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**HEALTH SYSTEMS FOR HEALTH AND
WEALTH IN THE CONTEXT OF HEALTH 2020:
FOLLOW-UP MEETING ON THE 2008**

TALLINN CHARTER

Tallinn, Estonia, 17–18 October 2013

Cover photo:

The Old Raeapteek (Town Pharmacy) and traditional house on Raekoja Plats (Town Hall Square) in Tallinn.

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EXECUTIVE SUMMARY

A WHO/Europe high-level meeting on Health systems for health and wealth in the context of Health 2020 (a follow-up to the 2008 WHO European Ministerial Conference on Health Systems) was held at the Radisson Blu Hotel Olümpia in Tallinn, Estonia on 17 and 18 October 2013.

In adopting the Tallinn Charter in 2008, Member States in the WHO European Region had taken upon themselves seven commitments:

- promote shared values of solidarity, equity and participation;
- invest in health systems and foster investment across sectors that influence health;
- promote transparency and be accountable for health system performance;
- make health systems more responsive to people's needs, preferences and expectations;
- engage stakeholders;
- foster cross-country learning and cooperation; and
- ensure that health systems are prepared for and able to respond to crises.

In 2012 the WHO Regional Committee for Europe had adopted a new European health policy framework, Health 2020, to address health inequalities and the growing burden of noncommunicable diseases.

The objectives of the meeting were to:

- review the Tallinn Charter and health system strengthening in the context of Health 2020;
- identify key health system challenges and opportunities to tackle Europe's major disease burden;
- share inspiring good practices of ways to strengthen health systems; and
- start the process of agreeing on future directions for health systems up to 2020.

The first plenary session provided an overview of health system strengthening initiatives in the WHO European Region, testifying to the fact that the Tallinn Charter, Health 2020 and the movement towards universal health coverage all shared a common foundation in values such as solidarity, equity and participation. In the second plenary session, participants gave evidence of good practice and innovations in strengthening health systems to accelerate health gains, taking noncommunicable diseases as an example.

Four parallel sessions were held. The first presented successful examples of a variety of models to achieve coordinated/integrated health services delivery (CIHSD). The second session explored health workforce challenges and opportunities arising from the changing burden of disease, new technologies, globalization and the economic downturn. The third session emphasized how strengthening the role of public health was of key relevance in promoting health and reducing inequalities, while the fourth session looked at how eHealth could be used to improve health systems performance.

A breakfast session on the second day of the meeting marked the official launch of the *Roadmap for strengthening people-centred health systems in the WHO European Region* and highlighted opportunities for stakeholders to participate in developing a framework for action towards CIHSD. The third and fourth plenary sessions were devoted respectively to governance (including improved accountability) and financing of health system reforms.

The meeting confirmed considerable enthusiasm for implementing the commitments of the Tallinn Charter, but numerous challenges remained to be faced. The economic and financial crisis continued to have repercussions on health systems, and it was difficult to put intersectorality into practice. On the other hand, the meeting underscored the centrality of patients as front-line workers in delivering their own care and recommended a holistic approach to help them do so. The Tallinn Charter and Health 2020 were synergistic in embodying the same aims, of improving people's health and reducing health inequalities.

INTRODUCTION

1. The WHO high level meeting on Health systems for health and wealth in the context of Health 2020 (a follow-up to the 2008 WHO European Ministerial Conference on Health Systems) was held at the Radisson Blu Hotel Olümpia in Tallinn, Estonia on 17 and 18 October 2013, attended by ministers of health and high-level representatives of Member States, specialized agencies of the United Nations system, and intergovernmental and nongovernmental organizations (for list of participants, see Annex 1).
2. Welcoming participants, Taavi Rõivas, Minister of Social Affairs, Estonia, recalled that in adopting the Tallinn Charter, Member States in the WHO European Region had taken upon themselves seven commitments:
 - promote shared values of solidarity, equity and participation;
 - invest in health systems and foster investment across sectors that influence health;
 - promote transparency and be accountable for health system performance;
 - make health systems more responsive to people's needs, preferences and expectations;
 - engage stakeholders;
 - foster cross-country learning and cooperation; and
 - ensure that health systems are prepared for and able to respond to crises.
3. Measuring health system performance focused attention on health outcomes and was a means to defend and reallocate resources during a financial crisis. Estonia had published its first health system performance assessment report two years after the first Tallinn Conference, in 2010, with WHO support, and was currently working on its second assessment. Five years after the Conference, it was time to take stock of the progress made. He hoped that the present meeting, by giving participants the opportunity to share their experiences of innovative ventures, would enable European countries to further improve their health services and ensure that their health systems were sustainable.
4. Zsuzsanna Jakab, WHO Regional Director for Europe, thanked the Government of Estonia for hosting the meeting. While spectacular health gains had been made in the Region in the past few decades, there were still significant health gaps between and within countries. To address those health inequalities and the growing burden of noncommunicable diseases (NCD), the WHO Regional Committee for Europe had adopted a new WHO European health policy framework, Health 2020¹, which

1 *Health 2020. A European policy framework and strategy for the 21st century*. Copenhagen, WHO Regional Office for Europe, 2013 (http://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf).

emphasized the need for “upstream” interventions such as strengthening public health and ensuring people-centred health systems that were universal, equitable, sustainable and of high quality.

5. Hans Kluge, Director, Health Systems and Public Health, WHO Regional Office for Europe set out the objectives of the meeting:
 - review the Tallinn Charter and health system strengthening in the context of Health 2020;
 - identify key health system challenges and opportunities to tackle Europe’s major disease burden;
 - share inspiring good practices of ways to strengthen health systems; and
 - start the process of agreeing on future directions for health systems up to 2020.

HEALTH SYSTEMS STRENGTHENING IN THE CONTEXT OF HEALTH 2020 AND OTHER RECENT HEALTH POLICY DEVELOPMENTS

6. The first plenary session was chaired by Mariam Jashi, Deputy Minister of Health, Georgia.
7. Zsuzsanna Jakab gave a keynote speech on taking the Tallinn Charter to the next level. The key elements of the Charter were that effective health systems promoted both health and wealth; that investment in health was an investment in future human development; and that well-functioning health systems were essential for any society to improve health and attain equity. Those messages had been reiterated at the first WHO European conference on health systems in times of global economic crisis (Oslo, 2009), at the European Health Policy Forum meeting (Andorra, 2011) and in the European public health action plan². The logic of preserving investment in health systems, even during economic and financial downturns, had again been underscored at the WHO High-level meeting on the impact of the economic crisis on health and health systems, held in Oslo, Norway in April 2013. The ten lessons and recommendations from that meeting had been unanimously endorsed by the WHO Regional Committee for Europe at its sixty-third session in Cesme Izmir, Turkey in September 2013.
8. Those policy milestones had been passed at a time of new and growing health challenges. Total health expenditure as a percentage of gross domestic product (GDP) had risen steadily in all parts of the WHO European Region until the onset of the financial crisis in 2009. Many countries had then had to cut back on their health spending, primarily on preventive programmes, with adverse repercussions on public health (increases in suicides, infectious disease and risk factors). The main drivers of rising costs were the growing elderly population, advances in technology, and increases in NCD and “lifestyle diseases”. The need for comprehensive policies to tackle the social determinants of health was being increasingly recognized, as highlighted in a recent review chaired by Professor Sir Michael Marmot³.
9. Health 2020, which mainstreamed the policy recommendations from the Marmot review, had two strategic objectives: to improve health for all and reduce health inequalities, and to improve leadership and participatory governance for health. It singled out four priority areas for action: investing in health through the “life course”

2 *European Action Plan for Strengthening Public Health Capacities and Services*. Copenhagen, WHO Regional Office for Europe, 2012 (http://www.euro.who.int/__data/assets/pdf_file/0005/171770/RC62wd12rev1-Eng.pdf).

3 *Review of social determinants and the health divide in the WHO European Region. Final report*. Copenhagen, WHO Regional Office for Europe, 2013 (http://www.euro.who.int/__data/assets/pdf_file/0006/215196/Review-of-social-determinants-and-the-health-divide-in-the-WHO-European-Region-final-report-Eng.pdf).

approach; tackling Europe's major disease burdens of NCD and communicable diseases; strengthening people-centred health systems and public health capacity; and creating supportive environments and resilient communities. In the area of health systems and public health, Health 2020 called for attention to be paid in particular to financing, service delivery, resource generation and stewardship (Fig. 1).

Fig. 1

The Tallinn Charter through the Health 2020 lens



10. In response to the Tallinn Charter, countries in the WHO European Region had taken a number of initiatives to strengthen their health systems. Inspiring examples were to be seen of efforts to reinforce solidarity and equity, by moving towards universal health coverage (UHC) and reducing the financial burden on the population; to improve health service delivery, by empowering people to take care of their own health and placing primary care in the “driving seat”; and to enhance transparency and accountability, by focusing on health system performance assessment and feeding back the evidence generated into policy-making, together with greater stakeholder engagement.
11. Three themes would therefore form the background to the ensuing discussions: the changing health needs of the population, the best ways to organize and deliver health services, and the importance of public health and primary health care. The Tallinn Charter and Health 2020 were synergistic, in that they both aimed to inspire countries to act on their values, in order to improve health and wealth; to affirm a value-based approach to strengthening health systems; and to empower health ministries to lead change for health improvement.
12. In the following panel discussion, on putting values into practice, the first speaker was Vytenis Andriukaitis, Minister of Health of Lithuania, the country currently holding the presidency of the Council of the European Union (EU). His country's

priorities during its term of office included drafting and adopting Council conclusions on modern, responsive and sustainable health systems; reaching agreement with the European Parliament on the review of the Tobacco Products Directive and on a regulation on clinical trials of medicinal products for human use; and making maximum progress concerning legislative proposals in the field of medical devices. In each of those priorities, it stressed health as a value that should be reflected in all policies. All the EU member countries shared a common goal of meeting their citizens' health needs, but the existing scientific evidence clearly indicated that the entire structure of contemporary society (and not just the health sector alone) had to contribute actively to that process.

13. Martin Seychell, Deputy Director-General, Directorate-General of Health and Consumers (SANCO), European Commission said that the Tallinn Charter remained applicable because of the fiscal consolidation that had taken place in recent years. The Commission's Annual Growth Survey launching the 2013 European Semester process (and accompanying staff working document on investing in health⁴) had underlined the need for reforms of health care systems, with the twin aims of ensuring access to high-quality health care and using public resources more efficiently. One policy lesson drawn from that analysis was that Member States needed to invest in their human capital and in providing their citizens with adequate services. Characteristics of a resilient health system included stable funding, solidarity (pooling of risks), transparency in flows of information, and an appropriate skill mix in the health workforce. The Commission was working to reinforce health system capacities and sustainability in line with the Tallinn Charter, not only in EU member countries but also in candidate countries and those covered by the European Neighbourhood Policy.
14. Nihat Tosun, Under-Secretary, Ministry of Health, Turkey recalled that, before the start of his country's Health Transformation Program, the health system had faced challenges with regard to accessibility, equity, productivity, health insurance coverage, immunization and primary health care services. A committed high-level management team, with decisive and consistent support from the President, Prime Minister, Cabinet and Parliament, had extended health insurance coverage to the whole population, introduced a performance-based pay system and flexible working hours for health care professionals, and established family medicine as the basis for primary health care. The training of health care professionals had been redesigned, different methods of financing had been introduced for expensive infrastructure investments, and outsourcing arrangements (for high-technology medical devices and services) had been improved. The country's achievement of UHC had been largely due to committed senior managers and clear lines of communication between them and members of the front-line implementation team.
15. Daniel Dulitzky, Health, Nutrition and Population Manager, Europe and Central Asia Region, World Bank said firstly that UHC was both a health and a fiscal issue. Better use would have to be made of existing resources in every country, in order to reconcile the aspirational goals expressed by health policy-makers with the realism expressed by finance technocrats. Second, UHC was a multisectoral issue: health

⁴ *Investing in health*. Brussels, European Commission, 2013 (Staff working document SWD(2013) 43, http://ec.europa.eu/health/strategy/docs/swd_investing_in_health.pdf).

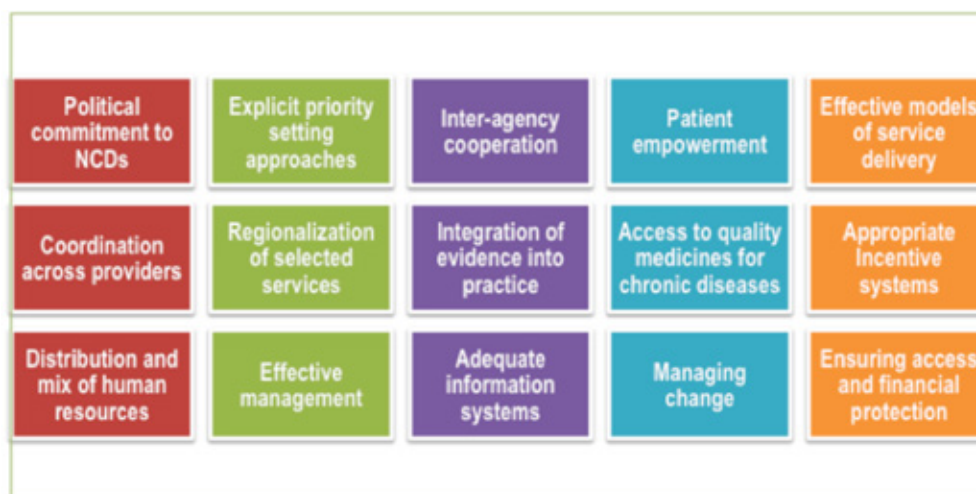
was central to attaining the World Bank's ambitious development objectives of eliminating extreme poverty by 2030 and boosting the prosperity of the poorer segments of the population. Third, while the path to UHC was country-specific, lessons could be learnt from sharing experiences. The World Bank was promoting the sharing of knowledge through its UNICO programme; the key findings from case studies in 25 countries were the existence of strong political commitment, clear definition of the benefits package, expansion of coverage financed mainly from general taxes, and a requirement for individuals to enrol in the expanded programmes.

16. In the ensuing general discussion, participants agreed that the skill mix of the health workforce was critical. There was a need for a multidisciplinary approach, with teams coordinated by family doctors in order to ensure patient compliance with treatment regimens and manage multiple morbidities. Better use should be made of specialists: dentists could undertake health promotion among adolescents, and pharmacists could give advice on vaccination or basic diagnostic tests, for instance. It was suggested that WHO might organize a regional consultation on health workforce management. With regard to the flow of information, ministries of health should be actively involved in discussions on data protection; while there was a need to protect individuals' privacy, health research should not be impeded and health system performance assessment must be carried out.

TACKLING EUROPE'S MAJOR HEALTH CHALLENGES: HEALTH SYSTEMS STRENGTHENING FOR BETTER HEALTH OUTCOMES

17. The second plenary session was chaired and moderated by Jan De Maeseneer, Professor and Head, International Centre for Primary Health Care and Family Medicine, Ghent University, Belgium. In his introductory remarks, citing the example of a person with HIV/AIDS under treatment with antiretroviral medication and at increased risk of diabetes, cardiovascular problems, etc., he noted that it was difficult to say whether that person had a communicable or noncommunicable disease and suggested that it would therefore be more appropriate to use the term “chronic condition”.
18. Marc Roberts, Professor Emeritus of Political Economy and Health Policy, Harvard School of Public Health, United States gave the keynote speech on strengthening health systems for better NCD outcomes. While many infectious conditions could be effectively treated in an episodic, “clinic”-based system, such settings lacked the continuity of care needed for chronic conditions, and health care providers lacked the specialized skills needed to deal with complex conditions. Some health systems in Europe had long since moved to relationship-based care provided through general practice or family medicine, but that arrangement was less common in eastern Europe and central Asia.
19. Primary prevention was both effective and cost-effective for conditions such as diabetes, chronic obstructive pulmonary disorders and cardiovascular disease (CVD) that were greatly affected by diet, exercise, and tobacco and alcohol use. Prevention programmes had to target both opportunities and behaviour, and many of the relevant policies required cooperation with non-health agencies and ministries. While screening was essential for identifying NCD cases, it should be targeted at higher-risk populations and would produce benefits only if it led to appropriate care and outcomes. Much of the cost and health impact of NCDs came from acute events for those with chronic conditions and from cancer. The former required coordination across specialists, disciplines and sites of care; the latter called for screening and early diagnosis and treatment.
20. Some challenges applied to all aspects of NCD care: the need for political commitment from the highest level of government, sophisticated management of the system, and incentives and leadership of the staff involved (Fig. 2).

Fig. 2
The 15 health system challenges posed by NCDs



Source: Division of Health Systems and Public Health and Noncommunicable Diseases and Life-Course, WHO Regional Office for Europe (commissioned to Marc Roberts, Harvard School of Public Health)

21. Exploring four of those challenges in more detail, Professor Roberts emphasized the importance of an explicit process for setting priorities: a lack of rules would lead to unfair and arbitrary individual care decisions, and public acceptance of limits could be fostered by a transparent and accountable process. Appropriate regionalization would entail the referral of the most complex cases to regional centres of excellence, with outreach and referral networks, together with supportive social services to ensure effective access to care for poor and socially unconnected people. Shortcomings in the area of management included the fact that managers often had little authority over personnel, purchasing and investment, that facility managers were not supervised by sophisticated “managers of managers”, and that information on the cost and quality of care was unstandardized, unreliable and not publicly available. Patients were the “front-line workers” for much NCD care, yet they often lacked a commitment to take control of their condition, while poor service quality and pressure for informal payments could further undermine patient trust. Examples of good practice in each of those areas included the explicit priority-setting work done by the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom and the Institute for Quality and Efficiency in Health Care (IQWiG) in Germany; the “provincial implementation teams” set up in Turkey and the regional cancer planning initiatives taken in Canada; the education requirements for hospital managers in Hungary; and the group appointments for chronic NCD patients pioneered by the Kaiser Permanente organization in the United States.
22. Six steps could be taken to overcome those challenges:
 - Ensure high-level political support
 - Identify which NCD outcomes to improve
 - Engage in a self-critical reform planning process

- Make sure the plan responds to local realities
 - Consider and plan for implementation problems in advance
 - Learn and adapt.
23. In the following panel discussion, Francesco Bevere, Directorate-General for Health Planning, Ministry of Health, Italy said that in order to develop a sustainable health system it was necessary to reconsider its organizational and structural aspects, avoiding a lack of trust among users and ensuring social, and not just economic, sustainability. The principles of the Tallinn Charter and Health 2020 were fully reflected in the “pillars” of the Italian national health service: UHC was being achieved by guaranteeing “essential health care levels” to all citizens. Mechanisms of decentralized governance had been adopted, and national planning was increasingly playing a stewardship role, as recommended by the Charter. Specific references to the Charter had been included in the country’s national health plan 2011–2013. A national disease prevention plan not only addressed the main risk factors but also aimed at reducing the negative impact of unfavourable determinants of health and promoting healthy behaviours and lifestyles. The primary health care network had been strengthened, with particular attention paid to healthy ageing, chronic NCD, palliative care, home care and community welfare. Performance assessment systems had been introduced at both national and regional levels, and Directive 2011/24/EU of the European Parliament and Council on the application of patients’ rights in cross-border healthcare was being fully implemented.
24. Ildikó Kissné Horváth, Head of Department, State Secretariat for Health, Ministry of Human Resources, Hungary emphasized the importance of support from the highest level of government: the Prime Minister of Hungary was fully committed to primary health care and disease prevention and had been one of the European Region’s recipients of a World No Tobacco Day 2013 award from the Director-General of WHO. The Ministry of Health had set up a university department for the management of health system reform, tasked with fostering exchanges of experience and best practice and with assessing the quality of information collected on the operation of the health system: accurate information on morbidity (in the form of diagnosis-related groupings) was essential for effecting changes in health system financing.
25. Helene Bilsted Probst, Senior Medical Specialist, Hospital Services and Emergency Management, National Board of Health, Denmark said that, following a structural reform in 2007 when the health system had been restructured from 13 counties to seven regions, a new health law passed in 2008 had empowered the Danish Health and Medicines Authority to define specialized functions and decide who should carry them out. Through a “bottom-up” process involving medical specialists and regional health representatives, 1200 specialized functions had been defined on the basis of criteria such as complexity, rarity and resources. The plan had been fully implemented in 2010; a recent evaluation showed broad commitment of all stakeholders, and the hospital sector had been transformed towards fewer hospitals and more specialized care. With regard to cancer, 26 care “pathways” had been defined and more were being developed, but it was evident that patients with

uncharacteristic symptoms had quite long and unsatisfactory pathways. Based on the experiences of one region, diagnostic patient pathways had therefore been created in all regions, managed by staff working in multidisciplinary clinics.

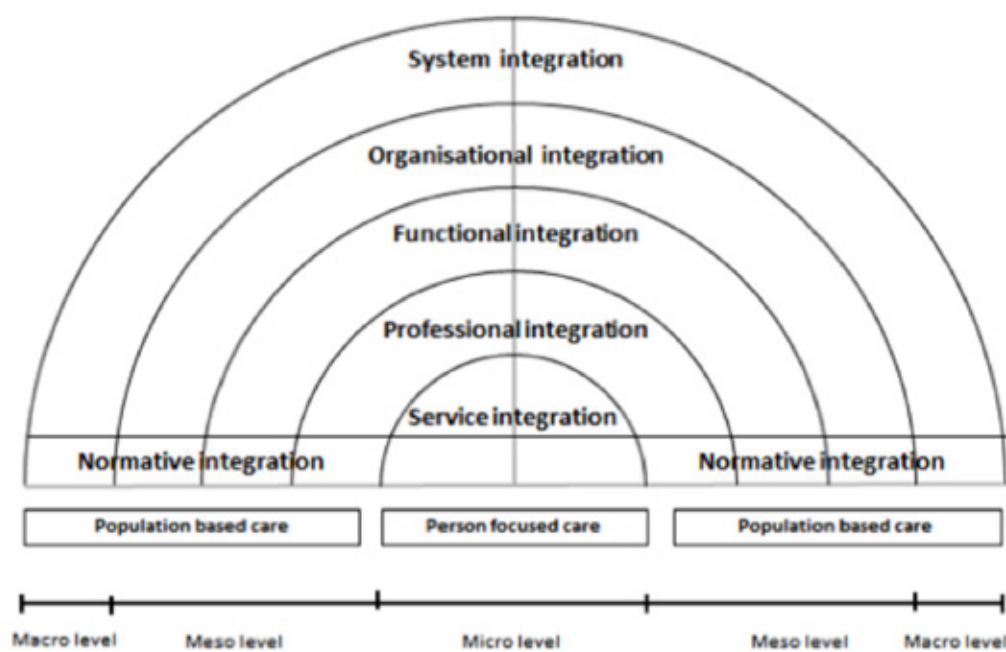
26. Before the general discussion, the session chair gave a short presentation on the role of primary health care in managing chronic conditions. In patients with multiple morbidity a paradigm shift was needed, from problem-oriented to goal-oriented care. What really mattered for patients was to be able to function and to engage in social participation. That entailed an evolution from chronic disease management to participatory patient management, within a strong primary health care system.
27. Participants in the general discussion noted that while Member States had committed themselves in the Tallinn Charter to reporting on health system performance, it was very difficult to do so for multiple morbidity. The lack of integrated knowledge on health systems strengthening and NCD was regrettable; under those circumstances, it was all the more important to engage in international and (particularly for small countries) subregional cooperation. The forthcoming WHO European Ministerial Conference on the Prevention and Control of Noncommunicable Diseases in the context of Health 2020 (Ashgabat, Turkmenistan, 3–4 December 2013) would offer a good opportunity to do that. In view of the findings from a World Bank survey that depression was widespread among patients with chronic conditions, a plea was made to take account of mental health in approaches to tackling NCD.
28. Given the impending “tsunami” of age-related conditions, it was important to strengthen public health services and ensure efficient health systems, over and above placing reliance on relationship-based general practitioner (GP) care. While some countries had lengthy experience of ensuring transparency in setting priorities, they lacked the tools to decide on the components of care that should no longer be provided: a global initiative might be necessary to remedy that shortcoming. The lifelong challenge of NCD called for continued national and international cooperation.

COORDINATED/INTEGRATED HEALTH SERVICES DELIVERY: TOWARDS PEOPLE-CENTRED HEALTH SYSTEMS

29. The first parallel session was chaired and moderated by Anders Olauson, President, European Patients' Forum.
30. Ilke Van Engelen described navigating the health system from a patient's perspective. In the summer of 2011 she had contacted her family doctor because of persistent coughing and hoarseness and had been referred to a hospital-based ear, nose and throat specialist, who had prescribed a course of antibiotics. After making repeated visits to her family doctor and expressing doubts about the request for a self-diagnosis, she had been sent to have a lung X-ray. The lung specialist had said he was almost certain that she had a contagious form of tuberculosis, in an advanced phase. Both she and her three year-old son had been given masks and sent home, where her partner had also been placed in quarantine. A public health nurse had then visited her, given her guidance throughout her period of treatment and led the contact tracing. After welcome news of limited infection of contacts, she had completed a course of treatment and regained her health after six months. From her experience, it was clear that the quality of communication was very important for the patient's quality of care, and that serious questions or concerns needed a proper response in order to build a relationship of trust. More integrated health service delivery was essential for ensuring a more people-centred type of health care.
31. Nick Goodwin, Chief Executive Officer, International Foundation for Integrated Care, gave a keynote speech on transforming health care in Europe, describing the lessons learnt from efforts to scale up coordinated and integrated health service delivery. The complexity in the way care systems were designed led to lack of "ownership" of a person's problems; lack of involvement of carers and health service users in their own care; poor communication between partners in care; duplication of tasks and gaps in care; and poor outcomes for the person, the carer and the system. While there were many different examples of innovative policies on integrated care and enough evidence to lend support to that approach, there was no single model that was universally applicable.
32. Nonetheless, some components for success could be identified. At the level of the health system, they included UHC or an enrolled population with care free at the point of use; a leading role for primary or community care; emphasis on chronic and long-term care, and on management of population health; alignment of regulatory frameworks with the goals of integrated care; flexible funding and payment arrangements; and a workforce educated and skilled in chronic care, teamwork and care coordination. In each health care organization, it was important to have strong (clinical and managerial) leadership; common values and a shared mission;

aligned financial and governance structures; integrated electronic health records; responsibility for a defined population or service; and a focus on continuous quality measurement and improvement.

Fig. 3
Integration necessary at every level



Source: Valentijn P et al. (2013) Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care. *Int J Integr Care*, vol. 13, Jan-Mar.

33. Clinical and professional integration called for case finding and the use of risk stratification; standardized diagnostic and eligibility criteria; comprehensive joint assessments and planning of care; a holistic, not a disease-based, focus; single or shared clinical records; decision support tools such as care guidelines and protocols; and technologies that supported continuous and remote patient monitoring. Lastly, integration between health and social services would entail support for assisted living and home care; a single “point of entry” to all services; care coordinators; case and medication management; centralized information, referral and intake; multidisciplinary teamwork and interprofessional networks; shared accountability for care; and supported self-care.
34. In the following panel discussion, George Ziniel, Director, Institute of Public Health, Austria said that despite the introduction of a long-term care allowance 20 years earlier, patients in his country were not receiving the necessary information and there was a lack of coordination and cooperation among care providers. The situation was complicated by the fact that there were two ministries involved at federal level, as well as nine provincial governments. A system of integrated planning in the Austrian health service had therefore been introduced in 2006, in part to tackle the problem of resource allocation when services had to be cut.

Long-term efforts were being made to promote early intervention and build up a sustainable network among health care providers. At the micro level, integration of follow-up treatment and social care of the elderly had led to a reduction of hospital readmission rates. While priority was being given to primary care, it took time to bring about structural change.

35. Inmaculada Navarro Pérez, Head of Service, Secretariat-General for Health and Consumers, Ministry of Health, Social Services and Equality, Spain described the strategy for addressing chronic conditions in the Spanish national health system. The initiative, launched in 2012 by the Ministry in agreement with the 17 regional authorities, was a response to the increase in the number of elderly people, the increase in the number of consultations for chronic conditions, and the need to move away from acute resolution of pathologies and towards a better coordinated and more interdisciplinary preventive approach involving social workers and patients. The guiding principles of the strategy included a patient-oriented design, a life course perspective, a focus on the social determinants of health, primary health care, patient empowerment and integration of health services. Six strategic lines of approach had been identified: health promotion; prevention of medical conditions and chronic limitation of activity; continuity of care; reorientation of health care; health equity and equal treatment; and the promotion of integrated health research and innovation. The strategy complemented and enhanced initiatives already being taken by the regions, which had the executive role in health and social care.
36. Raisa Bogatyryova, Minister of Health, Ukraine paid tribute to the fact that the Tallinn Charter and Health 2020 reflected a mutual understanding of values on the part of all the countries in the WHO European Region. In practical terms, however, constraints on organizational and financial resources would give rise to ethical discussions about access to health care by the elderly population. In addition, her country was facing the problems of epidemics of HIV/AIDS and tuberculosis: a coordinated, patient-oriented approach would entail not only medical treatment, preventive care and public health measures but also the involvement of patients' organizations and society as a whole, in dialogue with the authorities and the medical professions. That approach constituted an important element of building up civil society in the new democracies.
37. In the following general discussion, participants recognized that fragmented components of a national health system could best be brought together by effecting change at the clinical level, rather than by attempting to implement top-down structural reform, and agreed that such change would take time. In the case of communicable diseases such as HIV/AIDS and tuberculosis, governments had an essential role to play in integrating and coordinating care, which could not be done by nongovernmental organizations or funding agencies. Paediatric care should not be overlooked as part of an integrated system, and patients' organizations were ready and willing to be challenged to help deliver integrated care.

HEALTH WORKFORCE CHALLENGES: AN URGENT PRIORITY FOR STRENGTHENING HEALTH SYSTEMS

38. The second parallel session was chaired by Sergey Khachatryan, Deputy Minister of Health, Armenia and moderated by Matthias Wismar, European Observatory on Health Systems and Policies.
39. A keynote speech on moving towards a sustainable health workforce capable of addressing the population's changing health needs was given by Rüdiger Krech, Director, Ethics and Social Determinants of Health, WHO headquarters, Geneva, Switzerland. Beginning his talk by noting that in HRH we often talk about the 57 'crisis countries', he stressed that it is also a challenge for the European Region, providing the example of so-called 'medical deserts' in France and reflecting that "we're all together in the boat". Making a parallel with the work of the Commission on the Social Determinants of Health in 2009, it was emphasised that there is a need to focus HRH around a value base. That is, what do we want to achieve from HRH vis-à-vis our values? The Kampala Declaration and Agenda for Global Action was cited as a guide i.e., we want that "all people everywhere will have access to a skilled motivated, and supported health worker, within a robust health system". Beginning from such a value-based statement we can then explore whether this is achievable, and what it is that we need, especially around training, motivation and support. In this regard, the AAAQ framework (where all health-related facilities, goods and services must be: available, accessible, acceptable, appropriate and of good quality) was seen as applicable to developing and maintaining a sustainable health workforce.
40. Expanding on this, Rüdiger Krech explained that *availability* is about numbers and relevant competencies. *Accessibility* concerns equitable access (travel and transport, opening hours, workforce attendance, disability-friendly infrastructure, etc) i.e., we need to also look into our community environments. *Acceptability* involves patients being treated with dignity and in a trust-promoting way. And, finally, *Quality* means the appropriate skilled workers. In this regard, what needs to be addressed are: shortages of some categories of health workers (especially as more are forecast); greater disaggregation in reporting numbers, and better forecasting as replacement is a challenge; the persistence of skills-mix imbalances; wide variations in availability and accessibility because of attraction and retention difficulties; adapting education (which remains a challenge everywhere); and performance assessment where quality of care is afforded insufficient priority. It was further noted that the minimum social protection floors which Member State governments have taken up and endorsed in the International Labour Organization (ILO), need to be adhered to, and that WHO is working to support this.

41. In the following panel discussion, on efforts to address key health workforce challenges, the four panellists made introductory remarks. Taru Koivisto, Director, Health Promotion Group, Ministry of Social Affairs and Health, Finland, spoke first, reflecting on the multisectoral cooperation of all stakeholders at national level and the integration of workforce issues into all social and health development programmes adopted by the government. Stressing that workforce planning is about intersectoral collaboration (and that Finland does this collaboration well) she noted patients' requirements are changing, which in turn has an impact on planning requirements. It was posited that a national framework for monitoring supply and demand of health workforce requirements is a crucial tool in planning for future needs. Important in Finland' success here were said to be: a well-functioning monitoring system for monitoring stocks and flows; a tradition of partnership and multisectoral working; anticipation and planning to support political decision-making; that young people are encouraged to seek higher education and that responsibility here lies with the ministry of education not health. In terms of the extent to which collaboration in government is intersectoral, it was pointed out that long-term forecast reports on health workforce needs are produced by the ministry of finance jointly with health, education and culture, and employment. A strong education sector is crucial, and Finland has been able to establish transparency and accountability lines to education sector
42. Speaking on behalf of Andrei Usatîi, Minister of Health, Republic of Moldova, Alexandru Mocanu from the Ministry of Health reflected on the main developments in Moldova regarding implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted by the World Health Assembly in May 2010. He noted that challenges in HRH for Moldova are essentially the same as for anyone else – it is, he stressed, a global issue with different facets for different parties. He noted that HRH as an area of work is part of Moldova's cooperation with the WHO European Regional Office via the Biennial Collaborative Agreement (BCA) for 2013-2014, with specific emphasis on a project to address so-called 'brain drain' and 'brain waste' from Moldova. One of the issues important in the Moldovan context, he noted, was of changing health professionals' attitudes towards both patients and citizens – good progress was being made, but further improvements were possible he felt. Addressing workforce issues in and out of the country was regarded as a priority, and here he referred to Moldova having hosted a high level meeting, in June 2013, to discuss the Global Code of Practice. It was emphasised that HRH problems cannot be solved only by Ministry of Health, but collaboration within and without the government was important.
43. In moving the discussion along, the facilitator, Matthias Wismar, prompted Walter Sermeus, Professor, Center for Health Services and Nursing Research, KU Leuven University, Belgium, to talk about skill-mix issues. More specifically, he raised the concept of so-called 'nurse practitioners', asking about the apparent anomaly that as we push for more nurses, we still give them more tasks. Reflecting on the main priorities / strategies for addressing the growing nursing shortage facing countries in their efforts to tackle public health challenges, Prof Sermeus stated that the current estimate is that by 2020, Europe will be short of 1 million health professionals – 600,000 of which are expected to be nurses. He spoke about the FORECAST Project (which spanned 12 countries, over 3 years, with data from 500 hospitals and 30,000

nurses, using 9 million hospital discharge records) to tackle myths about shortage issues and to replace them with facts.

44. For instance, one myth the project has been able to dispel is that, due to claimed inefficiencies, it is possible to reduce the number of health workers because of a reduction in budgets (e.g., on account of the financial crisis), without affecting outcomes. This is not the case unless commensurate with reducing in numbers, you invest in technical and social innovation to strengthen the system at a wider level. He noted that changing environments and disease burden mean that nurses have to move on from focusing only on 'basic questions' e.g., hygiene, medication etc. Rather, they must help in areas traditionally the domain of doctors, and having an increasing role in educating or informing the patient. This is especially crucial when dealing with, for example, non-communicable diseases and, in Europe, cross-border healthcare issues. Another myth is that a reduction in numbers of nurses has an equivalent effect on healthcare costs i.e. that costs go down. However, the data from the project shows that nursing is not a cost but an asset to the health system and that if you want to be cost-effective, you should invest in nurses (there are particular gains to be made rather than investing in expensive new technologies). The project further reveals that creating a conducive working environment is perhaps the first priority, before all others, in retaining a good cadre of nurses (and health workers generally).
45. David Gordon, Professor, World Federation of Medical Education, then reflected on strategies / and actions, at the global and regional levels, with which to transform the education of health professionals to better equip them to address the health care challenges of the 21st century. He started his talk by stressing the need for transformation / change in educating healthcare professionals, and said that it was not true that this was only for lower income countries. The requirements may be different, but a transformation was needed in higher-income countries as well. There are several reasons for this need: (i) medicine and the allied professionals are becoming increasingly aware of their obligation to society and meeting societal needs on a wider scale (beyond treating disease and relieving illness); (ii) the health professions are becoming more global in outlook; (iii) we need to think what is possible within the resources rather than trying to address everything; (iv) even in the most developed countries there are inequities in healthcare; and (v) healthcare needs are not the same this year as next year. Amongst other things, this means a need to ensure that appropriate standards of education are in place; that young people are being educated for future rather than current health issues; and that a robust process of accreditation of medical schools exists and is adhered to. It was noted that in 15-20 years time the United States will no longer need to attract foreign doctors as they are investing in medical schools with appropriate accreditation (other countries are doing the same but without addressing accreditation which is a cause for concern).
46. In the following general discussion a number of interventions from the floor were made. Lieven De Raedt, Attache, International relations Department, Belgian Federal Public Service on Health, Food Chain Safety and Environment, Belgium reflected on the 64th WHA session on skill-mix issues which it had organised. The aim of which had been to challenge how citizens think about the health workforce, in that

there is a need to stop thinking about health professionals in boxes e.g., nurses, doctors, etc. Doctors' may be reticent to give up their monopoly on treatment, but there is evidence – such as in antiretroviral treatment administration by nurses in South Africa – that in some areas nurse outcomes are as good as doctors'. There is a need to get away from what Clive Needle, Director, Management, EuroHealthNet, Brussels, Belgium called the 'RyanAir approach' i.e., a focus only on the lowest cost in respect of health professionals; instead a Health in all Policies approach was required. Reiterating the point made earlier by David Gordon, Jan de Maeseneer, Professor and Head, Department of Family Medicine and Primary Health Care, Ghent University, Belgium, stated that the providers of tomorrow are still being taught in practices of yesterday, and that there is, therefore, a real need to change not just education but the health system as well and that these need to go hand-in-hand. Here, Volker Amelung, Professor, Medical School Hannover, Germany, stressed that inter-professional training was required from the start and not just at the end.

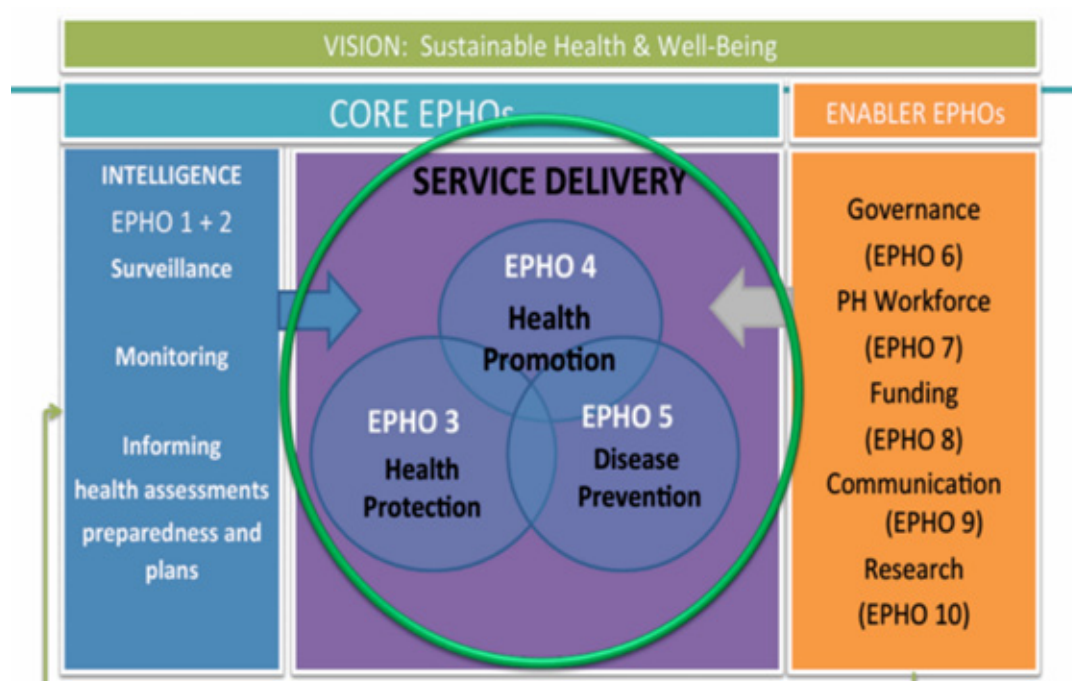
47. Alex Leventhal, Director, Department of International Relations, Ministry of Health, Israel, asked that as a community we take a step back, stating that we have been dealing with this for 10 years. He challenged the session to reflect on whether we have made any progress in this time given that we need new health professionals now. Hungary noted that they are indeed better off in terms of the health workforce now than 3 years ago, and with social approval. Better working conditions, pay, and other incentives has seen people returning to the profession and, indeed, to the country. Slovenia reflected on innovations they have made such as additional nurses in primary care teams to add quality in terms of health promotion and prevention programmes.
48. In closing the session, panellists were invited to offer some final remarks. Rüdiger Krech noted that while we are better off with data monitoring now than 10 years ago, and we do in most cases have a more efficient workforce than before, this needs to be juxtaposed against the changing burden of disease and other challenges. Taru Koivisto stressed that the well-being of health professionals has to be taken into account very seriously, including through continuing professional development (CPD) initiatives. Here the contents of education are important with public health training a priority in Finland. Alexandru Mocanu stated that civil society is perhaps our best reporter on future health system needs as they are closest to the issues. Walter Sermeus stressed that health system innovations and the changing of health professionals' roles need to go together, and that we need the right matrix to measure this; one where quality and not cost is the crucial variable.

STRENGTHENING THE ROLE OF PUBLIC HEALTH IN HEALTH SERVICES DELIVERY TO PROMOTE HEALTH AND ADDRESS INEQUALITIES

49. The third parallel session was chaired and moderated by Adrian Pan , Secretary of State, Romania.
50. Providing the session's keynote address, Jose Martin-Moreno, Professor of Public Health and Preventive Medicine, University of Valencia, Spain gave a keynote speech on strengthening the role of public health in health services delivery to promote health and address inequalities. The speech provided a framework for understanding public health within, and in line with, Health 2020 and the Tallinn Charter. Indeed, it was stressed that Tallinn Charter went beyond health systems to include public health and it is therefore a natural and positive progression into Health 2020. The WHO European Regional Office, via the Public Health Services Programme within the Division of Health systems and Public Health has, in 2012, set out a public health action plan which includes as series of 10 'Essential Public health Operations' (EPHOs). In profiling these, it was underlined that these do not represent separate elements in a health services delivery approach, but rather that they are integrated and mutually reinforcing. In this regard, committed inter-sectoral action is seen as a crucial part of the Ministry of Health's stewardship role vis-à-vis public health in line with Health2020. Evidence was provided to demonstrate that (and how) specialists in hospitals can help with health promotion activities i.e., that alcohol, smoking and physical education can be addressed in the context of a post-colorectal operation; the same for hip, knee and spinal operation. Indeed, post-operative primary health care counselling of patients at risk due to unhealthy lifestyles can be one of the most effective ways of changing behaviours. This is true also for public health interventions for better non-communicable disease outcomes. In Turkey it was stated that there is a commitment to seeing general practitioners develop capacity to manage primary and secondary prevention of common NCDs. And it was emphasized that public health interventions improve health outcomes while generating clear added value to tackle inequities.

Fig. 4

EPHOs for Strengthening Public Health Services Delivery



Source: Martin-Moreno, JM (2013) "Strengthening the role of public health in health services delivery to promote health and address inequalities", presentation given to Parallel Session C, 'Health systems for health and wealth in the context of Health 2020: Follow-up meeting on the 2008 Tallinn Charter, 17 October 2013.

51. In the following panel discussion, on the challenges and opportunities of integrating key public health operations into health services delivery, the five panellists provided insights from their respective areas.
52. Valikan Akhmetov, Director-General, Republic Health Care Development Centre, Kazakhstan, offered some remarks on how to integrate essential public health operations into primary health care. Since 2010, the national healthcare programme in Kazakhstan has been underway, the most crucial component of which is integrating care and promoting equality between regions. There is a core message towards help people become more motivated to take care of their own health on the one hand, while financial and economic tools / incentives are being offered to professionals towards promoting integration, on the other. For instance, during hospital treatment, health promotion activities around smoking cessation, adherence to medicine regimens etc are being offered. This resonates with the point made in the keynote by José Martin-Moreno. Kazakhstan has some concerns regarding patient flows from and to neighbouring countries, which impacts on health system reform initiatives and primary care in particular, but progress continues. In closing, he thanked the WHO European Regional Office and Division of Health Systems and Public Health for opening the geographically dispersed office on primary health care in Kazakhstan.

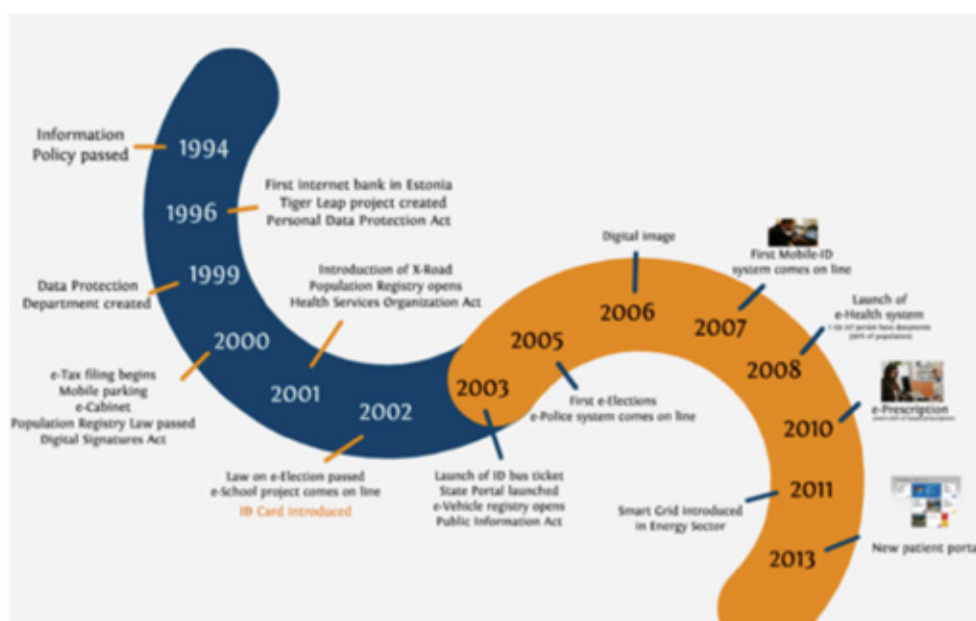
53. Hanne Toennesen, Chief Executive Officer, International Health-Promoting Hospitals Network (a WHO Collaborating Centre for Evidence-Based Health Promotion in Hospital and Health Services), then spoke on strengthening health promotion and disease prevention from a hospital perspective. After profiling the network, which includes more than 900 hospital and health service members in more than 40 countries, she argued that there is now considerable evidence to demonstrate effectiveness, both in terms of patient preferences and staff competencies for such hospital-based approaches. The clear message was that we need to cooperate, as patient-centred and staff-centred health promotion can and should be offered by hospitals. As a closing plea to delegates, she concluded that we should all require more public health from our hospitals.
54. Next, Alex Leventhal, Director, Department of International Relations, Ministry of Health; Israel spoke about community-based primary care, reflecting on Israel's experience using the 'National Program for Quality Indicators in Community Healthcare (QICH), with a particular focus on primary prevention. He noted that in Israel the public health sector had struggled for years to develop useful and positive health indicators to better understand the quality of health, as a differentiation from the 'negative' indicators around mortality and morbidity. Profiling the QICH as a well-functioning monitoring system, it has allowed Israel to show continuing improvements in healthcare (both to domestic audiences and in comparison with other countries), with increasing rates of quality over time. Additionally, through such a monitoring system, the overall quality of community healthcare in Israel has improved over the past years, and Israel has been able to maintain high levels for the majority of indicators. These results are largely due to the concentrated efforts of Israel's health plans and their active role in community medicine.
55. Clive Needle, Director, Management, EuroHealthNet, Brussels, Belgium, then reflected on EuroHealthNet's experience with tackling health inequalities. He noted that public health needs real capacity to act, and that we, as a public health and health systems community, need a realistic approach to prioritise so as not to undermine the good work being done. It is the case that services in Europe have been cut back heavily in many Member States, and many state actors cannot provide what they are being asked to deliver e.g., mental health, occupational health and safety. Despite growing evidence of cost-effectiveness, the funds available for health promotion remain insufficient – an average of 3% in countries does not allow us to deliver on quality and universality. According to Mr Needle, the reality of joined-up working is still lacking when we move away from inspirational charters and statements at a high political level. There are some good examples under adversity e.g., Ireland, but too often weak interfaces are the norm and there is insufficient solidarity with social services and children's services etc. It was emphasised that youth unemployment is a in fact public health emergency, and that we need to mainstream public health within systems rather than it being an add-on. The cost of inequalities undermines much work in other areas of health system strengthening. There is a need to better involve markets and the private sector, yet innovation remains a buzzword rather than a strategic direction. For EuroHealthNet, three new pillars are to be set up in 2014: (i) the launch Health Promotion Europe; (ii) the grounding of a new centre on innovation; and (iii) the launch of a platform for health and social equity.

56. The final speaker was Agis Tsouros, Director, Division of Policy and Governance for Health and Well-being, WHO Regional Office for Europe, who then spoke on the place of public health within the Health 2020 regional framework. Arguing that many current discussions on strengthening public health focus on prevention in connection to primary health care, and do not pay adequate attention to population based approaches, he stressed that Health 2020 represents a key political and strategic vehicle, based on evidence, for public health strengthening. Public health services and infrastructures remain weak and outdated in many parts of the Region, and practitioners often have low status and few opportunities for career development. Yet the scope and content of modern public health is very promising. Emphasis needs to be based on developing modern legislation, public health infrastructures at all levels and across sectors; and a vibrant multi-disciplinary public health work-force. In this regard, the EPHOs are useful a tool for thinking analytically on all aspects of public health and need to be taken together.
57. The session was then opened to general discussion with a number of interventions. Maris Jesse, Director, National Institute for Health Development, Estonia emphasised that she is passionate about public health and healthcare, stressing that integration is key. She echoed the point that public health is in Tallinn Charter, and expressed concern over a general trend to substitute patient contact for technology in the search for efficiency gains in healthcare. Zsuzsanna Jakab, Regional Director, WHO European Regional Office echoed this, saying that all in this room are all passionate about public health. She referred to the growing body of evidence to show benefits of investing in public health, and therefore the need to ensure the rightful place of public health professionals being at the same table as other professionals. Tone Poulsson Torgersen, Senior Adviser, Directorate of Health, Norway reflected on the need for increased action on population based activities. She stated that 95% of resources go into healthcare, but there was a clear need to look at increasing public health investment. Clive Needle, in sharing this view noted that politics involved tough choices, and asked what sort of evidence is needed in order to affect choices. Here, Martin McKee, Professor of European Public Health, European Centre on Health of Societies in Transition, London School of Hygiene and Tropical Medicine, London, United Kingdom stressed that we need to have, and be, better advocates for public health, as a single a community. Nicholas Goodwin, Chief Executive Officer, International Foundation for Integrated Care, Oxford, United Kingdom highlighted that this requires a transformative agenda in the funding and delivery of health services. In closing, Zsuzsanna Jakab and Martin McKee expressed the need for a platform for a single voice for public health in Europe.

USING EHEALTH TO IMPROVE HEALTH SYSTEMS PERFORMANCE

58. The fourth parallel session was chaired and moderated by Maryna Sachek, Director, Republic Scientific and Practical Centre for Medical Technologies, Informatization, Administration and Health Management, Belarus.
59. Taavi Rõivas, Minister of Social Affairs, Estonia, gave a keynote speech on the eHealth system in his country. The goals of introducing eHealth had been to decrease the level of bureaucracy, to increase the efficiency and improve the quality of the health care system, to make time-critical information accessible to attending physicians, and to develop more patient-friendly health care services. The path to eHealth (Fig. 4) had really started in 2001 with the opening of an electronic population register and the launch of X-Road, a layer of potential information systems. An electronic identity card had been introduced in 2002, and digital imaging had been incorporated in the system in 2006. A mobile ID system had come on line in 2007, and the eHealth system itself had been launched in 2008. Ninety per cent of the population had documents in that system, and the same proportion of GPs were able to access the nationwide Picture Archiving and Communication System (PACS) to see digital images made in different hospitals. Since 2007, approximately 82% of all radiological studies in Estonia were stored in PACS, and the foundation of that system had led to the development of a dedicated internet portal for GPs. E-prescription, launched in 2010, covered 90% of prescriptions issued.

Fig. 5
The path to the Estonian eHealth system



60. A new patient portal had been introduced in 2013: by law, all health care providers must send data to the electronic health record (EHR), repository, which could only be accessed by licensed medical professionals. The attending doctor concept was maintained. Security in the Estonian eHealth system was ensured by application of six main principles: secure authentication of all users with an ID card or mobile ID; digital signing or stamping of all medical documents; maximum accountability and transparency (all actions left an unchangeable and unremovable secure trail); coding of personal data, and separation of personal data from medical data; an encrypted database; and monitoring of all actions, together with the necessary counter-measures. Most importantly, patients had the right to access their own data in the central database, to close their data, to declare their intentions and preferences, and to monitor visits to their own EHR.
61. The lessons learnt to date included the importance of standardization and acceptance by all stakeholders; the need to elaborate the regulatory environment before calling for tenders for system development; the inclusion of stakeholders; and the reuse of existing know-how and infrastructure.
62. In the following panel discussion, Zetta Makri, Deputy Minister of Health, Greece, said that between 2005 and 2009 national pharmaceutical expenditure had increased from €2.8 billion to €5.6 billion. Her country's e-prescription system had been introduced in 2010 and currently covered all pharmacies, 90% of doctors and 92% of all prescriptions (more than 5 million a month). It was a valuable source of data for planning and control of the Greek health care system and was proving to be a powerful tool for improving patient services and public health planning, in addition to containing costs and combating abuse. Furthermore, a new system promoting the use of generic drugs or international non-proprietary names (INN) had been launched in early 2013. Features included compulsory diagnosis using codes from the tenth revision of the International Classification of Diseases (ICD-10), rules for prescribing based on therapeutic protocols, and digital signatures. The aim of those two measures was to bring spending on outpatient drugs down to about 1% of GDP (approximately €2 billion) in 2014, with total public expenditure on (outpatient and inpatient) pharmaceuticals at no more than 1.5% of GDP in 2013 and 1.3% in 2014. Quarterly reports on drug prescription and expenditure were shared with the European Commission, the European Central Bank and the International Monetary Fund, while detailed monthly feedback on individual prescription behaviour relative to the average was given to each physician. The Ministry of Health had decided to develop eHealth in Greece into a system, starting from the existing ePrescription system.
63. Bjørn Guldvog, Director-General, Directorate of Health, Norway said that, with regard to information technology (IT), the many independent entities in his country's health and care sector were currently responsible for setting their own priorities, for procurement and for system administration. The Government's main goal for IT development in that sector was "one patient – one record". To that end, the following objectives had been defined: to ensure that health personnel had easy and secure access to patient information; to give citizens access to user-friendly and secure digital services; and to make data accessible for quality improvement, health monitoring, management and research. To achieve those objectives, existing

activities and projects would be completed and consolidated. Alternative solutions were currently being studied, and it would be necessary to conduct a comprehensive review of the legislation. In addition, new digital services would be made available to citizens through a national health web portal, an important component of which was electronic identification with a high level of security. With regard to governance, there had to be a clear division of roles and tasks among the entities involved, and all measures of national importance must be decided nationally.

64. Olivia Wigzell, Deputy Director-General, Ministry of Health and Social Affairs, Sweden, fully agreed that there were benefits to be gained from investing in eHealth, but the costs were often much higher and extended over a longer term than initially envisaged. The electronic prescription system in her country, eScript, had been running for 10 years; after a pilot project in one region, and a questionnaire survey on perceived benefit, first among patients and then among physicians, the system had been extended to cover the whole country. The coverage rate was currently 90%, and the aim was to achieve complete coverage. Technical support and a reliable IT system were essential, and national standards were required. The eScript system improved patient safety, was hazard-free, and offered the possibility of monitoring both prescriptions and actual drug consumption, thereby generating valuable data for evaluation purposes.
65. Fabrizio Carinci, Technical Coordinator, European Best Information through Regional Outcomes in Diabetes (EUBIROD), said that diabetes killed some 325 000 people each year in the European Region and accounted for over 10% of health care expenditure in most countries. Despite many efforts, the situation was deteriorating, with a projected 23% increase in prevalence by 2030. The EU project on “Best Information through Regional Outcomes” (BIRO) delivered a solution to collect and exchange information across borders for public health monitoring, and BIRO partners specified how to exchange aggregate data at international level. Information on diabetes already existed in a fairly standardized format, but very few population-based registers existed at national level; regional registers were better suited to link across data sources and could be used directly to optimize health care provision. Training and direct interaction between researchers, policy-makers and clinicians led to efficient integration of the main data sources and enabled average results to be reported back to the individual. The lessons learnt from the EUBIROD platform included the need to understand the human component of data systems; the realization that problems were global, and that products could be transferred; that privacy by design was a “win/win” approach; and that collaborative work improved national information systems.
66. In the following general discussion, participants described some recent developments with regard to eHealth in their countries, including the introduction of a web-based system of death certificates. Questions raised included whether it was possible to make savings through the use of eHealth; who provided free internet access to the population; whether modules were developed locally or bought “off the shelf”; whether health insurers had access to patients’ personal data; and whether it would be opportune to create a common, Europe-wide protocol for the exchange of health information.

67. In response, panellists agreed that eHealth might take up more of doctors' time initially, so short-term savings were not immediately apparent, but other benefits (avoidance of duplication of efforts, reduced medical errors, improved emergency care, etc.) saved both costs and lives, although they called for strong project management capacity. In the case of Greece, however, ePrescription had been introduced precisely to save money, and it had done so. Internet access was typically ensured by an internet service provider company, while the Estonian government had provided the fibre optic connections. Cross-border exchanges of information should perhaps be organized initially on a bilateral basis, with data protection ensured as fully for the international as for the national level.

FRAMEWORK FOR ACTION TOWARDS COORDINATED/ INTEGRATED HEALTH SERVICES DELIVERY

68. A breakfast session on the second day of the meeting was chaired by Christiaan Decoster, Director-General, Department of Health Care, Federal Public Service for Health, Food Chain Safety and Environment, Belgium.
69. Zsuzsanna Jakab contrasted two “patient vignettes”: in the first scenario, a consultation with a GP, followed if necessary by the on-site provision laboratory and pharmacy services, would lead to PHC-led prevention that was of low complexity and fragmentation, entailed little coordination and resulted in high patient empowerment. A second scenario, involving government bodies at different levels (federal, provincial, municipal), inpatient and outpatient hospital services, institutional care (in a nursing home or day care centre), and interaction with health insurance companies, was of high complexity and would require extensive coordination. The WHO Regional Office was therefore promoting people-centred coordinated/integrated health service delivery (CIHSD), defined as “the management and delivery of health services such that people received a continuum of services through the different levels and sites of care within the health system, and according to their needs”.
70. A framework for action towards CIHSD was being developed, drawing on existing knowledge and field evidence and involving focal points in Member States, patients and providers, as well as international partners. Six phases of development had been identified: following a preparatory period in the first half of 2013, the “kick-off” phase was currently under way. That would be followed by technical development (to mid-2014), consolidation of evidence (to end 2014), review and consultation (2015), and finalization of the Framework for presentation to the WHO Regional Committee for Europe at its sixty-sixth session in 2016.
71. The Regional Director formally launched the *Roadmap for strengthening people-centred health systems in the WHO European Region*⁵.
72. Volker Amelung, President, German Managed Care Association (BMC), gave a keynote speech on understanding integrated care: a complex process, a fundamental principle. Health care expenditure in Germany had almost doubled in absolute terms in the previous 20 years but expressed as a percentage of GDP it had shown only moderate growth, and a 2009 comparison of developed countries’ per capita health care spending, adjusted for differences in the cost of living, showed Germany in a

5 *Roadmap for strengthening people-centred health systems in the WHO European Region. A framework for action towards coordinated/integrated health services delivery (CIHSD)*. Copenhagen, WHO Regional Office for Europe, 2013 (http://www.euro.who.int/__data/assets/pdf_file/0005/231692/Strengthening-people-centred-health-systems-in-the-WHO-European-Region,-Roadmap.pdf).

middle-ranking position⁶. Nonetheless, integrated care was necessary on a number of grounds: to take account of changes in demography (an ageing population, mobility, single households), morbidity (rise of chronic diseases, multimorbidity, complexity), technology (accessibility and compliance) and preferences (communication, cooperation, work-life balance, feminization), to counter “path dependency” (quasi-monopolies and lack of pressure to act), and to achieve a breakthrough (in terms of investments, remuneration and education).

73. Under Germany's Health Insurance Modernization Act (GMG) 2004, start-up financing for the promotion of integrated care had been provided for a four-year period, during which health insurance funds had concluded 6 000 selective contracts. The Pharmaceuticals Market Reorganization Act (AMNOG) 2011 in turn had led to 11.3% of sickness funds contracting in to new arrangements, while physician networks were being promoted under the Care Structures Improvement Act (VStG) 2012. Despite the fact that integrated care was better and cheaper, the current situation was characterized by relatively few physician networks and too small and too local programmes for disease management and integrated care, a large number of pilot projects, but little evaluation. Further reforms were expected in 2014.
74. In the following general discussion, participants noted that very few of the pilot schemes on integrated care implemented to date seemed to be scaleable and questioned whether the introduction of competition in the health sector in response to the economic crisis ran counter to the concept of integrated care. The keynote speaker pointed out that a successful pilot scheme on palliative care had led to legal changes to make it mandatory, and that payment systems could be refocused towards payment by outcome rather than by volume. Further evaluation was needed to encourage health insurance companies to contract in to new arrangements.

⁶ *Health at a Glance 2011: OECD Indicators*. Paris, OECD Publishing, 2011 (http://dx.doi.org/10.1787/health_glance-2011-en).

GOVERNANCE FOR HEALTH AND WELL-BEING, HEALTH SYSTEMS PERFORMANCE AND IMPROVED ACCOUNTABILITY

75. The third plenary session was chaired by Paulo José de Macedo, Minister of Health, Portugal. Introducing the session, he said that his country's current health policy was embodied in a national health plan, together with nine priority programmes, that would run until 2016. The plan established three main sets of indicators: of health gains, of health status and health system performance, and of the execution of actions and recommendations. The national health plan aimed to reinforce health system capacity as a fundamental response to the health crisis and a factor ensuring social support and economic development. In that context, the Ministry of Health had introduced the practice of issuing public reports on the results of "benchmarking" hospitals in the national health service, with the aims of improving access to and quality of health care services, as well as institutions' economic and financial performance.
76. Recep Akdag, former Minister of Health and Member of Parliament, Turkey, gave a keynote speech on good governance and accountability for UHC in Turkey. On taking office at the end of 2002, he had brought in a new team and drawn up an action timeline, with an urgent plan covering the first three months of his mandate, followed by longer-term strategic planning. The Health Transformation Program had involved officials at all levels, from the Deputy Minister of Health to field managers and coordinators. Ad hoc committees had been set up to deal with crises such as avian influenza outbreaks and earthquakes, as well as emerging situations with regard to family medicine and hospital reunification. Numbers of emergency cases transferred had increased nine-fold and catastrophic health expenditures had been significantly reduced. The ratio of full-time specialist physicians in public hospitals had risen from 11% in 2002 to 100% in 2011, and the public/private sector balance had been restored. Self-accountability (for attainment of set goals, with emphasis on an ethical standpoint) had been given prominence.
77. As a result, the population's rate of satisfaction with the health services had risen from 30% in 2003 to 75% in 2011. A call centre had been set up that handled 1 million applications per year, resolving 90% of them within 24 hours, and an online forum had been established for health staff to report directly to the Minister of Health. Evaluation was carried out through a variety of measures: face-to-face meetings with health staff, field coordinators, governors and mayors, the public (including family members), and party members and professional associations; statistical surveys; and audits from international organizations such as OECD, the World Bank and WHO. More recently, Decree Law no. 663 on the organization and duties of the Ministry of Health (2011) had introduced a performance model for hospital unions and management performance was currently being assessed, with a final performance review due to be carried out in January 2014.

78. In the panel discussion, moderated by Josep Figueras, Director, European Observatory on Health Systems and Policies, tribute was paid to Turkey's role in leading the fight against tobacco⁷. The first panellist, Mike Daube, Professor of Health Policy and Director of Public Health Advocacy Institute, Curtin University, Australia, reflected on how a comprehensive approach had led to smoking being "on the way out" in his country. That approach had included total bans on tobacco advertising and promotion for more than 20 years; progressive tax increases; hard-hitting advertising campaigns; protection for non-smokers and support for those wishing to quit; bans on any tobacco product display at point of sale; and progressively stronger health warnings. Plain packaging (but including government-mandated warnings and images) had been mandatory for all tobacco products since 1 December 2012. The tobacco industry was fiercely opposed to plain packaging for four reasons: it prevented the promotion of industry-preferred messages; it reduced uptake of smoking in children and encouraged adults to quit; it enhanced the public perception of tobacco companies as less reputable and more lethal than any other industry; and, once implemented in one country, it would be adopted elsewhere. Australia's experience was that a comprehensive approach to tobacco control could reduce smoking dramatically over time, that the involvement of a strong and determined health minister was the crucial factor, and that transparency both within and outside government was extremely helpful.
79. Miriam Owens, Public Health Specialist, Department of Health, Ireland described the "Healthy Ireland" strategy, a national framework for promoting health and well-being that had been developed after an extensive national consultation exercise and which comprised four goals and 64 actions in six thematic areas. Launched in March 2013 with support from the Prime Minister and all of his ministers, it addressed the social determinants of health and well-being throughout the life course and strove to deliver a whole-of-government and societal response. Importantly, in times of economic austerity, it highlighted the economic and societal benefits of protecting and maintaining health, preventing illness and intervening early. The main challenge was how the small unit in the Department of Health responsible for the strategy would engage with other government departments. Implementation was taking place at various levels, as part of the health system reform process, and regular progress reports were provided to the cabinet committee on social policy; in addition, a number of governance arrangements were being developed at department/ministry level, and senior policy-makers in different areas were being brought together within the Department of Health. There was also close cooperation with local government authorities, and a Healthy Ireland Council (with the Prime Minister as patron) was being convened to support public discourse. The strategy did not propose any new policy options, but it did look to new ways of working.
80. Tit Albreht, Head, Centre for Health Care Systems, National Institute for Public Health, Slovenia, said that a nationwide programme to identify and tackle health risks had been launched 10 years earlier, based on the experience of the North Karelia (Finland) project on comprehensive community-based control of CVD. A regional approach had been adopted in Slovenia, too, focusing on an area where the population's diet was high in saturated fats and calories; among other interven-

⁷ WHO report on the global tobacco epidemic, 2013. Geneva, World Health Organization, 2013 (http://www.who.int/entity/tobacco/global_report/2013/en/index.html).

tions involving ministries of education, agriculture, etc., advice had been given on what vegetables to grow in order to change people's diet. General practitioners had been won over to the project when they had seen the reduction in the burden of chronic diseases. Intersectoral collaboration, regional coordination and involvement of local communities had been secured at relatively modest additional cost, and the experience gained had helped with the development of national programmes on obesity and physical activity. As a result of a "spillover" effect to neighbouring areas, Slovenia currently had a rate of premature CVD mortality that was at the EU-15 average.

81. Agis Tsouros, Director, Division of Policy and Governance for Health and Well-being, WHO Regional Office for Europe suggested that health could be a whole-of-government indicator in the future. Health 2020 argued for strong leadership and emphasized the need to build capacity for accountability; the related "implementation package" included material designed to be used for that purpose. In that context, targets related to accountability should be seen not as sanctions but as tools for improving performance. Governance could indeed be exercised at multiple levels, notably that of cities, where mayors played the same role as that of a prime minister at national level. It was clear, however, that shared governance and accountability (at different levels and involving all sectors) were more complex matters than similar undertakings in the health sector alone.
82. Tamás Evetovits, Acting Head of Barcelona Office, Division of Health System and Public Health, WHO Regional Office for Europe paid tribute to Estonia for having championed greater transparency and accountability. The Tallinn Charter had come at the right time – its values and commitments had been put to the test in the economic crisis that had arisen immediately after its adoption. Countries that had had health system performance assessment (HSPA) in place had been able to monitor whether and how far poor people's health had suffered, and decision-makers had found themselves under closer scrutiny. One of the lessons learned was the need for stable and predictable revenues; huge fluctuations in spending should be avoided. More generally, it was important to "save in the good times, spend in the crises".
83. In the following general discussion, participants recalled the third commitment in the Tallinn Charter, to "promote transparency and be accountable for health system performance". HSPA did that, while supporting policy planning. It represented a comprehensive approach, covering all dimensions such as the accessibility and quality of care and questions of equity. The findings from HSPA could lead to the identification of priorities for further action on an interministerial basis. Peer reviews with other countries could help to improve the methodology used for HSPA. Even where health was not high on the government agenda, continued work on HSPA and evaluation would enable the health sector to have policy options to hand when required. The most important form of accountability was to the democratic decision-making process at both local and national levels, through which people could express their explicit expectations of the health system.

FINANCING HEALTH SYSTEM STRENGTHENING INITIATIVES

84. The fourth plenary session was chaired and moderated by Martin McKee, Professor of European Public Health, London School of Hygiene and Tropical Medicine, United Kingdom. Representatives of international organizations and countries gave partners' perspectives on how the international community could help ensure that sufficient resources were available to address Europe's major health challenges in an effective manner.
85. Daniel Dulitzky said that since the mid-1990s countries in the World Bank's Europe and Central Asia (ECA) region⁸ had enjoyed faster GDP growth than the EU-15 countries, but that had not translated into more rapid gains in life expectancy. There had been divergence in health indicators between eastern and western Europe, in spite of convergence in income levels. Tackling that development challenge would entail three separate but related agendas in the areas of health (improving health outcomes), financing (paying for better health without imposing an undue burden on household or government budgets) and institutions (improving performance across the board). In the first area, the ECA region had yet to achieve the "cardiovascular revolution" that had taken place in western Europe in the previous 50 years. Prevention and treatment would both be necessary: taxation was one of the most effective policies to curb tobacco consumption, and service provision to address chronic disease should be improved, by including medicines to treat high blood pressure and cholesterol levels in benefits packages and by introducing pay-for-performance incentives and disease management programmes. In financing, excessive reliance on out-of-pocket and informal payments could be addressed by measures to increase provider accountability, while pharmaceutical spending could be reduced through promotion of the use of generic drugs and rational prescribing. With regard to the institutional agenda, ingredients for a successful health system included patient-based provider payment, some degree of provider autonomy, the use of information for decision-making and substantial risk pooling. Investment by the international community should focus on output-based financing, using "pay for performance" models and disbursing against results rather than inputs.
86. Ankit Kumar, Health Division, Organisation for Economic Co-operation and Development (OECD) agreed that increased co-payments were not a good way to raise money. Instead, countries should take a more studied look at which services they funded. To ensure fiscal sustainability, attention should be focused on revenue. Many countries with social insurance-based health systems relied substantially on payroll taxes, but they might not be the best sources of revenue when labour force participation was falling, and "sin taxes" were unlikely to yield large and sustained flows of revenue; diversification of revenue sources was therefore important. Pre-

8 The World Bank's Europe and Central Asia (ECA) region comprises the following countries: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kosovo (in accordance with Security Council resolution 1244 (1999)), Kyrgyzstan, Latvia, Lithuania, Montenegro, Poland, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine and Uzbekistan.

vention and the social determinants of health were critical, and the public health community should focus on and advocate for a few, highly effective policies in those areas. OECD was working with WHO/Europe on bringing together senior budget officials and health ministry officials to discuss the fiscal sustainability of health and assessment of the quality of care.

87. Astrid Permin, Senior Technical Adviser, Ministry of Foreign Affairs, Denmark reported on her country's experience of cooperating with Ghana, a country that had recently moved from the low-income to the middle-income category, where donor funding for the health system was falling, and where universal health coverage was being implemented. In that context, Ghana had successfully introduced a 3.5% levy on tourism that was earmarked for the health sector. Denmark's development cooperation work was focused on supporting the Ministry of Health in achieving better management of the quality of care and greater cost-efficiency, strengthening the accreditation system and improving the health management information system. Efforts were also concentrated on support to district health management teams in developing efficient models for primary health care and integrating public health.
88. Alessandra Bardello, Senior Health Economist, European Investment Bank (EIB) described the scope of work done by the EIB. Taking account of recipient countries' strategic priorities, it made capital investments in the form of loans, not grants, totalling some €2 billion per year. While it did not engage in the field of policy, it tried to make the best use of resources by ensuring a strategic "fit" with national objectives, appropriate physical configuration of hospitals and the cost-effectiveness of treatments. Coordination at European level was also pursued by complementing EU structural funds where possible. Clients were encouraged to move towards "asset- and disease-based" planning and to take account of both capital investment and facility management costs, as well as repercussions on employment, energy use and access to health services.
89. Nicolas Cantau, Regional Manager, Grant Management Division, Global Fund said that the Fund's "new funding model" gave priority to activities aimed at strengthening health systems. In each country, the Global Fund relied on country coordinating mechanisms, multi-stakeholder partnerships formed to develop and submit grant proposals based on priority needs at the national level. After grant approval, they oversaw progress during implementation. The Global Fund was working with countries to develop a strategic investment framework for sustained impact on HIV and tuberculosis (TB) in eastern Europe and central Asia. That region was disproportionately affected by multidrug-resistant (MDR) TB: it included 15 of the 27 high-burden countries for that strain of the disease. The Global Fund viewed measures to control MDR-TB as a proxy for the broad health system and financing reform measures that needed to be carried out, such as giving priority to outpatient treatment. The savings from TB hospital care could be reinvested in outpatient/community care.
90. In the following general discussion, participants noted that the introduction of public health taxes on salty foods or those with a high sugar or fat content had yielded revenue in the short term, but that manufacturers had rapidly engaged in product reformulation. On pharmaceutical expenditure, it was important to

maintain affordable drug prices by implementing drug procurement systems and promoting the use of generics. More generally, health had to fight for its place in a competitive environment, and ministries of health needed to know what were their least cost-effective measures.

CONCLUSIONS AND NEXT STEPS

91. The final session was chaired and moderated by Ivi Normet, Deputy Secretary, Ministry of Social Affairs, Estonia.
92. Martin McKee said that participants in the meeting had taken stock of what had happened in the five years since the adoption of the Tallinn Charter. A number of key messages could be identified:
 - There was considerable enthusiasm for implementing the commitments of the Tallinn Charter.
 - Several countries were seriously moving forwards towards UHC.
 - Much thinking was being done about how to improve services, and particularly to address NCDs and multiple morbidity, as well as communicable diseases.
 - Improving accountability and governance were high on the agenda, and many examples had been given about how to do that, including through health system performance assessment.
93. On the other hand, there were still numerous challenges to implementing the Tallinn Charter:
 - The financial crisis had hit as the Tallinn Charter had been adopted and continued to have repercussions on health systems.
 - Resource allocation decisions could not be left to the market, but “quasi-market” decisions were important.
 - It was difficult to put intersectorality into practice.
 - While the solutions to problems in some areas (tobacco and alcohol consumption, for instance) were well known, far less was known about other areas, such as how to empower patients and how to combine management and leadership to obtain appropriate responses.
 - Incentives had to be properly designed to encourage people to take action.
 - Change would not happen unless the behaviour of front-line workers was changed.
94. Marc Roberts said that the meeting had underscored the centrality of patients as front-line workers in delivering their own care. A holistic approach was therefore needed, in order to help people improve their health. That would entail:
 - making health information available to them over various e-health platforms, involving them in effective patient support groups, designing cities and transport systems that facilitated their exercise, ensuring the availability of healthy foods,

and providing community support to overcome isolation and depression among seniors, all of which required working with other ministries;

- developing health care delivery systems that were focused on primary care and which offered continuity of care and relationships with care providers;
 - improving coordination across care providers (inpatient and outpatient settings, doctors and non-doctors);
 - ensuring the needed human resources – not only doctors trained in family medicine and primary care but also nurses, physical therapists, social workers, technicians etc.;
 - introducing the right incentives;
 - making information available for better clinical and managerial decisions, in a system that was easy to use and easy to access and which offered clinical guidance and benefits to those who input the data;
 - establishing the appropriate management structures, including managers of managers, and understanding the limits of incentives;
 - engaging in transparent policy-making and limit-setting, improving political processes, and exercising leadership and change management.
95. Anders Olauson, President, European Patient Forum welcomed the view of patients as front-line workers in their own health care and the need to adopt a holistic approach.
96. A joint statement was delivered on behalf of the European Public Health Alliance, Medicus Mundi International and HealthWorkers4all, calling on WHO and its European Member States to maintain their efforts to implement the Tallinn Charter, paying particular attention to economic governance processes and closely monitoring their impact on people's health.
97. Hans Kluge outlined the next steps in the process leading up the sixty-fifth session of the WHO Regional Committee for Europe (RC65) in 2015. A core group would be established to support the drafting of the Tallinn Final Report and would hold a series of meeting during 2014. The report of the present high-level meeting would be submitted to RC64 in September 2014. Following consultation with the Standing Committee of the WHO Regional Committee for Europe, the Tallinn Final Report and a draft resolution setting out priorities for health systems strengthening would be submitted to RC65 for adoption.
98. In his final remarks, Taavi Rõivas acknowledged that the financial crisis had obliged Estonia to give high priority to public health. Work on strengthening health systems was a continuous task, and he looked forward to renewing the commitments in the Tallinn Charter on its tenth anniversary in 2018, when Estonia would hold the presidency of the Council of the European Union.

99. Closing the meeting, Zsuzsanna Jakab reiterated that the Tallinn Charter and the European health policy framework Health 2020 were synergistic in embodying the same aims of improving people's health and reducing health inequities. She looked forward to two forthcoming events at which health systems strengthening would be further discussed: the International anniversary conference marking 35 years of the Declaration of Alma-Ata on primary health care (Almaty, Kazakhstan, 6–7 November 2013) and the WHO European Ministerial Conference on the Prevention and Control of Noncommunicable Diseases in the context of Health 2020 (Ashgabat, Turkmenistan, 3–4 December 2013).
100. Following the close of the meeting, a lunchtime session was held, chaired by Josep Figueras, Director, European Observatory on Health Systems and Policies, at which the Observatory publication *Health care in transition, Estonia 2013* was officially launched. A keynote speech on the main findings and international perspectives was given by Ewout van Ginneken, European Observatory on Health Systems and Policies, and the following discussion with the audience was led by Taavi Lai, Director, Department of eHealth, Ministry of Social Affairs, Estonia.

ANNEX I

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