there is the question of how well-being itself affects health. There is some evidence that people with higher well-being scores also have better health outcomes in general, though causality is always hard to establish. Evidence also suggests a more specific link, in particular that low subjective well-being can lead to depression. This area needs more investigation, however.

Selecting an approach

Fundamental conceptual issues must therefore be considered before addressing questions about indicators and methods. In choosing between these approaches, it is important to keep the ultimate aim of this process in mind. If WHO integrates the measurement of well-being in the Health 2020 strategy for the European Region, its approach must be meaningful to Member States.

The health community might care about well-being precisely because of what the original WHO definition of health sought to capture – not merely an absence of problems, but something more. This has been expressed through the growing recognition that clinical and observable outcomes are not the only ones that matter. The health community increasingly recognizes the importance of pain, discomfort and other subjective states, and the wide variety of mental health issues which, although diagnosed externally, depend on patient-reported states and information.

This is where the concept of well-being is relevant, specifically the focus on subjective well-being, because it adds value by capturing precisely those aspects that traditional and objective health measures do not. This also responds to the question why well-being should be a particular concern of WHO. The adverse outcomes where the lack of well-being manifests itself are health outcomes – depression and mental ill health. Therefore it is important for the health community to measure well-being, specifically subjective well-being, because health systems are a principal agency dealing with the consequences of poor well-being.

This focus on the practical concerns of ministries of health can also assist the choice between different measurement scales for subjective well-being. Using a method like the Personal Well-Being Index provides a basis for substantive engagement with other sectors about the factors undermining well-being that, if not acted on, cause harm that the health system will have to deal with. Measuring well-being in this way can provide substantive evidence about the problems in each country, and what help from outside the health sector is needed to address them. Moreover, using the term ‘well-being’ rather than ‘health in all policies’ provides a shared common objective that can be agreed across government. It avoids the perception that the health community is asking other sectors to act for health objectives rather than shared ones.

Key issues for the expert group

Mr Fahy concluded that the precise definition of well-being that the expert group recommended would depend on the choice of conceptual approach. It would effectively reflect the ontology and epistemology; to an extent, they would constitute the definition. The key issue was rather how well-being could be understood and measured in a way that added value to existing indicators.

The key issues for the expert group to consider were:

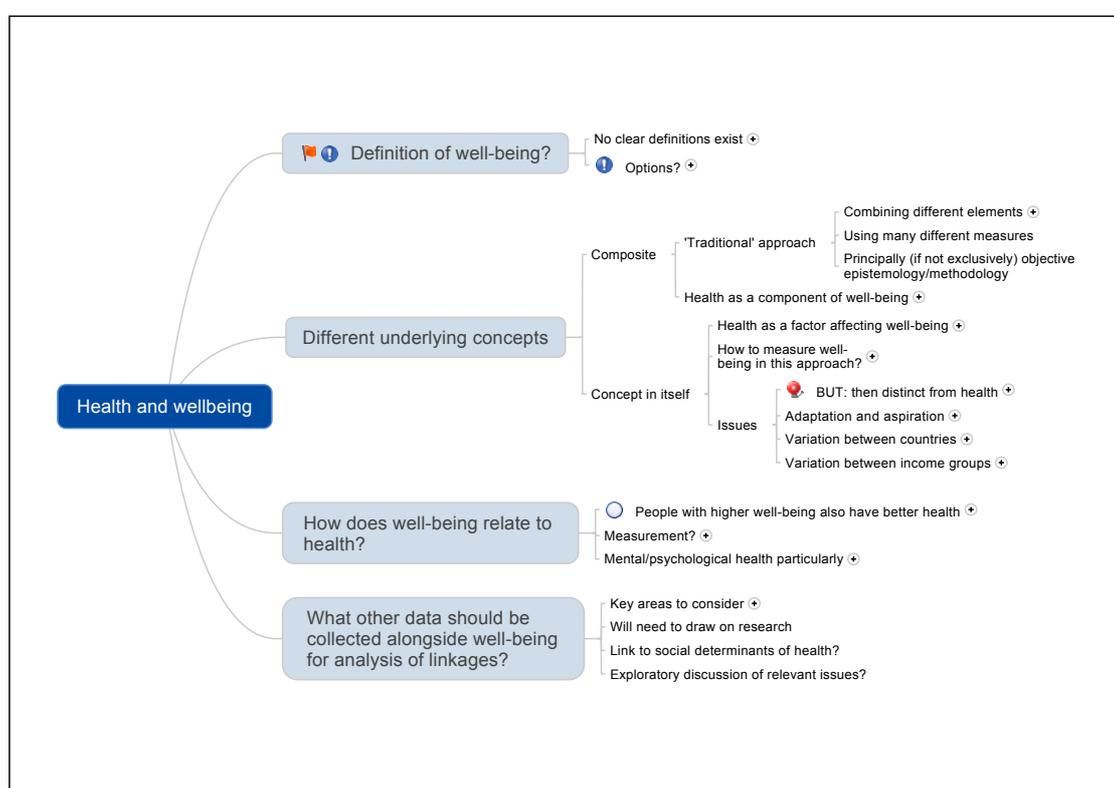
- which conceptual approaches to adopt;
- how to address the related measurement issues in each approach;
- once decided, what definition of well-being to use.

Further work would then be needed to refine the chosen approach, and devise an implementation plan. Mr Fahy used a mind map based on his paper to stimulate discussion (Fig. 1).

The dimensionality of well-being and its relation with health were debated, with two points emerging.

- The dimensions along which well-being is conceptualized are represented mostly by proxy measures, for example actual social participation as an approximation of disability. Furthermore, when choosing indicators the level of attribution should be clear, acknowledging the difference between – for example – measuring population health status and measuring the health status of individuals (comparable to the discussion on distal versus proximal, objective versus subjective, or using economically driven or psychologically driven variables).
- While remaining mindful of the WHO definition of health, it should not impede or limit the definition of well-being, which enables a multidimensional conceptualization of it. Nevertheless the initiative should acknowledge the interaction between (mental) health and well-being, while not needing to disentangle them or how they relate to quality of life. Defining well-being in a broad, general way might not provide enough leverage to encourage countries to formulate well-being policies.

Fig. 1. Conceptual overview of health and well-being (4)



Most participants agreed that well-being was multidimensional; it could carry both objective and subjective elements (that can be measured both objectively and subjectively); and there were interactions between health and well-being.

Measuring subjective well-being

Mr Conal Smith outlined OECD's work on measuring subjective well-being (1). There was a growing body of knowledge about how best to measure subjective well-being, but different bodies used widely different questions. Wording questions differently produces different results, undermining effective comparisons. An expert group convened by OECD is preparing guidelines to minimise these problems, for release early in 2013. They cover conceptual issues (What do we

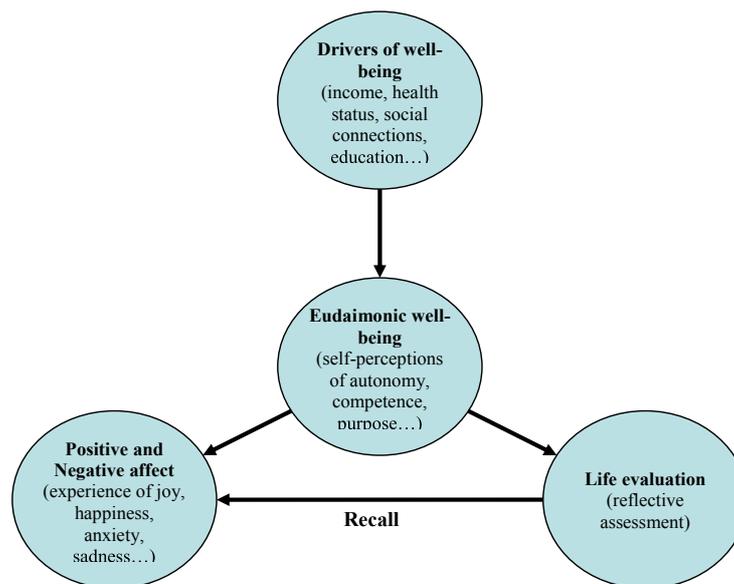
mean by subjective well-being? Why measure subjective well-being?), and technical issues in measuring subjective well-being (To what extent can subjective measures be made comparable? Managing respondent burden).

The guidelines will provide a standard set of prototype questions, a small set of core questions to form the basis of standard comparisons, and a more extensive set to support more detailed analysis. They will also cover survey issues (Which survey vehicles are most appropriate? Where should questions be placed in a survey? What analytical variables should be collected at the same time?), and output and dissemination.

The key element of the OECD definition of subjective well-being is that the concept itself is subjective, not merely the measurement approach (i.e. there can be subjective measures of objective concepts, although they will not be covered in the guidelines). Subjective well-being comprises all the various evaluations, positive and negative, that people make of their lives and the affective reactions of people to their experiences.

Conceptually OECD's subjective well-being contains three distinct concepts: life evaluation, affect (positive and negative) and eudaimonia (Fig. 2).

Fig. 2. The OECD conceptual framework for subjective well-being



The ensuing discussion elicited the following areas of agreement among participants.

- Well-being is multidimensional.
- Health contributes to well-being and well-being contributes to health.
- Well-being can be seen as a concept and entity in itself (with health as both a determinant and an outcome), and as a composite of various elements.
- General well-being includes objective and subjective elements.
- For the explicit purpose of setting targets, the WHO Regional Office for Europe should describe well-being using both elements.
- The Regional Office needs to consider reporting subjective well-being, and countries should begin to collect such information.

Some participants thought some current indicators pointed at well-being, but others wanted another specific indicator. Some said both were needed: a specific measure for (subjective) well-being, measured at the individual level by a single question or a specific questionnaire. There should also be a selection of indicators that point at well-being of societies and relate to health.

Proposed WHO definition of well-being

After further debate, the meeting proposed the following definition of well-being for use by WHO: **Well-being exists in two dimensions, subjective and objective. It comprises an individual's experience of their life as well as a comparison of life circumstances with social norms and values.**

This definition says that well-being and health are interactive concepts with some common determinants, such as health and social systems. Health influences overall well-being, yet well-being also affects future health. Across countries people usually agree on the minimum ingredients of well-being (the 'big picture'), even if the identification of important areas or components remains a normative exercise. Examples of life circumstance include health, education, work, social relationships, built and natural environments, security, civic engagement and governance, housing and work-life balance. Subjective experiences include a person's overall sense of well-being, psychological functioning and affective states.

The meeting also agreed measurement or indicator principles, in agreement with principles proposed for European health indicator definitions, as follows.

- Approaches to the measurement of well-being should aim to maximize coherence between international organizations.
- Information will be required for subjective and objective well-being.
- Information used to describe well-being should be based where possible on routinely collected and reported data.
- Indicators must have a clear normative interpretation; a change in an indicator can therefore be interpreted as an improvement or deterioration of well-being.
- Indicators should be selected on the basis of their availability for most countries, and be collected in international data collection efforts.
- The final number of indicators should be kept to a minimum.
- The list of indicators will not be able to reflect all relevant policy areas in a balanced way, because of availability and comparability issues.
- Some indicators may serve several targets.
- Data submitted to WHO for this purpose should ideally be accompanied by meta-data.
- Indicator data should be reported disaggregated where possible (i.e. by age, gender, ethnicity, socioeconomic strata, vulnerable groups, subnational); this will be subject to data availability and may vary according to the specific indicator.
- A set of core (Level 1) and expanded (Level 2) indicators is needed. Level 1 would be a basic minimum to facilitate regional-level assessments. Voluntary reporting on Level 2 indicators should be encouraged, to inform national target area evaluations.

- Core indicators need to be comparable across the Region as they will be used for regional target monitoring, while other indicators used at national level require only 'internal' comparability.
- Countries may report on indicators with qualitative information, when quantitative information is not available.

Road map for action

Some issues were identified that needed addressing through an action plan:

- formulating a conceptual and operational framework;
- thinking about how to present well-being outcomes;
- formulating what differentiates this well-being concept from health-related quality of life;
- encouraging the interest of Member States in the dimensions of well-being.

Next steps were agreed for the measurement of well-being.

1. Capitalize on the ongoing literature review and continue to map instruments, indicators and practices for measurement of well-being (including those in preparation); identify measurement challenges.
2. Commission work to understand various strands better, including the links between health and well-being, and the use of other terminology (e.g. health-related quality of life).
3. Identify stakeholders and policy uses of indicators for well-being, including policy levers for ministries of health.
4. Based on the results of actions 1–3, propose an operational framework to measure and set targets for well-being, including options to support Member States with different data and measurement starting points.
5. Synthesize elements 1–4 and seek interim guidance from Member States.
6. Ideally, finalize work for submission to the sixty-third session of the WHO Regional Committee for Europe in 2013.

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Annex 2. Agenda

Monday, 25 June 2012

Session 1 – Update on progress with well-being work

Purpose, objectives and expected outcomes of the meeting (WHO Secretariat)

Short update on progress with Health 2020 (WHO Secretariat)

Outcomes of last meeting and recommendations (Nick Fahy)

Agreeing the questions and outputs of this meeting

Defining time lines for delivery

Session 2 – Introduction to concepts, frameworks, and definitions of well-being and their link to health

Results of the review (Nick Fahy)

Which concepts, frameworks, and definitions are most useful for the work of WHO?

Recommendations to WHO for concepts to be included in the European health report 2012 and framework for Health 2020 targets

Session 3 – Measurement strategies and indicators for well-being

OECD guidelines on measuring subjective well-being (Conal Smith, OECD)

Policy use of well-being indicators (Carrie Exton, OECD)

What lessons can WHO draw from this analysis?

Which measurement options are the most relevant for WHO?

Tuesday, 26 June 2012

Session 3 – (Continued) Measurement strategies and indicators for well-being

Can agreement be reached on measurement strategies and indicators for well-being? If not, what steps are necessary to achieve this?

Do the discussions so far elicit next steps for target setting for well-being?

Make recommendations to WHO for next steps on this item.

Session 4 – Roadmap for action on well-being

Overview of time frames for Health 2020 and European health report (WHO Secretariat)

Recommend a detailed roadmap to WHO for measurement and target-setting for well-being

Identify areas of agreement for presentation to Member States at Regional Committee

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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Bulgaria	Republic of Moldova
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