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Interim report on implementation of the Tallinn Charter

This interim report on implementation of the Tallinn Charter is submitted to the WHO Regional Committee for Europe for guidance. The report was compiled by a team of WHO and external experts, aided by an external working group, on the basis of written responses to a questionnaire sent to Member States and contributions by heads of WHO country offices and other WHO staff. The report was finalized based on the received feedback of the discussions at the High-level Policy Forum in Andorra and the two SCRC sessions in March and May 2011 prior to the submitting to the Regional Committee.

As called for by the Regional Committee in its 2008 resolution on stewardship/governance of health systems in the WHO European Region (EUR/RC58/R4), this paper contains a mid-term report on the support provided by the WHO Regional Office for Europe and the progress accomplished by Member States in the framework of follow-up to the WHO European Ministerial Conference on Health Systems held in Tallinn, June 2008. In accordance with the request outlined in the Regional Committee's resolution on health in times of global economic crisis (EUR/RC59/R3), this report also presents some preliminary lessons learned at the regional level in the handling of the economic crisis.

The report has six chapters including the introduction in chapter I. Chapter II provides a brief overview of the Charter, with a particular focus on the "commitments" of both Member States and WHO. Examples are given of actions taken by Member States and support provided by the Regional Office that are consistent with these commitments. The rest of the report focuses in greater depth on three key dimensions of the Tallinn Charter: (i) assessing health system performance as a way of improving governance and accountability (chapter III); (ii) ensuring solidarity and health gain in times of financial crisis (chapter IV); and (iii) strengthening health systems impact through leadership of intersectoral action to improve health (chapter V). Chapter VI concludes the report, and offers perspectives on the lessons learned so far in implementing the Charter. It also describes future directions and highlights the synergies between the Tallinn Charter and Health 2020.

Because of the short period that has elapsed since the Tallinn Charter was adopted in 2008, the report does not aim to evaluate the extent to which the commitments of the Charter have been implemented, or to draw conclusive lessons from the implementation process. As requested in resolution EUR/RC58/R4, a final report on the support provided by the WHO Regional Office for Europe and the progress made by Member States in the framework of follow-up to the WHO European Ministerial Conference on Health Systems will be presented to the Regional Committee in 2015, which will allow for more conclusive lessons to be drawn from the Charter implementation process.

Contents

	page
I. Introduction and overview	1
Scope of the report	1
Overview of the report structure	2
Process and sources for compiling the report	2
II. Implementation of the Charter commitments: illustrations and highlights	4
Promoting solidarity and equity	5
Investing in health systems	6
Fostering pro-health and pro-poor investment across sectors	7
Transparency and accountability for performance	7
Promoting the shared value of participation: responsiveness of health systems to the population and engagement of stakeholders	9
Cross-country learning and cooperation	10
Health system preparedness and the International Health Regulations	12
Conclusions	12
III. Measuring the performance of health systems – the central theme of the Tallinn Charter ...	14
Introduction	14
Country progress and lessons learned	16
Progress in fostering and using international comparisons and outstanding methodological issues	19
WHO support for evidence-informed policy-making	20
IV. Sustaining equity, solidarity and health gain in the context of the financial crisis	24
Guiding the response to the financial crisis: the relevance of the Tallinn Charter	24
From values to action: The Oslo recommendations	25
Protecting health budgets and maintaining provision of essential services	26
Sustaining health gain through social spending	29
Extending benefit entitlements to the most vulnerable	30
Sustainability and trade-offs	31
The “invisible hand” of implicit rationing	32
Spending more efficiently	33
Implementing budget cuts	34
How to prepare better for economic downturns?	36
V. Improving performance through leadership of intersectoral action to improve health	37
Introduction	37
Health in All Policies (HiAP)	38
Governance tools that support HiAP	39
WHO support	43
Conclusions	45
VI. Summary of progress to date, and perspectives on future directions for implementation of the Tallinn Charter	46
From values to actions: a summary	46
From the Tallinn Charter to Health 2020	47
The way forward to the Sixty-fifth session of the Regional Committee in 2015	49

I. Introduction and overview

Scope of the report

1. The WHO European Ministerial Conference on Health Systems, held in Tallinn from 25 to 27 June 2008, was a milestone that marked the importance that Member States gave to both improving and being accountable for the performance of their health systems. The political commitment was marked by the signing of the Tallinn Charter: Health Systems for Health and Wealth, and its later endorsement in a Regional Committee resolution on Stewardship/governance of health systems in the WHO European Region (EUR/RC58/R4). Among other things, this resolution requested the Regional Director to “report to the Regional Committee in 2011 and again, with a final report, in 2015 on the support provided by the WHO Regional Office for Europe and the progress accomplished by Member States in the framework of the follow-up to the WHO European Ministerial Conference on Health Systems held in Tallinn, June 2008.”

2. Not long after the Tallinn Conference, the global financial and economic crisis commenced and by the end of 2008 it was clear that in many countries the commitments made in Tallinn were to be “put to the test” by the need to make some hard choices in a new context. In collaboration with the Government of Norway, WHO organized a meeting of all Member States in Oslo in April 2009 on “Health in times of global economic crisis: implications for the WHO European Region”. This was followed by the adoption of a Regional Committee resolution (EUR/RC59/R3) with the same title, in which the Committee took note of the recommendations of the Oslo meeting. That resolution also requested the Regional Director to report to the Regional Committee in 2011 on “lessons learned at regional level in the handling of the economic crisis”. Because of the close links between the commitments in the Tallinn Charter and the Oslo recommendations for response to the crisis, the reporting on both these aspects is brought together in this single paper.

3. The aim of this interim report is to illustrate some of the ways in which the various commitments and messages from the Charter have been made *operational* by Member States. Ultimately, the desire is to highlight innovative actions and inspiring examples of how Member States have turned values into actions. As only 2.5 years have elapsed since the Charter was adopted, it would be premature to expect the Charter commitments to have already been fulfilled, or to conclude on the experience in fulfilling them. The aim is therefore not to *evaluate* the extent to which the commitments of the Charter have been implemented, or to draw conclusive lessons from the implementation process. It is expected that the final report in 2015 will consist of an evaluation that will conclude on the extent to which the Tallinn Charter commitments have been implemented by Member States (accountability), as well as provide insight into the lessons learned during the process.

4. The year 2010 marked the launch of the WHO Regional Director for Europe’s “Vision for better health in Europe”, endorsed by Regional Committee resolution EUR/RC60/R2. A central pillar of this vision is the new European health policy – Health 2020. The Health 2020 process comes in response to the need to re-examine health policy across the WHO European Region in light of a number of mega trends that have become salient over the past decades. These include globalization, increasing population migration, increasing urbanization, increasing inequities in the distribution of wealth and in access to health and social services, accelerating technological innovation, increasing environmental pollution and climate change, the rapidly increasing access to information for patients and the general public, and a shift towards more horizontal and inclusive approaches to governance. In many ways, these trends will have a profound impact on health and health equity, as well as on the ways in which society

responds to health challenges. Against this backdrop, Health 2020 aims to provide a coherent, evidence-based health policy framework for the European Region of WHO that will unequivocally re-affirm the central tenets of the Tallinn Charter.

Overview of the report structure

5. The report has six chapters including this introduction. Following this introductory chapter, Chapter II provides a brief overview of the Charter, with a particular focus on the “commitments” of both Member States and WHO. Examples are provided that illustrate actions taken by Member States and support provided by the Regional Office that are consistent with these commitments.

6. Following Chapter II, the rest of the report will focus in greater depth on three key dimensions on the Charter:

- assessing health system performance as a way of improving governance and accountability (Chapter III);
- ensuring solidarity and health gain in times of financial crisis (Chapter IV);
- strengthening health systems impact through leadership of intersectoral action to improve health (Chapter V).

7. Although health system performance is the focus of Chapter III in particular, it is worth emphasizing that the fundamental pillar of the Tallinn Charter is the emphasis on accountability for performance. This theme accordingly runs through the whole report. Chapter IV sets the lessons from the response to the crisis in the context of the core principles and commitments of the Tallinn Charter. Chapter V is aimed both at reporting on how health ministries have led intersectoral action for health and illustrating the idea that those leading the health system have the responsibility to try to influence factors that affect health, even if those factors emanate from outside the system.

8. Chapter VI concludes the report and offers our perspective on the lessons learned so far in implementing the Charter and the key challenges that the Region is facing in terms of living up to the commitments made in Tallinn. It also describes future directions for the WHO Regional Office for Europe in light of these challenges, and it highlights the synergies between the Tallinn Charter and Health 2020.

Process and sources for compiling the report

9. The report was compiled by a team of WHO and external experts. The effort was aided by an external working group, comprising experts from a wide range of countries in the European Region and including some individuals who had previously served as members of the Tallinn Charter Drafting Group. The group met in October 2010 and February 2011 to develop the report outline and review chapter drafts. A revised draft of the report was presented and discussed at the first meeting of the European High-level Health Policy Forum for High-level Government Officials (Andorra, 9–11 March 2011), and feedback provided at that meeting was used to finalize the report.

10. The writing team drew on several sources, including:
 - feedback from Member States to a questionnaire sent to each of them in January 2011;¹
 - written input from members of the working group;
 - written answers from heads of WHO country offices and strategic objective facilitators at the Regional Office to a set of questions related to Tallinn-relevant activities, and
 - knowledge and written input from staff of WHO (including the European Observatory on Health System and Policies) and other members of the writing team.

11. Unless otherwise specified, the source of material used for this report is some combination of the above.

¹ Member States who completed the questionnaire were offered the possibility of having their response published on the WHO/Europe website. The response of those Member States who chose to take advantage of this possibility can now be down-loaded from <http://www.euro.who.int/>.

II. Implementation of the Charter commitments: illustrations and highlights

Key messages of this chapter

- To promote solidarity and equity, Member States introduced health system changes to respond to the needs of vulnerable groups, and included measures to extend coverage and create and sustain universality in entitlements.
- To secure investment in health, health systems increased their efforts to demonstrate good performance: A critical step for “defending the health budget” is to make the case by demonstrating that the health system has the capacity to use public funds effectively.
- To foster pro-health and pro-poor investment across sectors, health system stewards sought to understand and tried to influence factors outside of the system that impact upon health, incorporating evidence on social determinants.
- To move effectively “from values to action”, Member States fostered transparency and accountability. The focus on performance, its analysis, and feedback to policy decision-making allow for stakeholder involvement and increase transparency and accountability.
- To promote participation and put citizens at the centre of health policy, Member States sought to strike a balance between state, society and individual responsibility for health, making their health systems more responsive to their population and committing themselves to protect patients’ rights.
- To foster and benefit from cross-country learning and cooperation, the WHO Regional Office for Europe and Member States enabled health policy-makers around the Region to assess the potential of their health systems and their policy choice through networking, comparative analysis and benchmarking.

12. By endorsing the Tallinn Charter, the Member States of WHO in the European Region committed themselves to:

- **Promote shared values of solidarity, equity and participation** through health policies, resource allocation and other actions, ensuring due attention is paid to the needs of the poor and other vulnerable groups;
- **Invest in health systems and foster investment across sectors** that influence health, using evidence on the links between socioeconomic development and health;
- **Promote transparency and be accountable** for health system performance to achieve measurable results;
- **Make health systems more responsive** to people’s needs, preferences and expectations, while recognizing their rights and responsibilities with regards to their own health;
- **Engage stakeholders** in policy development and implementation;
- **Foster cross-country learning and cooperation** on the design and implementation of health system reforms at national and subnational levels; and
- **Ensure that health systems are prepared and able to respond to crises** and that countries collaborate with each other and enforce the International Health Regulations.

13. In paragraphs 7 and 8 of the Tallinn Charter, WHO committed itself to supporting Member States, in concert with partner agencies, on the implementation of the Charter, including “the exchange of experience on the above commitments”. In meeting this obligation,

the present chapter reports examples of country action and WHO support that are consistent with the commitments.

14. Because the commitments related to equity/solidarity, transparency and accountability, and cross-sectoral investment to improve health are reviewed in greater depth in other chapters of the report, the treatment of them here is quite brief. Finally, it is worth noting that in practice, many reforms and actions undertaken by countries and WHO reflect more than one commitment, and it is artificial and misleading to fragment these measures. Therefore, we have regrouped the commitments below to facilitate relevance of the reporting.

Promoting solidarity and equity

15. Most of the actions taken by the health authorities of Member States and by WHO can be interpreted as promoting solidarity and equity. To make this approach more operational, however, the review focuses on a few specific dimensions. In particular, we have identified examples of policies, actions and resource allocation decisions that explicitly incorporate a concern for equity in access to services and solidarity in the financing of services, with close attention to the needs of vulnerable groups. Countries' commitment to these core values was indeed put to the test by the global economic and financial crisis that began shortly after the Charter was approved, and the examples shown here illustrate how these values have helped guide the response of health systems. A more in-depth analysis of these issues is contained in Chapter IV.

16. In several countries, reforms in financing were central to alignment of health systems with the core values embodied in the Charter. In some cases, these included measures to create and sustain universality in entitlements or extend coverage/entitlements to defined vulnerable groups. A good example is Turkey's "Health transformation programme", which is merging benefits of formerly different insurance arrangements under a single national universal coverage scheme (including subsidized coverage for people with low incomes) and providing conditional cash transfers to pregnant women to promote antenatal care. In Republic of Moldova in 2009, following recommendations made by WHO, the government made primary health care coverage universal for all citizens, irrespective of their health insurance status, and initiated additional measures to ease enrolment for individuals and small businesses.² In Slovenia, amendments to the Health Care and Health Insurance Act introduced in 2008 gave approximately 100 000 citizens in the lowest income brackets the right to have their complementary insurance premium paid from the state budget. This measure partially reversed the previously regressive system where premiums were completely independent of incomes. A key factor in the success of these changes was the alignment of the policy to extend coverage with the resources needed to enable implementation. Failure to back reforms by a needed shift in resource flows would have resulted in them being more declarative than real.

17. Beyond resource shifts, effective reforms may also require procedural changes. For example, the Serbian government demonstrated its commitment to universal coverage through a decision to ensure coverage for the entire Roma population. However, administrative barriers prevented this legislation from being implemented. The Ministry of Health engaged WHO to provide technical advice to address this in 2010, leading to recommendations to ease the process of registration of Roma (and long-term unemployed) people with the national health insurance fund.

² Jowett M, Shishkin S (2010). Extending population coverage in the national health insurance scheme in Republic of Moldova.. Copenhagen, WHO Regional Office for Europe (Health Financing Policy Paper 2010/1, http://www.euro.who.int/__data/assets/pdf_file/0005/79295/E93573.pdf).

18. A key lesson emerging is the importance of aligning on-going efforts for monitoring and analysis with the needs of policy-makers (i.e. to provide a basis for evidence-informed decision-making). Many countries have extensive monitoring systems in place, but often organized for the needs of each specific program rather than the system as a whole. This was recognized as a concern in the Russian Federation where, for example, there is careful monitoring of mortality from vascular diseases by the relevant vertical program, but where there was little monitoring of the performance of the primary care providers who have an important influence on the incidence of vascular diseases. In the aggregate there is an abundance of information, but it is not organized in a way that is useful for policy-makers. Recognizing this, the Russian Federal Ministry of Health, together with leading Russian and WHO experts, convened a national workshop in May 2010 to initiate a dialogue on performance assessment and evidence-informed policy-making.

19. In addition to financing reforms, Member States introduced other health system changes to respond to the needs of vulnerable groups. One important area was changes to make services more “migrant-friendly”. This involved a combination of outreach and health promotion services targeted at migrants, as well as training and continuing education for health professionals so that facility-based services could be better adapted to the needs and cultural contexts of specific migrant populations. Portugal and Switzerland have implemented programmes that include these features. In 2010, as part of its collaboration with the European Commission, WHO provided guidance on how health systems can best address health inequities linked to migration and ethnicity.³

Investing in health systems

20. The financial and economic crisis had implications for the ability of governments to spend on health, though to differing degrees. While lessons learned from the response to the crisis are described in Chapter IV, here we focus on how several ministries of health engaged WHO support in this area.

21. At the time of the Tallinn Conference, no one was aware of the global financial crisis that was about to strike. Fortuitously, it was during the Conference that the Czech delegation approached WHO for support on the technical agenda for their European Union (EU) Presidency Conference on health system sustainability that was to be held a year later. In collaboration with the Czech Ministry of Health, WHO (including the European Observatory on Health System and Policies) produced the background technical material for the Conference.^{4,5,6} This technical work also laid the foundation for engagement and support to specific country efforts to sustain government health spending. In response to a request from the Latvian

³ WHO (2010). How health systems can address health inequities linked to migration and ethnicity. Copenhagen: WHO Regional Office for Europe. (http://www.euro.who.int/__data/assets/pdf_file/0005/127526/e94497.pdf).

⁴ Fernández JL et al. (2009). How can European states design efficient, equitable and sustainable funding systems for long-term care for older people? Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies (Health Evidence Network/Observatory Policy Brief 11, http://www.euro.who.int/__data/assets/pdf_file/0011/64955/E92561.pdf).

⁵ Rechel B et al. (2009). How can health systems respond to population ageing? Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies (Health Evidence Network/Observatory Policy Brief 11, http://www.euro.who.int/__data/assets/pdf_file/0004/64966/E92560.pdf).

⁶ Thomson S et al. (2009). Addressing financial sustainability in health systems. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies (http://www.euro.who.int/__data/assets/pdf_file/0018/76041/E93058.pdf).

Ministry of Health, for example, WHO addressed a parliamentary debate on the health budget in September 2010. In collaboration with the Estonian Health Insurance Fund and Ministry of Social Affairs, the report “Responding to the challenge of financial sustainability in Estonia’s health system”⁷ was published and launched at a national conference in 2010 attended by the Regional Director. Explicit reference was made to the Tallinn Charter in the report and at the conference, and the process of producing this work involved eliciting the value preferences of key stakeholders, reflecting another Charter commitment.

22. A key message from both the conceptual work and country-specific engagement is that a critical step for “defending the health budget” is that ministries of health have to make the case, i.e. demonstrate that the health system has the capacity to use public funds effectively. There is thus a crucial link between a core message of the Tallinn Charter and the ability to sustain public commitment to health spending: health systems need to demonstrate good performance.

Fostering pro-health and pro-poor investment across sectors

23. This commitment reflects the understanding that part of effective health-system stewardship is to understand and try to influence factors outside the system that impact upon health, incorporating evidence on social determinants. While the experience gained and the lessons learned are explored in depth in Chapter V, a few highlights are noted here, reflecting both comprehensive and targeted issue-specific approaches.

24. In Estonia, Poland, Portugal and Norway, governments introduced a comprehensive set of measures aimed at influencing social determinants of health and health inequalities. These included taxation (e.g. on alcohol, tobacco and sugar in beverages), interventions in housing, employment, schools and drug addiction and social support. In these countries, multiple ministries and local governments are involved, with the ministry of health playing a catalytic role. Norway’s programme promotes follow-up by incorporating a common reporting system for all ministries/sectors involved, with overall management responsibility assigned to the Directorate of Health. The Directorate published the first Norwegian public health policy report for 2009 and will be reporting annually, incorporating information from multiple sectors. Similarly in Estonia, the national health plan (NHP) 2009–2020 gives the Ministry of Social Affairs a leading role in the coordination of intersectoral collaboration. All ministries provide annual plans of health-related actions, report on their implementation and impact and belong to the steering panel of the NHP, where overall priorities for all ministries in regard to health are set.

25. Recognition of the importance of incorporating other sectors into health policy is also relevant to very specific issues. In the Russian Federation, for example, a large-scale federal programme was introduced to address trauma associated with road traffic accidents. This is being implemented in close collaboration with the Ministry of Internal Affairs, and with technical support from WHO.

Transparency and accountability for performance

26. The Charter draws attention to the importance of fostering transparency and accountability on the basis of progress against measurable results. In fact, the focus on

⁷ Thomson S et al. (2010). Responding to the challenge of financial sustainability in Estonia’s health system. Copenhagen, WHO Regional Office for Europe (Health Financing Policy Paper 2010/2, http://www.euro.who.int/__data/assets/pdf_file/0003/107877/E93542.pdf).

performance, its analysis, and feedback to policy decision-making is perhaps the central theme of the Charter, linked closely to the message of moving “from values to action”. Countries honouring this commitment will have acted to measure, analyse and publicly report on the performance of their health systems and/or the effects of specific reform measures. Because this is the subject of Chapter III of this report, we do not go into great depth here but simply highlight a few points.

27. Experience in the Member States indicates that performance assessment is indeed an effective tool to foster transparency and accountability. Not only can performance assessment provide a tool to crystallize lessons learned from the implementations of policies, it can also provide a process through which stakeholders can be involved, and transparency and accountability increased. An excellent example of this is the first Belgian health system performance report produced in 2010. The report and related documentation produced for the Belgian EU Presidency note two driving motivations for producing this work: one was an explicit mention of the Tallinn Charter, and the other was a part of the March 2008 coalition agreement on public health, which stated that “the performance of our health system (including quality) is to be assessed on the basis of measurable objectives”.^{8,9} The focus on measurable performance was the basis for agreement among the coalition parties. Similarly in Italy, performance assessment has been a means to bring together the country’s regions. In February 2011, for example, a meeting on subnational performance assessment was organized under the banner of the Tallinn Charter by the National Agency of Regional Health Services (AGENAS), involving participants from 18 of the country’s 21 regions and autonomous provinces. AGENAS is currently engaged in building common terms of reference for performance evaluation in Italy.

28. A key lesson emerging is the importance of aligning ongoing efforts for monitoring and analysis with the needs of policy-makers (i.e. to provide a basis for evidence-informed decision-making). Many countries have extensive monitoring systems in place, but they are often organized for the needs of each specific programme rather than the system as a whole. Often, a huge volume of data is collected, but the organization and analysis of this information does not serve either management or policy decision-making. This was recognized as a problem in the Russian Federation, for example, where each federal vertical programme has its own monitoring scheme with targets, and health care utilization and allocation of health funding across health subsectors is carefully measured in each region of the country. This has resulted in an abundance of information that is, unfortunately, of little use to policy-makers. Recognizing this, the Russian Federal Ministry of Health, together with leading Russian and WHO experts, convened a national workshop in May 2010 to initiate a dialogue on performance assessment and evidence-informed policy-making.

29. Another lesson is the importance of combining quantitative and qualitative analytical methods. While quantitative indicators provide a useful snapshot of performance in a given area, they rarely tell the story of the underlying causes and the potential solutions. Put another way, indicators can describe change, but they cannot explain it. For example, maternal mortality ratios, the standard international tool widely used for measuring improvements in maternal health, provide no indication of what clinical conditions individual women are dying from, what factors led to their deaths, how they could be prevented or which specific groups of mothers are dying. In response to this specific issue, Member States such as Kazakhstan, Kyrgyzstan,

⁸ Belgian EU Presidency Report (2010). Performance of the Belgian health system: a first step towards measuring...”. Brussels, Belgian Health Care Knowledge Centre (http://www.inami.fgov.be/information/all/studies/study48/pdf/performance_health_care_EN.pdf).

⁹ Vlayen J et al. (2010). A first step towards measuring the performance of the Belgian health care system. Brussels, Belgian Health Care Knowledge Centre (KCE) (KCE reports 128B (D/2010/10.273/26) with a French summary, http://www.kce.fgov.be/index_en.aspx?SGREF=5216&CREF=16543).

Republic of Moldova, Tajikistan and Uzbekistan have adopted the WHO “Beyond the Numbers” approach, whereby the results of confidential enquiries into individual maternal deaths are integrated into wider maternal health performance reviews. Similarly, with the support of WHO, a number of Member States have conducted in-depth environmental performance reviews in order to complement the information provided by the quantitative indicators in WHO’s Environment and Health Information System.

Promoting the shared value of participation: responsiveness of health systems to the population and engagement of stakeholders

30. “Participation” is one of the shared values to which Member States committed themselves in the Charter, as well as in the Health for All policy framework. Operationalizing this value becomes more apparent in two other Charter commitments: to make health systems more responsive to their populations, and to engage stakeholders in both the development and implementation of policies. The latter is a commitment to a participatory process, while the former reflects the goal of responding to people’s expectations, needs and preferences. Put another way, this goal can be thought of as putting citizens at the centre of health policy, aiming to strike a balance between state, society and individual responsibility for health. In this section, we highlight examples of Member States’ actions and WHO support to these different aspects of participation.

31. Several Member States have demonstrated the intention to have more citizen-centred systems within comprehensive national health strategies. A recent example is Estonia’s National Health Plan 2009–2020, one aim of which is to create an environment that makes healthy choices easy for everyone and that empowers people with regard to their health. Recommendations are provided on how individuals can take action to preserve and improve their own health, and a commitment to protect patients’ rights is matched by the intent to make citizens more aware of these rights in the health system. Health knowledge and healthy behaviours will be taught at schools. The effects of these changes, including changes in population health behaviour, will be measured with an annual survey.

32. Another mechanism adopted by many countries is the use of policy documents or legal/regulatory instruments to define and promote awareness of patients’ rights. Norway’s national health plan makes explicit key aspects of such rights, such as appropriate waiting times for accessing services. Latvia’s Law on the Rights of Patients, which was developed with technical support from WHO, came into force in March 2010. The law enumerates rights along a number of dimensions, such as people’s right to information about their medical documents, right to medical treatment (consent or refusal), choice of physician and health facility, personal data protection, and other rights. Regulatory instruments are also used, such as Portugal’s Charter on the rights and duties of users of the national health system and Charter for hospitalized citizens, each established by the Ministry of Health.

33. Many countries have used “hotlines” or web-based mechanisms. These tend to serve two functions: a means to provide feedback on citizens’ health- or health system-related questions, and a means for citizens to register their complaints. The web site of the Azerbaijan Ministry of Health includes the phone number for the Ministry of Health hotline that citizens can call with any questions. In Portugal, all facilities that receive a formal complaint are obliged to respond.

34. Countries have also sought greater stakeholder involvement in policy development and implementation processes, giving effect to this in a variety of ways. At the level of national health policy development, there are numerous examples of stakeholder engagement. In late 2009, Kyrgyzstan began developing its new health sector strategy for 2012–2016, led by a working group of the Ministry of Health. The working group meets regularly with civil society representatives to discuss key elements of the strategy. WHO has been providing technical

assistance to the process throughout, including the organization of wide discussions during November 2010.

35. Countries have also engaged stakeholders on specific health issues and subsectoral strategies. In Slovakia, for example, working groups were established to address a variety of issues, such as the definition of standards for the network of health facilities, policy for emergency health services, and drug policy. Stakeholders involved include health insurance companies, hospital associations, national experts and professional bodies. To support the drafting of a federal law on disease prevention and health promotion in Switzerland, a working group was established with representatives from the cantons, public and private agencies, and the federal state. It formulated the specification of national disease prevention goals, which was then integrated in the provisional version of the act. In Armenia, the national child and adolescent health strategy was developed by an intersectoral working group involving the ministries of health, education and finance, the police and other local and international stakeholders, with continuous technical support provided by WHO. The strategy was adopted by the government in 2009.

36. Latvia provides a good illustration of the importance of involving stakeholders to ensure effective implementation. To evaluate options for reform of payments for laboratory and diagnostic examinations, the Ministry of Health established a working group of experts from nongovernmental organizations (NGOs), different state institutions and independent diagnostic/laboratory facilities. This led to a practical solution: a two-step implementation plan incorporating first a transition period for implementing the new payment method, followed by an evaluation to determine if adjustments would be needed after the initial period.

37. These examples illustrate different ways in which Member States, often with the support of WHO, have reflected the value of participation in their health systems. These range from measures to ensure participatory processes of policy development and implementation, to efforts aimed at ensuring that their systems respond to the needs and preferences of their populations.

Cross-country learning and cooperation

38. A key role for WHO is to foster cross-country learning on a range of health issues, including lessons learned from the implementation of national and subnational health reforms. The Tallinn Charter specifically identified the importance of this, as a responsibility not only of WHO but also of the Member States themselves. Useful modalities include production and dissemination of technical/policy analyses and syntheses, direct engagement with policy-makers, national and multicountry meetings and workshops that provide a forum for policy dialogue, training programmes, and a combination of these. Cross-country comparisons of health system performance are another useful mechanism, and this is reviewed in Chapter III.

39. Policy analyses and syntheses have been the staple output of the European Observatory on Health Systems and Policies and the Regional Office's Health Evidence Network for many years. WHO technical programmes have also produced many such studies, often in collaboration with the Observatory, such as a recent book on lessons from implementation of health financing reforms. In addition, partner agencies such as the Organisation for Economic Co-operation and Development (OECD) and the World Bank have produced numerous analyses to the benefit of Member States, often with the contribution of WHO. Because countries vary along a number of important dimensions, a critically important step for relevant cross-country learning is tailoring lessons learned to the specific context of particular countries. Hence, lessons learned from the experience of several countries are best conveyed in direct dialogue with the "recipient" country, to ensure appropriate lessons are drawn. Such dialogue has formed a critical part of WHO's work in the Region.

40. WHO's engagement on health financing issues in Bulgaria in 2010 illustrates several aspects of this. At the request of the health ministry and in the context of intense internal debates about the direction of health insurance reforms, WHO was asked to organize a policy seminar including experts from a number of different countries. To ensure proper contextualization of international lessons, an expert mission preceded the workshop, providing an analysis of the health financing system and priorities for reform. With this as background, the seminar, which was organized by WHO with the support of the Observatory and important input from the World Bank, involved experts from the Czech Republic, Lithuania, the Netherlands, Slovakia, and Slovenia. Together, the seminar and the mission contributed to the debate on the direction of insurance reform and highlighted weaknesses in the existing system and the potential for different options in the Bulgarian context to achieve policy objectives consistent with the Tallinn Charter.

41. One specific mechanism directly inspired by the Tallinn Charter has been WHO's new Knowledge, Experience and Expertise Bank (KEE-Bank). KEE-Bank Technical Notes include both the process and content of reform, aiming for in-depth understanding of lessons for implementation. The first results of this exercise produced in 2010 stem from the rich and diverse health reform experience that Spain has accumulated over the last two and a half decades at the subnational level within the context of a single national law that grants universal access. The KEE-Bank enables health policy decision-makers to rely on their peers across the Region for assessing different policy choices. While initiated in Spain, these notes have proven useful for capacity-building and policy dialogue in Poland, Republic of Moldova and Montenegro, and they have also been used as the basis for training materials delivered in the Barcelona-based course on health systems development for the countries of central Asia and Caucasus. The KEE-Bank has thus become an effective instrument to facilitate cross-dissemination and mutual learning, both within and among Member States.

42. Networking and the exchange of information and experience are a powerful mechanism for cross-country learning: for several years, pharmaceutical policy-makers in the EU countries have met twice a year in the Pharmaceutical Pricing and Reimbursement Information network to discuss pharmaceutical policy issues (e.g. how to promote generic drugs, collaboration on medicines evaluation, ad hoc exchange of price information for setting prices of new products, reference pricing, etc.). The network, led by Gesundheit Österreich (the Austrian public health institute) and supported by the European Commission and WHO, has developed into a self-sustaining network of Member States.

43. As noted above, training programmes are also a means to enable cross-country learning on health reforms. Since 2004, the WHO Regional Office for Europe and the World Bank Institute have collaborated in the design and delivery of regional, subregional and national flagship courses on health system reform, health financing and poverty/equity issues. Partners in these courses have been institutes in Hungary and Kyrgyzstan. The European Observatory's Venice Summer School has addressed a wide variety of topics, such as EU integration and health systems, ageing, hospital re-engineering, and health technology assessment.

44. Other experiences reflect a commendable effort by Member States that have taken the initiative to share, discuss, and propose joint thinking around the challenges arising from efforts to improve the performance of their health systems. In 2010, a health task force was established by the prime ministers of Estonia, Latvia and Lithuania. The Task Force was mandated to assess the potential efficiency of setting up a common system for state-funded procurement of medicines and medical equipment, establishing joint specialized medical centres for more efficient use of professional skills, coordinating emergency help in the border towns of the three countries, and establishing a human organ transplant system and a common sperm bank and infertility treatment centre. In Croatia, the Ministry of Health and Social Welfare partnered with the School of Public Health to organize an international conference on "Experiences in the implementation of health reforms in the Republic of Croatia". The results of health reform in

Croatia were presented, and attendees from a large number of countries (Albania, Austria, Bosnia and Herzegovina, Hungary, Montenegro, Serbia, Slovenia and the former Yugoslav Republic of Macedonia), as well representatives of WHO and the World Bank, had the opportunity to reflect on the issues and offer input from their own experiences.

45. WHO's European Region in general, and groups of Member States in particular, have consolidated effective platforms to enable joint learning and structured cross-national cooperation, supported by WHO-backed expertise. Such endeavours have sought to support health policy-makers around the Region in making informed choices on the policy options they face; to base these choices on evidence stemming from their countries and subnational regions; and to assess the real potential of their health systems and policies through comparative analysis and benchmarking across the Region.

Health system preparedness and the International Health Regulations

46. The seventh commitment in the Tallinn Charter is that Member States will ensure that health systems are prepared and able to respond to crises, and that they collaborate with each other and enforce the International Health Regulations (IHR). Countries honouring this commitment have, for example, established a health sector-wide programme to build the capacity to anticipate, prevent, prepare for, respond to, mitigate the effects of and recover from health crises. This includes a variety of activities across all health system functions, such as a continuously refined and updated health sector emergency response plan, based on endorsed policies, established crisis management structures, risk reduction measures involving the communities and many other activities. A health sector crisis management programme should include links to other sectors involved in crisis management and standardize a management system to address crises.

47. WHO has provided input and guidance to Member States on how to assess national capacities and to develop and strengthen IHR core capacities, including the timely response to outbreaks and other public health events of international concern. For example, the Regional Office has co-developed and co-facilitated a "table top" exercise for Member States and key players in charge of implementing national IHR action plans; and joint crisis preparedness assessment missions to Member States have included IHR components in individual meetings and workshops. The functioning of systems for hazard detection and event risk assessment is assured through constant monitoring of the quality and timeliness of IHR notification and verification-related communications. Despite limited resources, a number of IHR capacity building activities in keeping with the Tallinn commitments have been implemented.

Conclusions

48. This chapter has presented only a part of the vast array of initiatives that illustrate the remarkable efforts made by Member States and the WHO Regional Office for Europe to reinforce – and, in some cases re-direct – health systems and to focus health policy on giving effect to the shared values of solidarity, equity and participation. Some of these policies and activities were ongoing at the time the Tallinn Charter was endorsed, including several that contributed to development of the Charter. All are consistent with the aims of supporting and enabling health systems to contribute to good health that is equitably distributed and to become more responsive to people's needs and preferences, while involving them in the process of policy development and implementation, contributing to a fairer distribution of the burden of funding systems and progressing towards the goal where no one becomes poor as a consequence of ill health. Yet other examples have indeed been triggered as a result of the more vigorous

(dynamic) policy dialogue in the Region on the importance of investing, reforming and preserving health systems as key instruments to improve the health status of the population.

49. In several cases, the Charter has been used in policy dialogue, and reference is made to it in important documents, such as the Belgian health system performance report mentioned earlier in this chapter. In some cases, the Charter may indeed have played an inspirational role in health policy development. The preamble to the new Italian national health plan (still in draft) refers to the Charter as the basis for strengthening the stewardship role in the national health system. And in Turkmenistan, the Charter was clearly inspirational in the 2009 initiation by the country of a long overdue national health policy document – many clauses of which are based on the Charter. These are but a few examples of how the Tallinn Charter has had a direct influence on national health policies. Key messages, principles and approaches that are consistent with the Charter are being used in many countries of the Region.

50. Finally, the chapter has synthesized a series of initiatives where the Regional Office has actively sought to discharge its mandate as laid down in the Tallinn Charter, through policy dialogue, technical support, and the enabling of cross-national learning and cooperation directed at strengthening health systems; and thus making them more instrumental in achieving solidarity, equity and participation in the Region.

III. Measuring the performance of health systems – the central theme of the Tallinn Charter

Key messages of this chapter:

- Systematic monitoring of health system performance makes it possible to enhance transparency and accountability among all constituents, including governments, health care providers, health authorities and all citizens.
- Member States have been increasingly producing and using health evidence in decision-making, as well as searching for effective ways to institutionalize this activity into their governance structures. Integrating health system performance assessment into the governance structure of Member States allows it to become a regular ongoing activity, with programmatic and funding consequences.
- Recent experiences indicate that performance assessment generates added value for governance, by engaging stakeholders, fostering intersectoral dialogue, mainstreaming evidence on gaps in equity, promoting a common vision across programmes or levels, or establishing mechanisms for solidarity across regions. Those perspectives will shape the scope and process of performance assessment.
- While there is still diversity in approaches to health system performance, key factors for its success are recognized: stakeholder participation and balancing the use of qualitative and quantitative information. In addition, we observe a tendency towards using comprehensive, system-wide approaches, including the broad determinants of health.
- International comparisons of health systems performance are receiving considerable attention in the media. There is a need to highlight not only the policy ‘uses’ but also the policy ‘abuses’ of such comparisons.
- Peer learning networks offer additional opportunities to understand variations in results and provide insight into how policies affect health system performance. WHO has a role to play in creating opportunities and providing tools for benchmarking within and between countries.

Introduction

51. Systematic monitoring of health system performance makes it possible to enhance transparency and accountability among all constituents, including governments, health care providers, health authorities and all citizens. Regular, open publication of performance results at all levels represents a common target aimed at improving responsiveness to public expectations and ensuring effective, evidence-informed policy-making.

52. The key role of measurement of health system performance had been recognized and translated into commitments in a number of previous charters and declarations, and this was reaffirmed in the Tallinn Charter. In particular, monitoring, accountability and redress are essential; and indicators and benchmarks are indispensable if governments are to be held accountable and meet the core obligation to adopt a national public health strategy and plan of action.¹⁰ By endorsing the Tallinn Charter, Member States committed themselves to promoting transparency and accountability for health system performance to achieve measurable results.

¹⁰ UNESCO (2000). The right to the highest attainable standard of health. E/C.12/2000/4, [www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En).

The most relevant aspects in the Tallinn Charter, related to performance measurement, are listed in Box 1 below. This commitment was further reinforced in the context of the economic crisis during the First Regional Tallinn Charter Follow-up Meeting (Copenhagen, 5–6 February 2009), when Member States agreed on plans to take the Charter forward and monitor progress in its implementation, highlighting the importance of developing their capacities for health system performance assessment and cross-country learning.

Most relevant aspects in the Tallinn Charter related to performance measurement and evidence-informed policy

- Commitment to “promote transparency and be accountable for health system performance to achieve measurable results” (paragraph 6).
- “Application of the broad goals in each country requires the identification of objectives that are linked to the goals and “actionable” by policy... Objectives should be specified in a measurable way to enable explicit monitoring of progress” (paragraph 12).
- “Ministries of health set the vision for health system development and have the mandate, for gathering intelligence on health and its social, economic and environmental determinants” and “should promote inclusion of health considerations in all policies...” (paragraph 13, stewardship 1,2).
- “Monitoring and evaluation of health systems performance and balanced cooperation with stakeholders at all levels of governance is essential to promote transparency and accountability” (paragraph13, stewardship 3).
- “Health system functions are interconnected; therefore, improving performance demands a coherent approach involving coordinated action on multiple system functions” (paragraph14).
- In the context of the points listed above, WHO committed itself to:
 - “support its European Member States in the development of their health systems and
 - provide cross-country coordination in implementation of the Charter, “including the measurement of performance” and the exchange of experiences on the above commitments” (paragraph7).

53. Member States have been increasingly producing and using health evidence in decision-making, as well as searching for effective ways to institutionalize this activity into their governance structures. Countries that have achieved a shift in culture towards a more evidence-informed approach have succeeded in establishing three key “pillars” over time: (i) regular demand for health evidence by policy-makers; (ii) high-quality supply of health evidence, and (iii) sustainable institutional solutions linking demand and supply. At the First Regional Follow-up Meeting on the Tallinn Charter, panel members highlighted the wide variety and rich experiences in the WHO European Region with regard to performance assessment. It varies in form, ranging from annual and biennial reporting to parliament, the health ministry or the public, to participation in specific projects measuring the performance of hospital care providers. The aims range from increasing transparency to implementing national health programmes, documenting and reducing health inequalities, or increasing the efficiency of the health system. Countries have developed various mechanisms to feed performance assessment results into policy-making. This has led, for instance, to changes in the strategy to manage cardiovascular diseases and related mechanisms for health system funding, linking performance to funding and hospital reforms.

54. In accordance with the integrated approach supported by the Tallinn Charter, performance measurement demands a coherent evaluation scheme to understand how the system

as a whole meets its objectives. In this chapter, we will focus on the most recent initiatives that have taken the whole health system as the subject of analysis (at national, subnational or local level). The examples below illustrate some of the most salient trends in performance measurement in the European Region over recent years, grouped according to country progress, international comparisons and innovation, and WHO coordination. The recent approach of “Health Systems Performance Assessment” (HSPA) will be positioned in the framework of governance tools, in particular with regard to national health plans and strategies and evidence-informed policy development.

Country progress and lessons learned

Promoting the shared values of participation, equity and solidarity through the assessment process

55. Since open publication of performance results at all levels represents a common target aimed at improving responsiveness to public expectations and ensuring effective, evidence-informed policy-making, most countries have established mechanisms whereby the health minister reports to parliament or through a parliamentary commission on health. Public accountability for health system performance has been enhanced by the release of “report cards”. The British National Health System (NHS), the Netherlands and the Nordic countries have been paving the way, with the publication of indicators on the web. In the Tuscany region of Italy, extensive reports on achievement of targets (drawn up for directors at the different organizational levels) are made publicly available, with positive results in terms of professional benchmarking and enhanced accountability/transparency to the public.

56. Patients’ requests for information will grow with increased citizens’ awareness and participation, as well as with increased patient mobility (especially between EU countries or between regions within countries). This is exemplified by the increasing role of media and consumer reports. They have been channelling much attention to the quality of health care providers and are now entering the wider sphere of international health system comparisons. For instance, the Health Consumer Powerhouse ranks national European health care systems across six dimensions selected to represent a “consumer-centred” position. Though these reports have been challenged on methodological grounds, they continue to arouse interest and are taking in additional indicators such as efficiency and sustainability, chronic care disease management and the role of patients: “Bang-for-buck” (BFB) adjusted score, Diabetes index (2008), Heart disease index (2008), HIV index (2009) and Patient empowerment index (2009).

57. The task of engaging stakeholders has been a feature of many different experiences across Europe. In Belgium, a report (2010), based on interviews with policy-makers, was issued under the responsibility of the Belgian Health Care Knowledge Centre, the Institute of Public Health and the National Institute for Health and Disability Insurance. The administrations in charge of social affairs and public health, whether regional, community-based or federal, were also involved in the project. In Turkey, HSPA was conceived as a tool for defragmentation, to highlight the importance of all actors contributing to the goals of improved health for all citizens. The process of HSPA was highly participatory, involving all departments within the ministry of health, as well as the ministries of education and the environment and the social security institute, were consulted for the development of the strategic framework; they defined indicators, provided data, and validated interpretation and policy recommendations. The evaluation of Norway’s quality indicator system highlights the need to involve all stakeholders (users/patients, health personnel, researchers and leaders/administrators) at all levels in the development of indicators and to make the results readily accessible (e.g. via internet) (2008).

58. In the context of a highly decentralized system, performance assessment supports solidarity and equity among regions. In Sweden, the National Board of Health and Welfare

(NBHW) monitors and evaluates health services to determine if they correspond to the goals laid down by the central government. Together with the Swedish Association of Local Authorities and Regions (SALAR), NBHW has published two reports on health care quality and efficiency in the 21 Swedish county councils and health care regions.¹¹ Seventy-five quality and performance indicators were grouped in four main areas: medical results, patient experiences, availability of care and costs.

Informing intersectoral dialogue and promoting health as a “whole-of-government” approach through performance assessment

59. In many countries, health ministers may not possess the authority within the government to promote change outside of their own portfolio. By adopting comprehensive assessment frameworks, an evidence base for intersectoral dialogue can be provided, recognizing the contribution of other sectors to immediate and ultimate health outcomes. In Estonia, HSPA informed alcohol and nutrition policies. National health plans and strategies spanning settings and population groups might contribute in the same way. Although questions of how we can attribute high-level health outcomes and where are the boundaries of the health system have been raised on multiple occasions, the use of comprehensive frameworks strongly supports the clear mandate of ministries of health to define a broad vision for health and gather intelligence on health and its social, economic and environmental determinants and to establish a national health equity surveillance system.¹²

60. Comprehensive frameworks that make explicit the role of socioeconomic determinants of health, lifestyles and environment in health outcomes have been very broadly adopted across Europe. They are widely applied both by national authorities (Belgium, Estonia, the Netherlands, Portugal, and Turkey) and by international organizations (OECD, the European Community Health Indicators Monitoring [ECHIM] project). Both the Dutch and Belgian frameworks are built on three interconnected tiers: health status, non-medical determinants of health and the health system. The health system includes five domains: health promotion, preventive care, curative care, long-term care, and end-of-life care. In this framework, equity is an overarching dimension that is presented across all tiers of the framework. Armenia, Estonia, Georgia, Portugal and Turkey built their country-specific frameworks on the WHO framework. Turkey, for instance, then translated this framework into a strategic map that visually represents the causal relations between functions, objectives and the final goal of improved health. Two intermediate objectives are identified: effectiveness of utilization (access, use and quality of services), and healthy lifestyles and the environment.

Aligning performance assessment with development and monitoring of (sub)national policies and strategies

61. The Tallinn Charter recognizes that “application of the broad goals of health systems in each country requires the identification of objectives which are linked to the goals and actionable by policy”. Health system reviews look at health system functions. Both Switzerland (OECD and WHO) and Turkey (OECD and World Bank) have undergone such a review and their health systems are in the process of revision. Targets in national health plans (NHPs) are designed to monitor attainment of ultimate population goals and intermediate outcomes. A strategy-based assessment of the health system aims to link the functions (or strategies) to the goals and objectives.

¹¹ Swedish Association of Local Authorities and Regions (2008). *Quality and Efficiency in Swedish Health Care – Regional Comparisons 2008*. ISBN 978-91-7164-452-7.

¹² Commission on Social Determinants of Health Closing the gap in a generation: health equity through action on the social determinants of health. Geneva, World Health Organization, 2008.

62. In Estonia and Portugal, the NHP evaluation and HSPA processes were conducted in parallel. In 2010, WHO and the Ministry of Health of Portugal jointly published two reports resulting from their collaboration between 2008 and 2010. The NHP evaluation and the HSPA are mutually devoted to supporting the Ministry of Health's efforts to improve the performance of the Portuguese health system. HSPA was implemented through a mix of quantitative and qualitative methods. In addition, the Office of the High Commissioner for Health requested specific reviews on several aspects of national health system performance so that the Ministry of Health could be provided with the evidence base and policy options to inform preparation of the next NHP (2011–2016). This experience suggests that there is merit in including perspectives at all different levels (including regional and local ones), as well as working with the research community as much as possible and with a mixed team of national and international experts.

63. In Kyrgyzstan, HSPA is a continuous activity in the context of health sector programmes. It consists of annual health and health system monitoring, a complementary system of policy studies and an annual review of progress in health system performance jointly by the Ministry of Health, wider government bodies and development partners. Health system performance monitoring in Kyrgyzstan entails the regular tracking of health sector programme outputs (direct results from implementing programme activities), outcomes (programme results), and impacts (programme effects) by the Ministry of Health through record-keeping and reporting on the basis of a table of measurable characteristics (indicators). The conclusions of the annual reviews of sector performance are documented in joint annual review notes, which contain not only a statement of progress but also agreed policy, programmatic and budget consequences.

Using performance assessment for performance management

64. A number of initiatives are aimed at embedding performance assessment in mechanisms for accountability and performance management. Experience suggests, however, that carefully balancing indicators (e.g. process vs. outcomes) or incentive schemes (e.g. reward vs. sanction, internal vs. public reporting) is challenging and requires a dynamic approach to acknowledge the behavioural response to the evaluation (looking better might not actually mean doing better) and as new evidence is generated. The United Kingdom has a complex history of measurement and target-setting at different national and subnational levels for at least three decades. In 2006, the balanced scorecard model encouraged NHS organizations to develop their mission-specific set of performance measures, retaining an emphasis on financial objectives. It was then complemented with an “annual health check” – a performance measurement system that looked at a broader range of issues than the targets used previously, for instance by including the judgment and expertise of people who use and provide health care services. Since 2010, “quality accounts” have been submitted: these are annual reports from NHS providers to the public about the quality of services they provide. The phrase “a golden thread” has been used to point to coherence in the chain of objectives, targets and indicators consistently applied from the central Government to local administration and service delivery.

65. In Italy, since 2008 a complicated “budget recovery plan” has been extended from the seven regions originally involved to a total of ten, of which five have had their decentralized powers suspended and taken over by a government commissioner who undertakes operational plans locally. During the biennium 2009–2010, the ministries of finance and of health substantially intensified procedures for the regular monitoring of systems' functions in recovering regions. Substantial deviations from a core list of agreed objectives are associated with reduced funding or the imposition of penalties. A common set of indicators and tight deadlines have been imposed in order to ensure the maintenance of essential levels of care, the achievement of health and economic targets and the capacity of the regions to maintain robust information systems on a routine basis. Indicators include aspects such as prevention, community care, acute care, outcomes and health status. The same monitoring system, albeit with less pressure on targets and deadlines, is also applied in the other regions.

Progress in fostering and using international comparisons and outstanding methodological issues

66. In addition to analysing national trends over time or looking at regional disparities within a country, comparator countries provide insights into the level of performance and potential targets. There is evidence of national initiatives embedding international comparisons in a national process of performance assessment. The Portuguese national health plan draws from OECD and WHO databases to set targets based on international reference points, where available. In a 2008 report entitled “Dare to compare”, the Netherlands used the ECHI indicators to compare health items between 27 European countries and sought to determine the availability and comparability of data. While the report focused on understanding the performance of the Dutch health system relative to its EU counterparts, the exercise also examined the feasibility of undertaking this type of performance benchmarking exercise. The “Dare to compare” report is published in alternation with a “Health care performance report” and a “Public health status and forecasts report”. In addition, a report entitled “High quality care for all” described how a national quality board for the United Kingdom was to be established and should collaborate with other OECD countries and academic institutions to agree on some internationally comparable measures.

67. The EU also encourages the collection of standardized health system indicators at national and international levels, to expand the ECHI indicator system towards a sustainable health monitoring system in Europe that can facilitate both performance and practice benchmarking initiatives. Part of this effort has consisted of establishment of the European Community Household Panel (ECHP) and initiation of the EU Statistics on Income and Living Conditions (EU-SILC) survey, as well as special health modules in the Eurobarometer surveys. Other developments include the Survey of Health, Ageing and Retirement in Europe (SHARE), which collects panel data on individuals of aged 50 years and above, and the European Core Health Interview Survey (ECHIS).

68. International comparisons have heightened awareness of issues regarding the availability, quality and reliability of data for international comparisons, as well as methodological questions regarding indicator development. The Nordic Council of Ministers’ Quality Project has documented difficulties to do with international benchmarking: “Even for common indicators as survival and mortality rates for breast cancer, colorectal cancer and lung cancer. etc., it is difficult to yield data that are representative to the international nations as a whole. It seems that modern health care systems are not able to document their quality. At national and international level we need to invest in quality measurement systems and in international collaboration”.¹³

69. In this context, there is a need to highlight not only the policy ‘uses’, but also the policy ‘abuses’ of comparisons. In other words, as well as drawing out the information content and potential of performance measures, researchers should indicate what cannot be inferred from the analysis, showing the limitations of current measures and suggesting fruitful future improvements. This is one of the objectives of the European Observatory’s programme of work on comparative assessments of health systems.

¹³ Mainz J, Hjulsgaard M, Thorup Eriksen M, Burgaard J. *National benchmarking between the Nordic countries on the quality of care*. Journal of Surgical Oncology 2009;99:505–507.

Table 1. Methodological issues

Performance domain	Key methodological issues
Population health	Attribution of variations in population health to different causes, including the broader social determinants of health
Health service outcomes	Outcome measures beyond mortality; assuring comparability of definitions across countries
Responsiveness	Agreement on appropriate metrics; adjusting for differences in interpretation and expectations
Equity (in health and access to services)	Development of meaningful metrics capable of international implementation
Financial protection	Development of metrics for prevalence of those who cannot use services for cost reasons
Efficiency	Better comparability of accounting practices; currency conversion; development of agreed metrics

70. Bringing countries around the table to develop common indicators has been a huge accomplishment for raising awareness, building capacity and improving information systems. Using the data in a cautious manner is a prerequisite for their improvement. Peer learning networks for formative evaluation offer additional opportunities to understand indicators and provide insight into how policies affect health system performance. The Nordic Council, for instance, focuses on seven areas of cooperation, including public health and general well-being, with an explicit effort made to reduce inequalities in health and to spread knowledge about healthy lifestyles. The cooperation project for health involves several Nordic institutions in the social and health affairs domain, including the Nordic Medico-Statistical Committee (NOMESCO), which publishes a comparison of medical statistics among the Nordic countries. Similarly, practice benchmarking could take place among neighbouring countries through existing networks (e.g. Baltic countries or the south-eastern European Health Network) or regions (e.g. the Regions for Health Network) or around thematic areas or common resources and structures.

WHO support for evidence-informed policy-making

WHO support for building and sustaining demand and capacity for evidence-informed policy

71. WHO has supported Member States with capacity-building and institutional development, in addition to providing support on technical aspects of HSPA, policy analysis and regular sectoral monitoring. The first pillar is **demand generation** or changing the policy-making culture, whereby evidence is sought by both senior and mid-level policy-makers and managers prior to decision-making on a regular basis and evaluating major policies. As examples of key activities and good practices, WHO has been raising the profile of evidence-informed health policy through ongoing policy dialogue with Member States on various aspects of health system strengthening. In terms of high-profile activities, WHO has been invited to testify in front of national legislatures on key aspects of health financing policy (e.g. Latvia in 2010 and Kyrgyzstan in 2011). In some cases, WHO and Member States agreed to strengthen policy development by placing “resident” policy advisers/analysts in WHO’s country offices, who worked closely with ministries of health (e.g. in Kyrgyzstan between 2000 and 2009, in Azerbaijan between 2006 and 2008, in Tajikistan since 2006 and in Republic of Moldova since 2011). This arrangement allows long-term relationships to be forged with policy-makers within and outside the health sector and the use of evidence to be demonstrated in making better decisions and in conducting high-quality policy dialogue with key stakeholders such as the government, parliament and the nongovernmental sector. Since the signing of the Tallinn

Charter, there is increasing demand for this modality of technical assistance from Member States.

72. The second pillar is **building capacity** to produce high-quality performance assessment, policy analysis and sector monitoring. A mainstream approach to capacity-building is through topical courses, such as international and country-level courses in health systems strengthening (e.g. flagship courses undertaken in partnership with the World Bank Institute in Estonia, Hungary, Kyrgyzstan and Spain), health sector monitoring (Kyrgyzstan and Republic of Moldova), and various aspects of policy analysis (e.g. a multicountry course on the estimation of catastrophic and impoverishing health expenditures for Azerbaijan, Georgia, Hungary, Latvia, Kyrgyzstan, Republic of Moldova and Ukraine in 2008 or one on the analysis of access and equity through household data for Azerbaijan, Kyrgyzstan and Tajikistan in 2009). Another approach to capacity-building is to engage in joint analytical work with Member States. Projects of this kind have included “Improving financial protection in Kyrgyzstan through reducing informal payments (2009)”; “The impact of the basic benefit package on utilization and patient expenditures in Tajikistan (2009)” and “Extending population coverage with health insurance in Republic of Moldova (2010)”. In addition, WHO has guided the design of sectoral monitoring instruments in Hungary, Kyrgyzstan, Republic of Moldova and Tajikistan. These joint analytical activities provided the opportunity for capacity-building throughout the health sector, through on-the-job training and by capitalizing on learning-by-doing processes. A third instrument for building capacity in order to improve the quality of health evidence is by facilitating peer-to-peer learning exchanges among Member States. For example, Kyrgyz policy analysts provided support to counterparts in Tajikistan on a number of studies and also hosted a team from Azerbaijan when the policy analysis unit in the health ministry there was established, in order to share experiences on institutional issues and work processes (2009).

73. Finally, the third pillar involves **institutional development**, i.e. putting in place sustainable institutional arrangements where demand for health evidence is articulated, where it is satisfied through the supply of high-quality evidence, and where there are knowledge translation platforms that create a real bridge between evidence and policy. Several Member States have established or are in the process of establishing policy analysis or sectoral monitoring units in their health ministries. Experience suggests that where there is high-level political commitment to evidence-informed policy-making, these units are fully staffed, have clear terms of reference and produce useful work for the entire ministry and other health sector agencies. In Republic of Moldova, for example, policy units were established in 2007 as a government-wide initiative in all “line” ministries, testifying not only to sectoral commitment to a greater reliance on evidence, but also to a government-wide commitment. Institutional assessment has been carried out in several Member States (Azerbaijan, Kyrgyzstan, Republic of Moldova and Tajikistan) to rationalize governance arrangements and identify the appropriate approach to integrating evidence into the policy process. Different countries opt for different arrangements and there is no one model that fits all. In Azerbaijan and Tajikistan, the policy analysis unit in the ministry of health is more a unit directly managed by the ministry itself, carrying out sectoral monitoring and analytical work and participating in policy development at the request of the health ministry. Republic of Moldova is currently developing its arrangements: it is already clear that the Department of Monitoring and Policy Analysis will have a key role to play in commissioning policy analysis from various public and private agencies, while itself taking charge of sector monitoring.

74. Engagement in strengthening capacities and institutions for evidence-informed policy development has delivered synergies with other areas of health system strengthening. Sector planning and the development of national health plans benefit greatly from strong sector monitoring, good HSPA reports, and analytical work (Kyrgyzstan, Tajikistan). Health management training courses can integrate the results of sector monitoring and policy analysis into their curricula and ensure that knowledge is disseminated not only to senior managers but also to health facility managers. Finally, a regular sector monitoring exercise with agreed

indicators and targets matching the objectives of the national health plan is a powerful tool for sector coordination. It reduces the burden on the ministry of health by reporting in various ways towards various development partners, and it allows for better harmonization and alignment of development assistance. Such approaches are in progress in Kyrgyzstan, Republic of Moldova and Tajikistan.

75. There are important reflections to be made with respect to HSPA with a view to performance management. The first obvious dilemma is whether to pay for performance indicator targets or not. And then, if the decision is taken that such payments should be introduced, the following issues remain to be resolved:

- paying for end outcomes or for processes or intermediate outcomes;
- paying for a combination of current and mid-term performance indicators;
- adjusting indicators to the current needs; and
- developing mechanisms on how to avoid gaming with indicators (e.g. introduction of GP P4P in the United Kingdom).

WHO support to Member States to develop health system performance assessment and ensure international comparability

76. The WHO Regional Office for Europe has been providing technical assistance and policy support, in the framework of biennial cooperation agreements (BCAs), to Armenia (2009), Azerbaijan (2009), Estonia (2010), Georgia (2009), Kyrgyzstan (ongoing), Portugal (2010) and Turkey (2011) in order to develop HSPA. Those countries have developed – or are in the process of developing– HSPA reports that are generating considerable interest from stakeholders. WHO has facilitated the process and provided technical expertise, but the process itself remains entirely “country-owned” and tailored to the country’s expectations and capacities (in terms of both data availability and quality and of capacity to analyse these data and translate them into policy questions or recommendations). In addition to valuing technical assistance, country experiences suggest that WHO is viewed as a privileged partner to bring a neutral perspective into the process. Countries such as Estonia and Portugal considered WHO’s support to be invaluable for quality assurance and external validation of the process.

77. In addition to providing technical support to individual Member States, the Regional Office aims to make the wealth of experience in the WHO European Region widely available. The objective is to provide Member States with the tools to support them in developing, implementing and institutionalizing HSPA. In this perspective, the value of comparative evaluation is highlighted and the role of benchmarking networks is recognized, but ownership of the HSPA process lies in the hands of the national (or subnational) government.

78. WHO has been engaged in developing a comprehensive package of tools to support countries in implementing HSPA. The package covers the whole assessment, from the creation of demand, through the generation of evidence and its use for performance management and strategy development, to dissemination for increased transparency and accountability.

79. While the work in this direction is still ongoing, a number of products are presently available to inform Member States and partners on HSPA. These include analytical papers on review of health system and HSPA frameworks, and on international comparisons; a concept note on benchmarking; and a compendium of indicators; together with draft guidelines and case studies on HSPA, and an example of an “indicator passport”. These draw on literature reviews, expert meetings and interviews with key stakeholders in the countries. All draft material will be presented for validation and discussed with a peer review group consisting of experts and officials from interested countries. The process draws on experience and expertise available at

the WHO Regional Office for Europe and in the countries, as well as on international experience from OECD and the EU.

- 1) **Review of health system and HSPA frameworks used internationally:** this inspires and informs policy-makers when developing their own frameworks for assessment.
- 2) **Guidelines and case studies** on HSPA: theoretical and methodological foundations and practical examples from countries. This shares some of the lessons learnt in developing HSPA.
- 3) **Compendium of indicators** proposed by various national and international organizations, and two- or three-page “**indicator passports**”, which identify the definition, functions and key associated issues for selected indicators. This is a useful resource when selecting and interpreting indicators and discussing policy options.

80. Indicator passports will be gradually developed and published in bundles of 10–15 documents. This highly participatory process will build on a concerted corporate effort and will draw on centres of excellence through WHO’s network of partners and collaborating centres. The objective is to develop a tool that will be user-friendly, action-oriented and built on the countries’ experience. Further steps include establishing the compendium and indicator passports on a web-based “wiki”-type of platform. A section entitled “Indicators in action” would be open for partners to present interventions to improve results, to discuss potential policy uses and abuses, to share their results and to ask questions on a forum.

81. WHO can help support the development of benchmarking networks, for formative evaluation, in a safe and constructive environment. WHO has proved to be a solid information broker, it is a neutral organization and it has recognized expertise in the field of information systems, policy analysis and direct work with countries.

82. The European Observatory on Health Systems and Policies has been asked by its partners to initiate a programme of work on comparison of health system performance. The objectives are “to help governments, regulators, citizens and other commentators gain a better understanding of the comparative performance of their health systems, to improve approaches to measurement and analysis, and to demonstrate how comparative metrics can help in the design and evaluation of initiatives intended to strengthen health systems.” The first substantive product of this initiative is a book on the key methodological challenges outlined above, and exploring the current interface between evidence and practice that will inform the future priorities and content of the programme. Other anticipated products include a series of reports on metrics, methodology and performance comparison taking into account all domains of performance outlined in the Tallinn Charter. The intention is to produce approximately three methodological papers per year, addressing a statement of the problem, current approaches and state of knowledge, the proposed methodological development, implementation issues (including the benefits from a policy perspective) and recommendations for future comparisons.

83. In addition, the programme will produce a biennial comparative report for the WHO European Region on one of the domains of performance. The intention is that the first report in 2012 will be on population health. It will include summary data and narrative commentaries from acknowledged experts and a guide for policy-makers on further analysis and data sources.

IV. Sustaining equity, solidarity and health gain in the context of the financial crisis

Key messages of this chapter:

- Economic and social distress affects attitudes to solidarity. The Tallinn Charter is a powerful instrument to guide policy responses to the crisis by making explicit the commitment to solidarity.
- Indiscriminate cuts in expenditure on health and social welfare increase poverty and reduce the health of the population. When budget cuts are inevitable, they should be implemented wisely to protect the poor and the vulnerable.
- Balancing the budget should not be treated as a simple accounting exercise; it is about priorities in public policy and priorities in health policy.
- The crisis is an opportunity not to be missed: Introduce long overdue efficiency-enhancing reforms that may have not been politically possible in the past, because these can reduce the severity of the sustainability trade-offs that become more salient during a crisis.
- Learn from experience – prepare better for a crisis! Some countries provide good examples for counter-cyclical revenue flow to health and therefore protection for health budgets.

Guiding the response to the financial crisis: the relevance of the Tallinn Charter

84. The Tallinn Charter has at its core the principles of equity, solidarity, financial protection and maximizing health gain through leadership and performance improvement in health systems. The Charter was signed in mid-2008, at a time when the magnitude and implications of the emerging financial and economic crisis were not yet clear. When it hit, the commitments of Member States to the above principles were “put to the test” since they can easily be compromised in the face of fiscal pressures created by deteriorating public finances. Commitment to equity, solidarity and financial protection has to be reinforced during an economic downturn so that the health and social sectors are protected from across-the-board budget cuts or, if cuts in health budgets are unavoidable, they are implemented in a manner that minimizes their adverse effects on these objectives. The focus of this chapter is to review policy experiences in response to the crisis that are consistent with the values, principles and policies in the Tallinn Charter.

85. For many countries, the recent global financial/banking crisis triggered a collapse of credit markets leading in many cases to bailouts by governments and in turn to a rapid drop in economic activity and rising unemployment. This has led to lower revenues for governments as a result of falling payroll and other tax revenues. Growing unemployment has also meant increased public spending on social security programmes. Countries with sufficient reserves or the willingness to increase borrowing (deficit financing) have been able to deal with the resulting fiscal imbalance without having to take drastic measures. The health and social sectors are particularly vulnerable to budget cuts during times of economic downturn, not only because of their size within any government’s budget but also because of the often relatively weak position of health ministries. However, where the commitment to equity, solidarity and financial protection is strong, governments have taken careful steps to maintain a balanced budget and avoid adverse effects on these objectives. Health systems with strong leadership and well

functioning governance arrangements prove to perform better in general, and during a crisis in particular.

86. From a purely fiscal perspective, the question of sustainability is limited to maintaining a balance between a government's income and expenditure. However, sustainability is meaningless if not linked to objectives. An orientation towards performance gives a more nuanced approach to the concept of sustainability and shifts the focus of attention to the question of what level of achievement of the different public policy objectives we can or are willing to sustain. While it may not be possible to increase or maintain absolute levels of health expenditure during an economic downturn, governments can choose how to implement budget cuts, which in turn reflects their priorities.

87. The financial crisis affected most health systems in the WHO European Region, but some were better prepared to deal with the downturn than others. Values, commitments and institutional arrangements were severely tested by the crisis, and while there is no single approach to preparing for and reacting to such an event, there are lessons to be learned. In addition to those policy responses that directly address the health system, this report also considers the wider social policy responses that affect the health and financial protection of the population. The aim of this chapter is to document selected policy responses, which may provide lessons for those policy-makers still facing difficult decisions in the coming years, and to provide a reference document for policy-makers faced with similar crises in the future. Throughout, examples of WHO support to Member States are noted.

From values to action: The Oslo recommendations

88. A high-level meeting was convened jointly by the WHO Regional Office for Europe and the Government of Norway in Oslo in April 2009. It was the first attempt by WHO to reflect on responses to the financial crisis and provide guidance to countries on how best to navigate through difficult times. A set of recommendations were proposed for guiding pro-health and pro-poor policy responses and these were in line with and driven by the Tallinn Charter commitments. Later in 2009, the Regional Committee adopted a resolution (EUR/RC59/R3) that urged Member States to ensure that their health systems continue to protect the most vulnerable, to demonstrate effectiveness in delivering personal and population services and to behave as wise economic actors in terms of investment, expenditure and employment.

89. Crises offer governments the opportunity to reaffirm their values and priorities. A careful assessment of the relative importance of the wide range of publicly funded programmes can inform decision-makers on where to cut more or less when budget cuts cannot be avoided. The Oslo recommendations are the product of an exercise of this nature. Member States strengthened their commitment to solidarity and agreed on a set of recommendations on how to shape policy response to the crisis and set priorities. In particular, the recommendation on protecting cost-effective public health and primary health care services is an example of explicit priority-setting.

90. The Oslo recommendations recognized the importance of ensuring the efficient use of public funds ("more health for the money"), which is a prerequisite of effective advocacy for "more money for health". The call to protect health budgets included very practical proposals on how the taxation system may be adjusted to fill the gap caused by revenue shortfalls during an economic downturn. The Oslo recommendations argue for the introduction of new taxation on sugar and salt consumption, as well as increases in levies on alcohol and tobacco. These measures are at the same time effective public health interventions, despite their regressive nature (i.e. the burden falls more heavily on the poor than the rich).

91. The following sections document the major responses to the financial crisis using selected examples from countries in the European Region.

Protecting health budgets and maintaining provision of essential services

92. In some countries, institutional arrangements help protect the health budget from major cuts in public expenditure. Estonia is such a country where the health insurance fund is obliged to accumulate reserves that provide a buffer when payroll-tax income drops due to an economic downturn. The decision on when and how these reserves can be released ultimately lies with the government, and indeed the severe shock to the Estonian economy prompted the government to delay the release of these reserves. Nevertheless, these were earmarked savings that could not be diverted to other sectors, and eventually they were released to ease the pressure on the health system. Drawing down reserves is an obvious first response, when this option exists. Estonia provides an example of good management, in that it accumulated more reserves than legally required during the years of high economic growth, and this has greatly contributed to the relatively modest imbalance between projected expenditure and available resources for health. It has to be noted, however, that similar institutional arrangements were not in place to protect the budget for public health programmes, and as a result they were more vulnerable to budget cuts when the country decided to keep its overall budget deficit at a low level in order to join the Euro zone in 2011.

93. A more contentious¹⁴ fiscal policy response is to delay investments during a crisis. Delaying investments allows the health sector to maintain the level and volume of health services (including public health services) for a few years, provided that up to this point investments have been maintained and the proper infrastructure is available. The Estonian government retained the budget for capital expenditure that is normally meant to be transferred to the health insurance fund. However, later the health sector benefitted from new investments in tertiary-level hospitals and long-term care infrastructure as part of the economic stimulus package.

94. The Russian Federation provides an example of the importance of political commitment to protecting the health budget. Remarkably, the country even managed to increase health expenditure during the crisis. This was the result of effective advocacy by the Ministry of Health and acceptance of the condition set by the Ministry of Finance, namely that efficiency in service delivery should be improved at the same time. The source of increased revenue was an increase in the insurance contribution from a relatively low level. While political commitment played a similarly important role in Hungary, the instrument used there was different. As part of the economic policy package adopted in response to the crisis, the payroll tax was further reduced (to stimulate the labour market, while the government increased general tax revenue transfers to the health insurance fund (Fig. 1.)). Ultimately, responsibility for sustaining public expenditure on health lies with the Government, but this is facilitated by institutional arrangements that help secure a relatively stable revenue flow, such as earmarking or an explicit allocative formula.

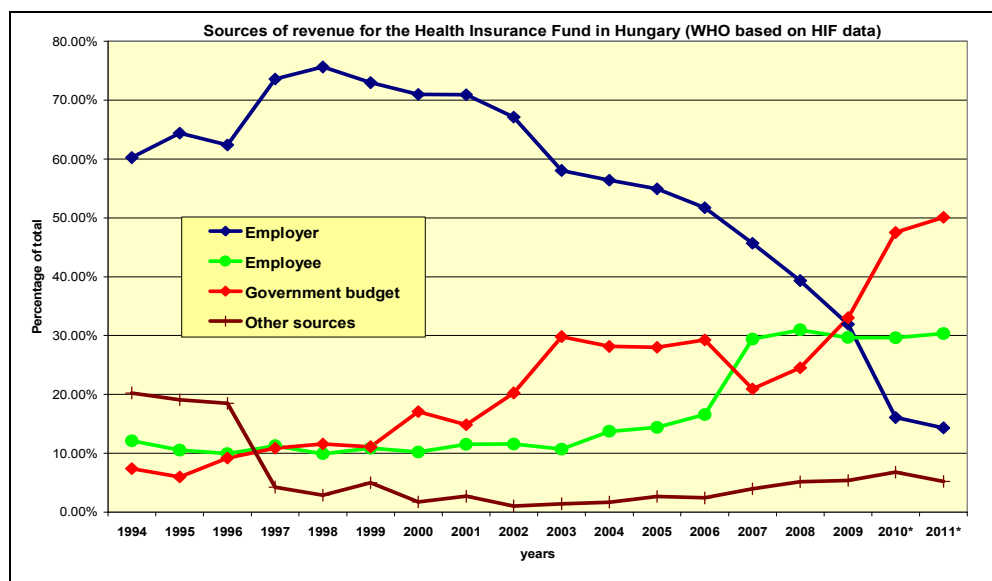
¹⁴ Contentious, because the counterargument to delaying investments is that this will further deepen the economic crisis, and indeed, several countries opted for increased deficit financing to keep the economy running and to maintain employment levels.

Table 1. Even high income countries are affected by a reduction in utilization due to the crisis

Country	Changes in Utilization of Routine Health Care Since the Crisis				N
	Reduce	Same	Increase	Net Change (Reduce - Increase)	
United States	26.5	66.5	7.0	19.5	1901
France	12.0	82.7	5.4	6.6	868
Germany	10.3	83.0	6.7	3.6	879
Canada	5.3	89.3	5.4	0.0	1032
Great Britain	7.6	84.4	7.9	-0.3	757
5 Country Avg	15.2	78.3	6.6	5.9	5437

95. Typically, the economic crisis leads to a reduction in utilization, even though the needs for health care are likely to be greater. Reductions in routine care today can lead to undetected illness tomorrow, and to reduced individual health and well-being in the more distant future.¹⁵ Where the cost of seeking care is lower, the reduction of utilization during a crisis is also lower (Table 1). Hence, the way in which the health system is organized plays a key role in mitigating potentially harmful declines in utilization.

Fig. 1. Explicit crisis response policy of reducing payroll tax and increasing budget transfers to the Health Insurance Fund



(WHO staff calculations based on official HIF data – 2010*: actual by end of year, 2011*: planned)

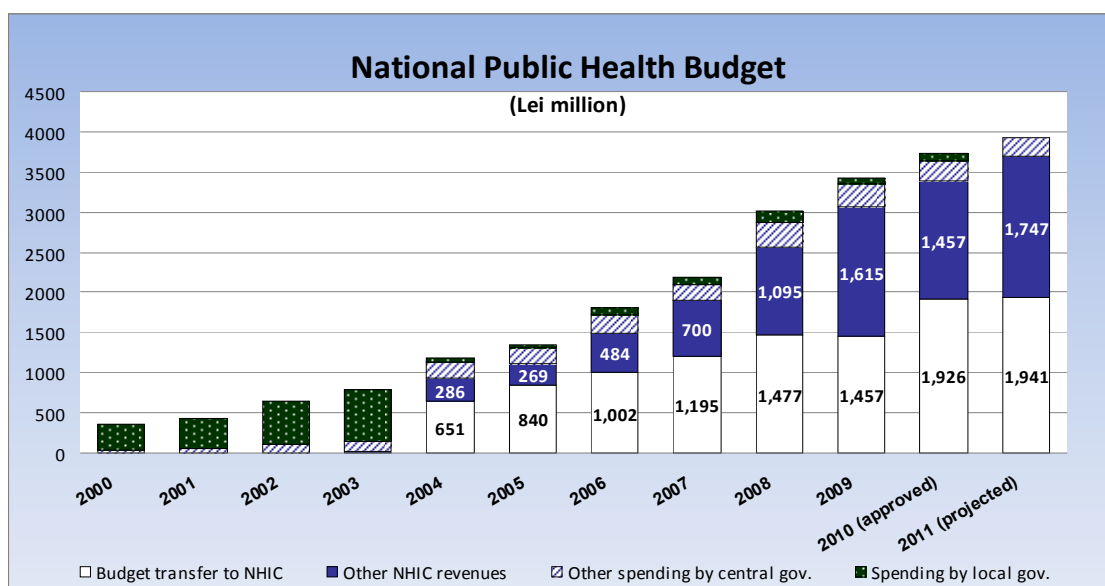
96. Increasing budget transfers to compensate for lower payroll tax revenues during the crisis is a potential solution for effective protection of the health budgets in countries where revenue collection relies predominantly on employment-related insurance contributions. As mentioned above, this requires a very strong commitment to the objectives of the health sector, given that it

¹⁵ Lusardi A, Schneider D, and Tufano P. *The Economic Crisis and Medical Care Usage*. Harvard Business School Working Paper, No. 10-079, March 2010.

is likely to require cuts in other government programmes. Germany made a general budget revenue transfer to the health insurance system to compensate for the loss of revenue and increase in expenditure of the sickness funds during the crisis, and it also made a slight reduction in the health insurance contribution rate. Even though this was a one-off measure, it was an instructive development for a traditional social insurance system that relied predominantly on employment-related insurance contributions. As Fig. 1 illustrates, Hungary incrementally shifted from near exclusive reliance on payroll tax to a 50-50% mix of general budget transfers and payroll tax revenue to finance its health insurance system. These developments allow for a lower tax burden on the labour market, which is expected to boost the economy and reduce unemployment. As part of the Tallinn Charter follow-up process, WHO has provided technical assistance to Estonia in order to assess measures that would improve the sustainability of health financing, drawing on international evidence and a careful analysis of the value preferences of key stakeholders. The resulting report was launched by the Minister of Social Affairs and the WHO Regional Director at a major conference in Tallinn two years after the Tallinn Charter was signed.

97. Republic of Moldova has in place institutional arrangements for budget transfers that, in addition to expressing political commitment, secure a balancing act so that, when revenues from health insurance payroll contributions fall, revenues for health are increased when public expenditure in general rises. This is a function of the rule, or formula, used to assess budget transfers to the national health insurance company on behalf of vulnerable groups unable to contribute financially. The budget transfer is fixed at the three-year average ratio of public health expenditures to the overall public budget (minus expenditures for special purposes), most recently calculated to be 12.1% of the government budget. As public funding rose for payments linked to unemployment, for example, budget transfers to the health sector automatically increased. The International Monetary Fund provided significant budget support to Republic of Moldova during this period. (Fig. 2.)

Fig. 2. Increasing the share of government budget revenue for health insurance as payroll tax income declines in Republic of Moldova in 2010

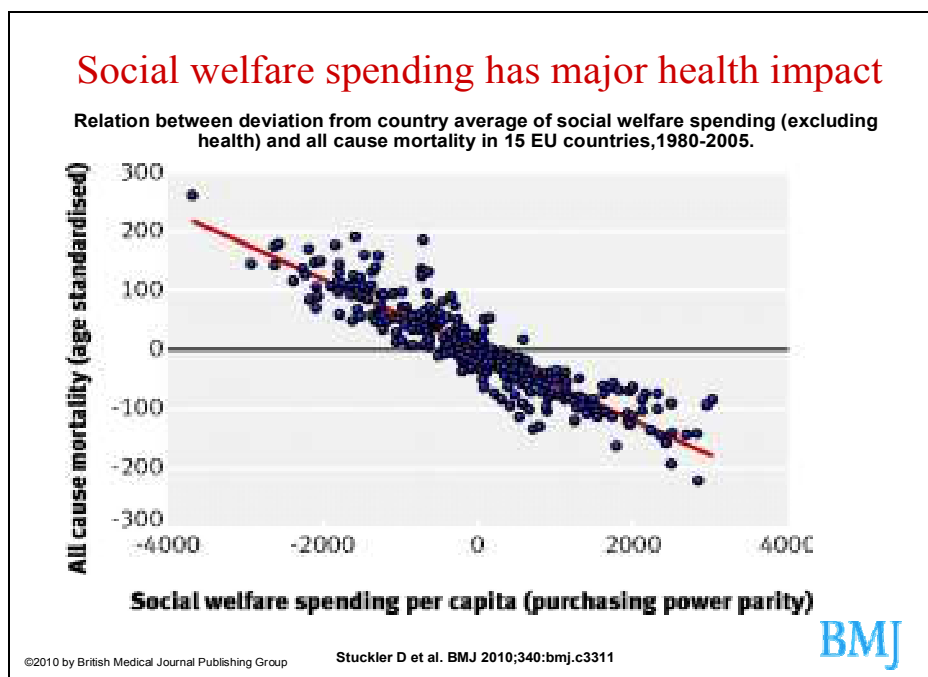


(WHO staff calculations based on official data)

Sustaining health gain through social spending

98. Health is at risk at times of rapid economic change, but the effects can be mitigated to a considerable extent by appropriate spending on social protection and, in particular, measures that promote the workings of the labour market. Research findings¹⁶ suggest that there is an association between all-cause mortality rates and economic crises, using unemployment as a measure of the economic stress and accompanying uncertainty faced by the population. During the early 1990s, weak labour market protection in central and eastern Europe left populations vulnerable at a time of fast-rising unemployment.¹⁷ However, further research has shown how a modest increase in social welfare spending can exert a substantial protective effect¹⁸ (Fig. 3). Notably, a rise in social welfare spending was associated with a sevenfold greater reduction in mortality than a rise of similar magnitude in gross domestic product (GDP).

Fig. 3. Social welfare spending correlates strongly with reduction in mortality



99. Rising unemployment is specifically associated with increased suicide rates although, once again, research shows how increases in social welfare spending and active labour market policies designed to retain and reintegrate the workforce can minimize this effect. This can be illustrated by comparing Spain and Sweden during the severe economic problems that each faced in the late 1980s and early 1990s. While suicides increased in parallel with unemployment in Spain, the two measures diverged in Sweden, where the long-term decline in suicides continued despite increasing unemployment. Further work in EU countries showed that rising unemployment rates had no effect on suicides when spending on active labour market programmes, which aim to maintain jobs and quickly reintegrate workers who lose their jobs into the workforce, was above US\$ 190 per capita. This suggests that governments can protect

¹⁶ McKee M, Stuckler D, Martin-Moreno JM. Protecting health in hard times. *BMJ* 2010;341:c5308.

¹⁷ Stuckler D, Basu S, Suhrcke M, Coutts A, McKee M. The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis. *Lancet* 2009;374:315–323.

¹⁸ Stuckler D, Basu S, McKee M. Budget crises, health, and social welfare programmes. *BMJ* 2010; 340:c3311.

their populations during economic crises, specifically by additional social welfare spending and introducing active labour programmes.

100. Both Estonia¹⁹ and Hungary²⁰ drastically reduced their public expenditure on health in the past, yet by maintaining or increasing expenditure on social welfare, in particular pensions, the impoverishing effects of the expenditure cuts were modest, especially in Hungary.

Extending benefit entitlements to the most vulnerable

101. In Bosnia and Herzegovina, Bulgaria, the Czech Republic, Hungary, Serbia, Slovakia intense activities took place in order to secure coverage for the respective Roma populations in these countries. That was due to the fact that entitlement to health services is linked to financial contributions, which typically leads to limited access for the more vulnerable groups of the population. Serbia has a policy in place that provides coverage for the unemployed Roma population living in poor, “traditional” settlements. Implementation of this policy is facilitated by a very successful outreach programme through Roma health mediators, who facilitate registration with the health insurance fund. A WHO mission in 2010 found that significant barriers to access for the Roma still remain, however, and suggested practical actions to make this excellent pro-poor policy more effective. In line with the Tallinn Charter recommendations, the Regional Office recommended the extension of the benefit entitlement to the long-term unemployed, especially during the financial crisis.

102. During the crisis, several Member States (Belgium, Bosnia and Herzegovina, Latvia and Serbia) introduced exemptions from co-payments and service fees for health services for populations below the poverty line. It continuously monitors poverty levels and adjusts the poverty threshold accordingly, if further exemptions and benefits are necessary to meet the health needs of the population. Estonia extended entitlement to health insurance benefits to those long-term unemployed who are registered and actively seeking employment; this measure has greatly contributed to protecting the growing number of unemployed during the crisis. Of course, controlled fees can still be more transparent and more equitable and actually countervailing the negative impact of informal out-of-pocket payments. Some countries (e.g. Kyrgyzstan, Estonia) have been able to prevent chaotic increases in private payments and reduce the scope for implicit rationing in times of crisis.

103. In Republic of Moldova the government passed two new pieces of legislation which extended benefits to the most vulnerable. The first new law, adopted in 2009, ensured that all those registered as poor automatically received fully subsidized health insurance.²¹ Further measures have also been taken to ensure that employers are making health insurance contributions on behalf of their employees. The second piece of legislation, passed in 2010, extended full primary health care services to all citizens, irrespective of their status under the national health insurance programme. Outpatient medicines at subsidized rates and emergency ambulatory care were also included in this amendment, which effectively ensured universal access for all Moldovans to essential services.

¹⁹ Vörk A, Habicht J, Ke X, Kutzin J. *Income-related inequality in health care financing and utilization in Estonia since 2000*. Health Financing Policy Paper 2010/3. WHO Regional Office for Europe.

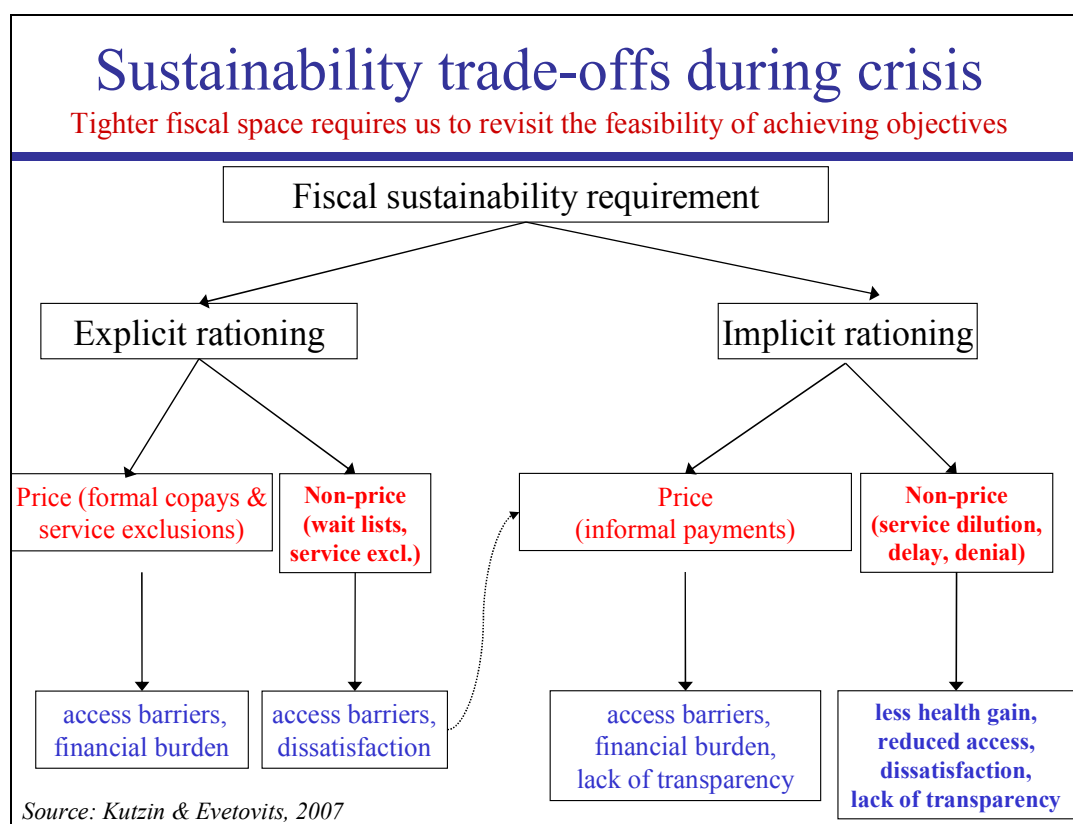
²⁰ Gaál P, Evetovits T, Ménesi É. *Analysis of financial protection in Hungary*. Poster presentation at the European Conference of Health Economics, Helsinki, 2010.

²¹ Jowett M, Shishkin S. *Extending population coverage in the national health insurance scheme in the Republic of Moldova*. Health Financing Policy Paper 2010/1. WHO Regional Office for Europe. WHOLIS E93573.

Sustainability and trade-offs

104. While there is a strong case for protecting health and social budgets during economic downturn, if the options for governments to do so are simply not there and cuts are inevitable, then health policy-makers face the challenge of minimizing the adverse effects on population health and poverty. Fig. 4 below describes the different forms of rationing mechanisms and their likely consequences on policy objectives. All countries face sustainability challenges, simply because all countries must address trade-offs between competing priorities and objectives in the face of limited resources, irrespective of how rich or poor they are. There is, however, increased pressure on the level of public spending that governments can devote to health improvement during an economic crisis.

Fig. 4. Conceptualizing sustainability trade-offs²²



105. Shifting the burden of financing health care from pooled public sources to the patient via increased direct payments (user fees, co-payments, etc.) is the most common form of explicit rationing to address public revenue shortfall. It reduces utilization of health services, at least in the short run, although the evidence suggests that this is a blunt instrument that cannot differentiate between inappropriate utilization and clinically justified needed services. This measure introduces greater cost considerations in the care-seeking decisions of often inadequately informed patients. Among them, the poor and less educated population groups are most likely to make decisions that either lead to an increased financial burden on their households or to delays in seeking care, which may eventually result in higher costs for the health system and worse health outcomes for the individual. Still, the problems associated with

²² Kutzin J, Evetovits T (2007). *Health financing policy objectives and fiscal sustainability challenges*. Presentation at the Conference “Getting to the roots: linkages between health system performance and deficit spending”, Zagreb, Croatia, 26-27 March 2007.

this rationing mechanism may be less clear-cut in those countries of the WHO European Region that have been struggling with informal out-of-pocket payments. In such contexts, the use of formal co-payments can represent an overt effort to control private expenditures with legally defined rules and may, if implemented as part of a comprehensive set of financing reform measures, reduce informal payments.²³

106. The Tallinn Charter states that “today, it is unacceptable that people become poor as a result of ill health”. When governments look to shift the burden of financing to households as a policy response to fiscal pressures, there is a real danger that this objective may be undermined. Unfortunately, many countries with already high private expenditure also opt for this policy tool. Studies of financial protection may inform decision-makers about the effectiveness of exemption mechanisms that are intended to protect the poor. The Regional Office has supported numerous such studies in Member States in recent years, for example in Estonia, Hungary, Kyrgyzstan and Republic of Moldova.

107. Typically, the economic crisis leads to a reduction in utilization, even though the needs for health care are likely to be greater. Reductions in routine care today can lead to undetected illness tomorrow and to reduced individual health and well-being in the more distant future.²⁴

The “invisible hand” of implicit rationing

108. There is an unexplored area of non-price-based rationing mechanisms that are less tangible to both patients and policy-makers and difficult to research. This may take different forms of delaying, denying and diluting clinical services (“quality skimping”), with significant implications for health gain and efficiency in the use of limited resources. There is anecdotal evidence of such a response by providers to budget cuts. Reports of delaying surgery in a non-transparent manner and deviating from clinical practice guidelines on the grounds of cost considerations are just two of the many implicit rationing mechanisms on the supply side. Where monitoring of provider compliance with clinical standards is weak and professional organizations are less rigorous in enforcing good clinical practice, implicit rationing mechanisms may hide some of the adverse effects of the financial crisis. In times of crisis it is particularly important to make government commitments regarding waiting time explicit. Of course, this approach requires also control and monitoring tools, such as the establishment of tougher mechanisms of waiting time control, ensuring civil society involvement and developing patterns for the most vulnerable. The crisis is a good time to activate forming a new culture of explicit rationing. Targeted research programmes are needed to explore the magnitude of implicit rationing and provide evidence to inform policy-makers.

109. This message was brought out in a policy summary on addressing financial sustainability in health systems produced by WHO and the European Observatory for a ministerial conference during the Czech EU Presidency in 2009.²⁵ This conceptual paper sheds light on the notion of financial sustainability and examines its policy relevance in practical terms. The paper argues that financial sustainability should not be seen as an accounting problem, where the imperative

²³ Gaal, P, M Jakab, S Shishkin (2010). “Strategies to address informal payments for health care.” In Kutzin, J, C Cashin, M Jakab, eds. *Implementing Health Financing Reform: Lessons from Countries in Transition*. Copenhagen, Denmark: World Health Organization, on behalf of the European Observatory on Health Systems and Policies

²⁴ Lusardi A, Schneider D, and Tufano P. *The Economic Crisis and Medical Care Usage*. Harvard Business School Working Paper, No. 10-079, March 2010.

²⁵ World Health Organization (2009). Addressing financial sustainability in health systems. Policy summary prepared for the Czech European Union Presidency Ministerial Conference on the Financial Sustainability of Health Systems in Europe, ISSN 2077-1584.

is to achieve fiscal balance by simply aligning revenues and expenditures, without taking account of the policy objectives for which public financing is in place to start with. So, rather than treating financial sustainability as an objective to be pursued for its own sake, it is more useful to see the requirement of fiscal balance as a constraint to be respected. This allows policy-makers to consider how best to maximize the attainment of health system goals subject to the constraint of “fiscal space”.

Spending more efficiently

110. Spending more efficiently helps reduce the severity of the impact of budget cuts. As illustrated by the example of the Russian Federation, the commitment to address inefficiencies in the health sector helped the health ministry advocate for higher expenditure on health overall. Similarly, Italy introduced a range of performance indicators that provide the basis for continued funding in the regions. It is important to highlight that contrary to common perception, increasing efficiency is not equal to overall cost savings. Efficiency gains may come in the form of increased health gain for the same expenditure. Cost-effective use of medicines, for example, may free up resources that can then be used elsewhere or for more volume if needed.

111. All European countries are increasingly using evidence and health technology assessment (HTA) to inform their reimbursement decisions on medicines. Both through national efforts, as well as through international networking (for example EUnetHTA, and the Medicines Evaluation group, with support from the EU and WHO) the use of HTA in reimbursement decisions has become more sophisticated and improved the quality and transparency of decision-making.

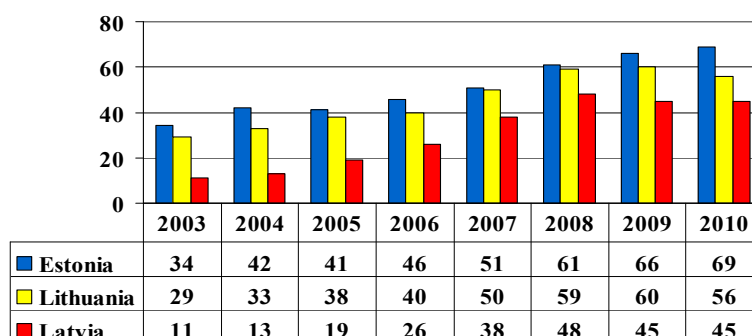
112. Spending on medicines ranges between 10% and 25% of total health expenditures in EU countries, and between 20% and 40% in transitional countries. Given that this is a large single item, cuts in public expenditure on pharmaceuticals are always high on policy-makers’ list of options for dealing with a deficit. During the financial crisis, however, the consumption of medicines in Europe remained relatively stable, with slight growth in some countries, which indicated that health budgets for medicines seemed well protected and/or that efficiency gains allowed consumption to be maintained.

113. Many countries further introduced cost-containment measures by announcing overall price cuts for manufacturers (Spain, Greece) and negotiating lower prices (Poland, Iceland), regulating prices (the Russian Federation), more efficient purchasing of medicines through tendering (the Netherlands, Germany), enhancing policies on prescribing and using generic medicines, reducing distribution margins for wholesalers and pharmacies and taking measures to increase the rational prescribing of medicines (Estonia, Spain).

114. In 2010, Estonia hosted the Seventh Baltic policy dialogue, together with WHO and the European Observatory, specifically to address pharmaceutical policies in the Baltic countries and the response of governments in light of the economic downturn. Whereas Latvia and Lithuania had actually reduced their public spending on medicines, in Estonia the health insurance fund still registered a slight growth in expenditures in 2009, albeit with a slight drop in volume (indicating that the average price of the medicines used had increased slightly).

Fig. 5. The drop in public expenditure on pharmaceuticals was relatively modest in the Baltic countries

Public expenditure for reimbursement of pharmaceuticals
in the Baltic countries, EUR/per capita, 2003-2010



(Source: data from ministries of health and social affairs, 2010)

115. Latvia and Lithuania also reacted with a range of measures to increase efficiency in their medicines sector, including stronger incentives for the use of generics, price negotiations with manufacturers and tighter distribution margins. Latvia reduced the reimbursement percentages of certain medicines, thus leading to higher co-payments, but at the same time allocated funds from the IMF/EU loan package to compensate low-income groups for these increased co-payments.

116. From utilization data²⁶ it also became clear that even where there was a drop in pharmaceutical consumption, this was mostly related to therapeutic groups for less serious diseases (painkillers, dermatological preparations, cough preparations, vitamins, etc.). One side effect of the crisis may therefore have been more rational use of medicines. However, there were also drops in the use of certain cardiovascular medicines, oral anti-diabetics and antidepressants, among other drugs, that signal concerns about access to medicines and quality of care. Research²⁷ on the distribution of patients who do not take up prescriptions suggests that the poorest quintile of the population is most affected. They frequently forgo seeking care when ill or do not take up prescribed medicines owing to the high costs involved.

Implementing budget cuts

117. Budget cuts create huge pressure on service providers to increase efficiency in service delivery. However, there is a limit to how much and how fast efficiency gains can help to deal with a financial crisis. Savings may not be immediate, and the transition to a new, lower-cost delivery system needs to be carefully managed, so that patients get access to the care they need even during transition. The experience from Hungary offers insights to illustrate this point. Two

²⁶ There are many methodological issues around monitoring the use of medicines (classification, measurement units, and large out-of-pocket segment in medicines spending in the Baltic countries for which it is difficult to obtain information). Further monitoring and research is needed to obtain more qualitative information to understand the precise nature of changes in medicines consumption in order to develop appropriate policy measures.

²⁷ Latvia Public Expenditure Review 2010. The World Bank, Washington D.C.

years before the financial crisis, the Hungarian hospital sector went through a major and rapid restructuring as part of a public sector-wide attempt to balance the government budget. The swift restructuring of acute care hospitals to full or partial long-term care facilities contributed to balancing the budget by the end of the year; however, patient pathways were not managed carefully enough, and this resulted in delays in appropriate treatments and increased barriers to access, especially in the field of mental health, as reported by the Parliamentary Commissioner for Civil Rights.²⁸ The relevance of this experience to the response to the crisis is that the magnitude of the budget cuts in the health sector was similar to those experienced during the crisis.

118. Restructuring of the hospital sector in Latvia had been long delayed. Expenditure on hospital inpatient care increased rapidly for three years before the crisis, pouring additional resources into the same infrastructure and missing the opportunity for restructuring the service delivery system to better meet the current needs of the population and medical practice. The impact of the crisis on the hospital sector in Latvia was dramatic. Given the severe fiscal imbalance in 2008 when the crisis hit the country, Latvia had no choice but to cut overall health expenditure. In the first two years of the crisis, hospitals lost almost 50% of their revenue and volume dropped dramatically.²⁹ Table 2 describes the re-composition of the hospital sector, indicating a significant reduction in acute inpatient care facilities and turning them into “outpatient only” facilities or day care hospitals. The effects of the unprecedented cuts in hospital inpatient care should be carefully monitored, as the Hungarian experience described above suggests. It is highly probable that the reduction in volume went far beyond what could have been justified on the grounds of inefficiency and unnecessary utilization alone. However, the Latvia story is one of implementing budget cuts according to explicit priorities. The Ministry of Health should be congratulated for giving priority to primary care, financing an additional nurse in each general practice, protecting the poor through exemptions and so ensuring coverage with essential medicines, and making the emergency services more efficient. Indeed, the crisis is an opportunity not to be missed when it comes to long-overdue reforms. However, both the Hungarian and the Latvian experience offer an important lesson for the future: much-needed hospital restructuring should not be delayed until it is no longer possible to maintain the same level of infrastructure and volume of care, because the change becomes more painful and the measures more drastic.

Table 2. Drastic reduction in spending on inpatient care called for a structural change in the Latvian hospital sector

Composition of the hospital sector	2009	2010	Change
Emergency hospital	34	22	-12
Care hospital	0	7	7
Specialized hospital	22	12	-10
Other hospital	16	0	-16
Outpatient institution	0	30	30
Merged	0	1	1
Total	72	72	0
Hospitals (inpatient care)	72	41	-31

Source: Latvia Public Expenditure Review 2010, World Bank based on Ministry of Health data.

²⁸ Report by the Parliamentary Commissioner for Civil Rights, 2009. AJB 3536/2009
<http://www.obh.hu/allam/aktualis/htm/kozlemany20091214.htm>.

²⁹ Latvia Public Expenditure Review 2010. The World Bank, Washington D.C.

119. In some countries (Bulgaria, the Czech Republic, Hungary, Ireland, the Baltic countries), the crisis prompted governments to cut or freeze salaries in the public sector, and this affected health workers. Again, the impact of these measures on access to and quality of services is as yet unknown. However, several countries have already been facing significant losses of health workers to countries where salaries are higher and certain specialist doctors and nurses are in demand. As a result, clinical and service quality may decline, and services may have to be delayed or even denied if qualified staff are not available. Cutting salaries may reduce the gap between revenue and expenditure in the short run, but if this leads to losing highly qualified medical staff, then the long-term negative consequences become much more costly to deal with. This is an example of an unsustainable efficiency gain, where the focus is only on cutting costs, without considering the benefits forgone.

How to prepare better for economic downturns?

120. This chapter has reviewed a wide range of examples of policy responses to the financial crisis. The lessons learned during the crisis can help policy-makers to prepare better for future crises, both in terms of available, effective policy instruments and in preparing better for other times when the budget comes under greater pressure. Just as in medicine, prevention is better than a cure. While it may not be possible to completely prevent economic downturns and their adverse effects on health and social budgets, there are ways to reduce vulnerability to these shocks. Countries that accumulate reserves during periods of economic growth, or at least reduce budget deficits and external debts, can opt for deficit financing through borrowing or deplete reserves when the crisis hits. Whether these counter-cyclical strategies are guaranteed through institutional arrangements or simply as a result of political commitment to health varies across countries, sustainability of financing health and social services is fundamentally a question of how much countries value the benefits of these publicly funded programmes. For this, commitment to continuous improvement of performance is a prerequisite.

121. The European Observatory is in the process of conducting a comprehensive study of the responses to the crisis in the WHO European Region. Lessons will be identified to ensure that health ministers and policy-makers are informed when managing budgetary pressures in a way that mitigates the potentially adverse effects of the crisis on health systems. The main output of the project will be a policy summary in the series issued jointly by the Observatory and the Regional Office's Health Evidence Network, to support the discussions at the Regional Committee session in 2011. The full report of the study will be published in the Observatory's Studies Series.

122. The Tallinn Charter recognizes the importance of strengthening performance and accountability in governance, in particular. Governments' commitment to equity, solidarity and financial protection during the years of an economic downturn has to be reinforced, so that if cuts in health budgets are unavoidable, they are implemented in a manner that minimizes their adverse effects on these objectives. In a way, the financial crisis has the potential to bring about increased popular support for solidarity as more people become exposed to the risk of unemployment, feel less secure about the future and experience health problems. In turn, they may be more likely to use social and health services, for which sufficient public financing is needed in order to ensure equity and efficiency in providing universal coverage.

V. Improving performance through leadership of intersectoral action to improve health

Key messages of this chapter:

- The determinants of health encompass the whole of society and require a focus on intersectoral action – Health in All Policies (HiAP).
- Inequities in health are shaped by factors within and outside the health sector and form a key concern of HiAP.
- The focus of HiAP is on governance, to reach out to other ministries and sectors in society and include health systematically in policies, as entry points for changing determinants of health.
- A variety of governance tools have been developed to foster policy coherence, collaboration and partnership, and thereby to further HiAP.
- Across Europe there is currently a lack of comprehensive pan-European studies showing the effectiveness of the different governance tools that have been deployed, and of relevant analysis and literature.
- For the success of HiAP, some necessary structural and functional elements can be identified:
 - strong high-level government and health system leadership;
 - a clear health vision and well-articulated policy;
 - an organizational structure and funding to support HiAP;
 - a supportive legal environment; and
 - action at all organizational levels.
- A variety of WHO actions have focused on strengthening the capacity of ministries of health to analyse and understand the determinants of health and health inequality.

Introduction

123. The Tallinn Charter indicates that health systems “encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health”. Charter goes on to indicate that health systems “are more than health care and include disease prevention, health promotion and efforts to influence other sectors to address health concerns in their policies”. “Ministries of health should promote inclusion of health considerations in all policies and advocate their effective implementation across sectors to maximize health gains.”

124. Increasing knowledge of the multiple determinants of health, and of the ways in which these determinants extend across the whole of society and the responsibilities of governments, has increased attention and focus on intersectoral action for health. This thinking has come to be called Health in All Policies (HiAP). Building on this and on the increased recognition of persistent and increasing inequities in health, which are determined by factors within and

beyond the health sector, there is increasing acknowledgement of the imperative to address equity in Health in All Policies.^{30,31}

125. The concept of HiAP entails health improvement as a societal goal shared across all parts of government and all sectors. HiAP addresses complex health challenges by promoting an integrated policy response across sectoral and portfolio boundaries, incorporating concern with health impacts into the policy development process of all sectors and agencies. This allows governments to address the key determinants of health in a more systematic manner, as well as to take into account the benefit of improved population health for the goals of other sectors.

126. This chapter will consider the principles of intersectoral working and HiAP in more detail, and will review some experiences to date within the WHO European Region. To the extent that this is known, the chapter will consider what has worked and why. Successful advocacy strategies and other instruments and mechanisms that ministries of health have used to promote both Health and Health Equity in All Policies as “healthy public policy” will be reviewed.

Health in All Policies (HiAP)

127. The focus of HiAP is governance. The aim is to reach out to other ministries and sectors in society, in order to develop and sustain dialogue on the health-related aspects of all policies as entry points for changing the determinants of health and health inequities. Policies on agriculture, education, housing, labour, transport, taxation and welfare, for example, shape and affect the social determinants of health and patterns of health inequities in society.

128. Many policies relevant to health lie outside the remit of the ministry responsible for health, and most social determinants are found in other sectors. Yet the consequences (often unintentional) of other sectors on health become the responsibility of ministries of health. HiAP therefore involves putting health on society’s and governments’ agenda as an asset for development and integrating common objectives, targets and indicators that improve and sustain health and health equity into the policies of other ministries and sectors.

129. The imperative to act in partnership with other sectors and stakeholders in society is also born out of resource- and cost-efficiency measures linked to the social and economic costs of health and health inequities. The cost of inequalities in health can be felt at the level of individuals and families in communities, as well as on a broader societal level. For example, at the level of individuals and family, loss of health affects earning and related financial security linked to pensions and savings; at the level of communities and regions, costs are felt in terms of reduced labour productivity, regional development capacity and inward investment potential; and more broadly, costs show up in terms of increased demand on social security systems and health care. Together, these costs have a negative impact on the degree of community and social cohesion and are a persistent (but avoidable) challenge to attainment of our values of solidarity.

130. The extent to which HiAP is systematically adopted and implemented is still under development. To this end, we need increased know-how, tools and instruments to strengthen

³⁰ *Closing the gap in a generation: health equity through action on the social determinants of health.* Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2008 (http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf).

³¹ Chomik TA. *Lessons learned from Canadian experiences with intersectoral action to address the social determinants of health – summary report.* Ottawa, Public Health Agency of Canada, 2007 (http://www.who.int/social_determinants/resources/isa_lessons_from_experience_can.pdf).

and support practices of Health and Health Equity in all Policies, and more learning from evaluation of results and impact.

Governance tools that support HiAP

131. A variety of governance tools that foster coherence, collaboration and partnership have been used to further intersectorality and HiAP.³² These will be briefly reviewed here. Most of these tools or approaches have not been studied or evaluated in detail. Variations in approach reflect not only different HIAP goals but also differences in know-how and human resource capacity, as well as fragmentation of institutional arrangements.

132. Governance for Health is one of the pillars of the WHO long term vision in Health 2020. Increasing health and well-being are to become goals of the whole of governments and societies. There is a need for 'smart' governance that will develop new types of leadership, new types of engagement and new types of democratization.

133. Governance in about how governments and other social organizations interact, how they relate to citizens and how decisions are taken in a complex and globalized world. There is a strong link between health and well-being and, in that respect, social determinants of health are very important.

134. The 21st century determinants of health are the result of transnational dynamics. It is important to note also the stratification of the actions in the different concepts and activities, thus HiAP is a typical government action, whereas corporate social responsibility is a business action. Finally, community and consumer action is at the level of citizen's involvement.

Structural approaches

135. These include whole-of-government forms such as cabinet committees which demonstrate the high level political commitment that can be identified as a key requirement for success.

- The United Kingdom has had a long history of strategies for health improvement (*Saving lives: Our healthier nation and Reducing health inequalities* from 1999), then in 2003 a truly intersectoral strategy (*Tackling health inequalities: A programme for action*) was launched among twelve government departments and regional and local authorities. The strategy proposed a clear national target of reducing the health gap for infant mortality and life expectancy by 10% by 2010. These commitments were ratified and overseen at cabinet level, including the Department of Finance and the Department of Health.
- In Norway, a 2003 white paper (*Prescription for a healthier Norway*) was introduced at government level as a ten-year national plan to consider the social gradient of health in the context of promoting a balance between individual and social responsibilities. In 2007 the *National strategy to reduce social inequalities* was published, calling for the linkage of policies across multiple sectors. An intersectoral review and reporting system has been established to provide a systematic and regularly updated overview of progress towards achieving the policy objectives. The Norwegian Directorate of Health is responsible for coordinating the design and development of indicators as part of the reporting system, in close collaboration with relevant ministries, directorates and professionals. Based on this

³² St. Pierre L et al. Governance tools and framework for health in all policies. The Hague, Council for Public Health and Health Care, 2009 (http://www.rvz.net/data/download/IS_studie_Brussel_-_engels.pdf).

review and reporting system, an annual policy review has been published since 2009. Each annual report includes the main national initiatives and strategies, goals for reducing inequalities and comments on the trend for each indicator. These reports are then used as a basis for annual reporting in the national budget through joint reports in the budget proposal of the Ministry of Health and Social Care Services.

- In France, a new national cancer plan was launched in 2009 to cover the period between 2009 and 2013 with regular interim reporting. There are five main vertical areas (called axes) – research, monitoring, prevention and screening, care, living during and after cancer – and three horizontal or transverse areas – inequalities, individual and environmental factors and increasing the role of all treating physicians involved in the whole course of the disease. The two dimensions are combined through 30 indicators at the most important intersections where they are used for the monitoring of progress and show a clearly multisectoral and multidisciplinary approach. Current priority is in mobilising population to undergo colorectal cancer screening. Apart from cancer a series of other public health problems have received attention at health policy level – reducing alcohol consumption, the role of adults in preventing drug abuse in children and adolescents, campaign for physical activity.
- The current Finnish health policy, *Health 2015*, is a cooperation programme providing a broad framework for health promotion in various areas of policy, reaching across different areas of administration. Intersectoral policy programmes are overseen by the Prime Minister’s Office. Finland subsequently released an inequalities strategy or action plan for 2008–2011. This seeks to build on existing government approaches in other areas. It provides an update about intentions and follow-up on intersectoral working.

136. Interdepartmental committees fall short of this highest-level government support but are a more usual organizational form. These promote understanding of different responsibilities, but they can add organizational complexity.

- In the United Kingdom, a cabinet subcommittee was established under the responsibility of the Minister of Public Health to ensure that different government departments contributed to the national inequality reduction targets.
- In Kyrgyzstan, the Ministry of Health in 2006 elaborated an intersectoral action plan for promoting population health within the framework of the national health care reform process, “Manas Taalimi”. The aim was to better coordinate actions and resources for health with other government sectors, in order to improve daily living conditions such as water supply and housing, improved health behaviours and access to primary health care services; and also to coordinate the support of United Nations agencies and international donors around common objectives for improving health at the community level. The action plan was formally adopted by Parliament and included a clear description of the responsibilities of the various stakeholders; dedicated resources linked to the Health Sector-Wide Approach (SWAP) and line agency budgets; health promotion training for community health workers; awareness-raising through local media; and supporting and developing nongovernmental organizations (NGOs) and community health action working groups.

137. Steering committees may support overarching, high-level implementation plans and be a more effective mechanism for supporting effective cross-agency implementation. Clearly defined cross-agency dependencies and responsibilities are essential.

138. Networks may provide for more flexible coordination, provided there is a high level of trust and confidence between the members.

139. The creation of specific organizations or units to support implementation ensures long-term commitment but is expensive in terms of resources.

- In England, a health inequality unit was established as part of the Ministry of Health to support the strategy and targets for reductions in health inequality.
- In Norway, the Directorate of Health in 2007 coordinated the development of indicators to support the National strategy to reduce social inequalities, providing an inner “portal” with information on how to include inequality concerns in planning; developing the skills of local public health actors; fostering collaboration between municipal and local public health authorities; and developing new knowledge that supports the practice of collaboration between different ministries and between municipalities and local health authorities.

Process approaches

140. Shared planning and priority-setting allows for the sharing of goals as an important condition for the success of collaborative work. Leadership has been shown to be critically important for successful integration.

- In Norway, mechanisms for promoting intersectoral working included interministerial cooperation and a variety of other measures such as health impact assessment and, at the municipal level, social and land use planning were introduced with an action plan to reduce inequalities.
- In Sweden, public health policy reports aim to provide an account of the measures taken by central agencies, county councils and municipalities to influence public health and identify future directions for action. A national public health survey shows the latest state of the population’s health and follows up over time. This is an ongoing collaboration between the Swedish National Institute for Public Health and county councils and regions.

141. “Joined-up” evaluation can support integrated outcomes, as well as promoting the recognition of shared and overlapping organizational missions.

- In the United Kingdom, regular evaluation of the national strategy and targets for reducing health inequalities have taken place annually under the auspices of a scientific reference group on health inequalities. These have revealed some improvements in child poverty and have taken a positive view of the intersectoral convergence strategy. The government has commissioned the Scientific Group to develop a new intersectoral strategy.
- In Finland, all ministries are legally required to provide the information necessary for evaluation of performance against national and interdepartmental public health objectives.

142. The use of intersectoral tools and health targets has been relatively common in Europe, for example in the European Health for All Policy.

- In Finland, several national research institutes have been requested by the Ministry of Social Affairs and Health (YEAR?) to develop the tools needed to carry out and monitor actions defined by public health policies and programmes. Among these are an internet portal, pilot projects, curricula development in diverse sectors, a database on innovative practices, and development of indicators for monitoring health at the local level.
- In Sweden, after the publication of the 1998 bill (*A renewed public health policy*), health targets were grouped under eleven main objectives, formulated to reflect the way in which public administration was organized. These targets support the policy, with its overarching goal “to create the conditions to ensure good health, on equal terms” for the whole population. The Swedish National Institute of Public Health is responsible for monitoring implementation of the policy and attainment of its objectives, and the Institute

developed new monitoring indicators appropriate to the policy's cross-cutting objectives. The public health policy requires an evaluation report to be presented to the Swedish Parliament every four years, although evaluation is complex and difficult in view of the highly decentralized nature of the Swedish governance system, with many actors involved at different levels.

Financial approaches

143. Financial approaches include collaboration and alignment of financial flows in the context of investment planning, with flows linked to statutory objectives,

- In the United Kingdom, new measures were taken to support collaboration and alignment of investment planning with statutory objectives, through which resources flowed to support the reduction of health inequalities. Two management mechanisms were established. The first included cross-cutting spending reviews related to the inequality reduction targets. The second was a process for reaching agreement between central government and its departments, on the one hand, and local levels, on the other, in order to attain broad national objectives. These public service agreements are linked with the spending reviews and give the framework through which departments, local authorities and other local organizations agree on targets for steering and coordinating public action. This means that health and well-being are incorporated into national policy.
- In Finland, financing for public health policy is ensured by a special budget specified through intersectoral action plans such as the 2008 National action plan to reduce health inequalities.

144. Joint financing conveys a strong commitment by partners. Grants and other financial support mechanisms can provide certainty around funding commitments, an aspect that has also been identified as an essential element of success.

- In France, financial incentives within the national cancer plan were used to reduce tobacco consumption by increasing the price of cigarettes by 45% in the first two years, resulting in 1.8 million fewer smokers.

Mandate-based approaches

145. Laws and regulations are powerful levers for integration, if so drafted. Agreements, protocols, exchanges of letters, memoranda of understanding, contracts and similar instruments should clearly identify the objectives and intended outcomes of the arrangement, the roles and responsibilities of each of the resources involved, the methods of evaluation and the mechanisms for operational and financial accountability.

Approaches based on health impact assessment and health equity impact assessment

146. Health impact assessment (HIA) and health equity impact assessment (HEiA) are intended to support decision-makers in choosing between different options and predicting their consequences. These are by definition intersectoral and prospective. So far, these techniques have been most often used at regional and local levels. However, there are some examples where the approach has been used at national level.

- In Wales, reducing health inequalities is one of the priorities of the Welsh National Assembly. HIAs have focused on the health equity impact of specific measures. For example, an HIA initiated by a local residents' association was conducted to analyse the impact of a road construction project. The intention was to document health impacts of the impending road construction on the already poor and vulnerable population. The HIA

took account of the health impacts of pollution, noise and physical activity levels. The evidence collected led to the conclusion that the road construction would have negative health impacts on the local population. The HIA empowered a vulnerable group to raise their concerns, while making planners in various sectors aware of the health impact of their activities. The eventual outcome was that the road was not constructed, although it is not possible to define precisely the extent to which the HIA results informed this decision.

- In Slovenia, an HIA was conducted of the agricultural and food policies proposed as a result of the country's accession to the European Union. This appears to be the first time that any government has attempted to assess the health effects of agricultural policy at national level. The HIA followed a six-stage process: policy analysis; rapid appraisal workshops with stakeholders from a range of backgrounds; a review of the research evidence relevant to the agricultural policy; analysis of Slovenian data for key health-related indicators; and a report on the findings to a key cross-government group; and evaluation. The experience in Slovenia shows that the HIS process has been a useful mechanism for raising broader public health issues onto the agricultural agenda, with positive results for policy formulation.

147. The European Commission has included health in its impact assessment procedure, reflecting the requirement in Article 152 of the Treaty of Amsterdam that “a high level of human health protection shall be ensured in the definition and implantation of all Community policies and activities”.

Decentralized systems of government

148. Decentralized systems of governance and planning pose new challenges for ensuring that health is considered in subnational policies and strategies.

- In Slovakia, regional governments have increased autonomy in relation to social and economic decisions and investments, many of which affect health and health equity and their determinants. At the same time, health remains essentially a centrally managed and organized function. Regional parliaments formally adopted a health chapter into regional development plans and related investment objectives and funding flows. Cross-sectoral and interdisciplinary planning teams were established, using regional planning cycles and mechanisms to include health equity considerations in priorities and investment plans. Goals related to the health of the most vulnerable groups (e.g. elderly persons, the Roma, rural communities, homeless or migrant populations, and the unemployed) were integrated into regional cross-sectoral priorities and actions, backed up by resources and financial investments. There was also a need to ensure that the health promotion and public health goals set out in national policies were reflected and delivered through regional development plans and investment frameworks. A range of mechanisms was used to ensure that cross-sectoral consideration of health in regional development plans.

WHO support

149. WHO has made numerous efforts to strengthen the capacity of ministries of health to (a) analyse and (b) understand the determinants of health and health inequalities. Examples of this work include:

- playing a role as a broker of innovation, evidence and know-how, (for instance in the knowledge networks set up by the Global Commission on Social Determinants of Health – CSDH), providing a synthesis of determinants of health and engaging in policy dialogue on findings with partner countries and within regions. A WHO report on

measurement and evidence related to the socioeconomic determinants of health outlines tools, guidance and examples;

- issuing a CSDH report on “Crossing sectors” from the Public Health Agency of Canada, which sets out countries’ experiences and learning to date and demonstrates that some impact has been achieved. Cross-sectoral studies of action taken to address social determinants and health equity include critical and common mechanisms that have been used effectively in different countries throughout the world;
- putting health into European platforms for cross-sectoral action, such as for Decade of the Roma;
- developing tools and methods;
- direct technical assistance in analysing countries’ specific health inequity challenges;
- national reports that indicate the main social determinants and non-health sector policy domains for advancing cross-sectoral action;
- a tool for appraising governance in terms of socially determined health inequalities in order to assess the coherence of policies and governance mechanisms to address the specific health inequity challenges of a given country at national level. This tool has been used in Slovenia, with the results translated into cross-government action to reduce social inequalities in health within that country;
- web-based “atlases” to support ministries of health in assessing health inequalities and their social determinants, as well as health system performance. These “atlases” are now available on line. The tool also includes a companion resource guide of country health policy assessments and suggested evidence-based options and actions. Ten of these options are intersectoral and HiAP approaches to social determinants and reduction of health inequalities;
- analysing social determinants of health and health inequities – a multicountry workshop in 2010 provided a forum in which policy-makers, planners and analysts (specifically from countries of central and eastern Europe, the Baltic states and Balkan republics) could debate, test and apply know-how, tools and practical techniques to monitor and analyse social inequities in health. The workshop increased participants’ familiarity with using evidence and analytical tools to advance their own national strategies and targets to reduce social inequities in health;
- developing alliances and building partnerships in 2008 such as (a) the Kosice Institute for Society and Health – a partnership for strengthening WHO support to the Ministry of Health in the analysis of social determinants and health inequities and (b) a WHO collaborating centre for capacity-building on cross-sectoral policies for health equity at the Centre for Health and Development (Murska Sobota, Slovenia);
- leading intersectoral action and influencing other sectors to address these determinants:
- in Kyrgyzstan, WHO has played a convening role around intersectoral action for health within the national reform process. An intersectoral action plan was formally adopted by the Government and included in the country’s Reform Law;
- in Slovenia, the Mura Investment for Health Program was part of the WHO Verona Investment for Health European Initiative (1996–2003). This led to integrated health and development plans with evidence of sustained impact. The approach has been integrated into the review of public health strategy and functions currently under way in the country. The project saw its high point in a jointly organized conference on health inequalities in Slovenia by the MoH of Slovenia and WHO Office;
- in Slovakia, regional parliaments formally incorporated a health chapter into regional development plans and related investment objectives and funding flows. This approach is an example of WHO support helping a country to allow health to influence the priorities

and investment plans of other sectors, so that social determinants and health can be addressed as a core part of the mandate of regional authorities.

Conclusions

150. While these examples show the range of activities being carried out to promote coherence and intersectorality in the context of HiAP, Europe is currently lacking a comprehensive and methodologically sound pan-European study on the whole-of-government approach and on governance tools and frameworks for HiAP. Many developments may remain unreported, particularly with the federalization, devolution and decentralization of health and health care that has been seen over the past decades in several countries.

151. There is a lack of scientific literature with regards to governance tools and frameworks for HiAP, perhaps owing the newness of the field of work. Specifically, there are challenges in scientifically assessing the effectiveness of HiAP, as methodological problems limit the scientific robustness of evaluations of governance strategies and tools.

152. Despite these difficulties, the case studies and existing literature point to several essential elements for successful implementation of HiAP:

- strong leadership at the highest government level;
- strong leadership from the health system;
- a clear vision of health with a well-articulated policy that includes objectives and targets; and
- a supra-departmental authority/organization in charge of HiAP.

153. The establishment of new organizational structures supportive of HiAP, or a substantial assignment of new responsibilities to an existing structure

- legal support of HiAP through revision of public health laws;
- legal support for endorsing specific activities;
- simultaneous action at different organizational levels; and
- dedicated HIA units with sustainable funding.

VI. Summary of progress to date, and perspectives on future directions for implementation of the Tallinn Charter

From values to actions: a summary

154. The Tallinn Charter: Health Systems for Health and Wealth was a significant landmark for health policy in the European Region of WHO. In the Charter, Member States enshrined their belief that investing in health is investing in social well-being and wealth; that it is unacceptable for people to become poor as a result of ill health; that well-functioning health systems are essential to improving health and therefore that health systems need to perform well. In other words, they affirmed the fundamental importance of health for society and their collective responsibility to foster health and health equity. Moreover, Member States stated their conviction that the services provided by health systems entail more than health care services and also include public health services, such as disease prevention and health promotion, as well as efforts to influence other sectors to address health concerns in their policies.

155. Many policies and innovations consistent with the Tallinn Charter have been implemented in recent years throughout the Region. Strengthening solidarity and equity in health systems have been top policy concerns, addressed particularly through the overhaul of health financing arrangements and by making health services more inclusive of disenfranchised groups. Investing in health and maintaining investments at the time of the financial crisis have been the subject of intense discussions in many Member States, with several successful examples from which lessons can be learned. There have been a number of instances of innovative governance arrangements involving a “whole-of-government approach” in order to influence health determinants outside the health sector. Member States have been promoting participation and engaging stakeholders in, for example, fostering intersectoral dialogue, mainstreaming evidence on gaps in equity and promoting a common vision or establishing mechanisms of interregional solidarity. Most Member States now ensure that health systems are prepared and able to respond to crises, and that they collaborate with each other and enforce the International Health Regulations through practical approaches. In all these areas, increasing use of evidence in policy development has allowed greater transparency of policy processes. Cross-country learning and cooperation has been an important tool to foster knowledge and experience, with WHO taking on a leading role as a facilitator. This vast array of activities demonstrates enthusiasm to operationalize the messages of the Charter, which is an indication of its importance throughout the very diverse WHO European Region.

156. A central theme of the Charter is fostering transparency and accountability for health system performance. Several countries’ health authorities focused on “getting their own house in order” and not simply pleading for more resources or asserting the importance of health. The principles and approach outlined in the Charter provide a basis for improving performance through strengthened health systems.

157. Member States have been increasingly producing and using evidence on health system performance in decision-making, as well as searching for effective ways to institutionalize performance assessment in their governance structures. Key health sector stakeholders – governments, purchasers, providers, health authorities and civil society – have been eager to engage in discussions of health system performance, making this an important tool to foster transparency and accountability throughout the health sector and to promote intersectoral dialogue.

158. Member States’ commitment to the principles of the Charter was put to the test when the financial crisis hit. The commitment to equity, solidarity and financial protection can easily be compromised in the face of fiscal pressures created by a deterioration in public finances during the years of an economic downturn. Across-the-board budget cuts for health and social sectors

have led to an increase in poverty and ill health. Having reviewed the response of Member States to the financial crisis, it is concluded that if cuts in health budgets are unavoidable, they should be implemented in a manner that minimizes adverse effects on the poor and vulnerable. This process should be coupled with the implementation of overdue efficiency-enhancing reforms, because they can reduce the severity of the “trade-offs” in terms of sustainability that became more even more necessary during a crisis.

159. It has been seen how health ministries have led intersectoral action for health and how they have the responsibility to try to influence factors that affect health, even if those factors emanate from outside the system. This is the agenda to incorporate health concerns in all public policies (Health in All Policies), which aims to establish health improvement as a shared societal goal to be reflected in the priorities across all parts of government. It addresses complex health challenges by promoting an integrated policy response across the boundaries of sectors and portfolios. This allows governments to address the key determinants of health in a more systematic manner, as well as to take account of the benefits of better population health for the goals of other sectors.

160. Countries that have been implementing the commitments embedded in the Charter have demonstrated that moving from values to action within a short period of time is possible with leadership, innovation, and openness. Leadership has been a key factor in success and has been necessary for standing behind the values of equity, solidarity and financial protection, particularly at the time of the financial crisis, guiding the development of a vision to achieve these objectives and driving change within and outside the health sector. Innovation in vision, policies, funding arrangements and governance has been critical when old approaches have failed to lead to health improvement and to address the needs of vulnerable groups. Finally, openness towards key health sector stakeholders and their engagement in health system performance assessment, policy development and implementation and health advocacy have brought about a new era of governance.

161. Successes notwithstanding, there are a number of challenges and barriers that prevent Member States from translating the values of the Tallinn Charter into action. While health sector policy-makers are enthusiastic about the commitments made to the Tallinn Charter, it can prove to be challenging to get the broader government and politicians “on board”, and especially to engage them in activities for long-term health gain and more comprehensive approaches to governance. Implementing some of the commitments in the Tallinn Charter, particularly on financial protection and access, requires resources. The years since the financial crisis have been challenging for many countries from the perspective of maintaining a fiscal balance, adding to the underlying tension already present between growing demand for health care and limited resources. In many countries, funding has not been sufficient to honour commitments to the social values of financial protection and equity.

162. Overall, Member States unequivocally committed themselves to use the Charter as a basis for transforming their shared values into action on strengthening health systems. In some Member States, the merit of the Tallinn Charter was to draw the attention of policy-makers to the importance of comprehensive health systems strengthening and to catalyse the policy agenda in this regard. In other countries, the Tallinn Charter stimulated specific areas of health systems strengthening such as improving governance through performance assessment and intersectoral work or improving health financing arrangements to better address the needs of the poor.

From the Tallinn Charter to Health 2020

163. The lessons emerging from implementation of the Tallinn Charter will serve to inform the development of the new European health policy, Health 2020. That policy will reaffirm the central tenets of the Tallinn Charter, such as the urgent requirement to redress health

inequalities by focusing on the needs of the poor and the vulnerable, the value of engaging patients and other stakeholders in making decisions about personal health and that of the society in which they live and the necessity of tackling modern health challenges through partnerships for learning and cooperation. In three areas, the synergies between the Tallinn Charter and Health 2020 will be particularly meaningful: rejuvenating public health services and action, implementing health in all policies and improving governance through performance assessment.

164. Notwithstanding the considerable progress that has been made in implementing the commitments in the Tallinn Charter, there are indications that the time is right for renewed emphasis to be placed on strengthening public health services in the European Region. The current predominant burden of noncommunicable disease is one reason why this renewed emphasis is absolutely needed. Because of their focus on the long-term health of the population, public health programmes often find themselves at odds with the relatively short electoral cycles that tend to dictate policy imperatives and which often lead to a political preoccupation with health care services. There is a growing concern that in the wake of the financial crisis, the critical public health services of disease prevention and health promotion have suffered disproportionately from efforts to reduce health system budgets. This concern is reinforced by indications that, even before the financial crisis, public health services in many countries of the Region had become institutionally and functionally weak.

165. Taking advantage of the Health 2020 process, the Regional Office has committed itself to rejuvenating its efforts in the area of public health, and in this context it will be drawing up a “Framework for action on strengthening public health capacity and services in Europe”. The public health action framework will build on the Tallinn Charter’s explicit recognition of the importance of health promotion and disease prevention by proposing actions to scale up and improve the delivery of essential public health operations and services as well as to strengthen public health organizations and human resources in the WHO European Region.

166. In the Tallinn Charter, Member States acknowledged the decisive influence of social, environmental and economic determinants on health outcomes. By recognizing, in the Charter, the stewardship function carried out by health systems, the Member States sought to empower health ministries to act on these broader determinants of health. Through that stewardship function, the Tallinn Charter recognized the mandate and responsibility of health ministries to promote the inclusion of health considerations in all policies and to advocate for their effective implementation across sectors.

167. Experience in implementing the Tallinn Charter has shown that, in order to exercise their stewardship function effectively, health ministries require more than the simple mandate to do so. In many countries of the WHO European Region, health ministers do not possess sufficient authority within the government to initiate and sustain change outside of their own portfolios. Experience has shown that it is therefore important that the responsibility for health improvement is “nested” at the highest level of government. Furthermore, formal and informal governance mechanisms must be put in place to support ministries of health in leading intersectoral policy responses to health challenges. Such mechanisms include institutional platforms (e.g. a jointly staffed health policy unit embedded in the prime minister’s office, joint committees and working groups), incentive and accountability schemes (e.g. joint targets and budgetary mechanisms for joint funding and accountability) and formal requirements to assess the health impacts of major policy proposals.

168. In the light of the above, Health 2020 will advocate a “whole-of-government” approach to health governance. Strong leadership will be singled out as a determining factor influencing the ability of health ministries to engage other sectors and enact change. Health 2020 will highlight how health ministries can effectively navigate horizontal governance processes to promote better health as one of the shared goals of society that is pursued by all parts of government. Furthermore, it will thoroughly outline the governance mechanisms of the Health

in All Policies model, by which governments can empower their health ministries to mediate effectively in the complex networks of determinants of health and health inequalities.

169. Member States' experience with performance assessment and policy analysis indicates that measurement, monitoring and evaluation may also serve to further a number of principles that are of broad relevance to health governance, and therefore to the development of Health 2020. In addition to transparency and accountability, a key objective of performance assessment is to support participatory and adaptive policy-making. Involvement of patients and other stakeholders in decision-making, monitoring and evaluation are important elements.

170. Owing to the many value judgments that are implicit in performance assessment exercises (e.g. in the choice of indicators or the relative importance attached to different objectives), they can provide valuable arenas for different actors and stakeholders to debate their different perspectives and preferences and learn from one another. The ensuing synergies can be invaluable in furthering the pursuit of shared societal goals. By their very nature, health policy problems such as the interrelated epidemics of obesity and cardiovascular disease are characterized by complexity, uncertainty, high stakes and conflicting values. In the face of these challenges, policies must be implemented as large-scale experiments in which monitoring and evaluation efforts provide an essential mechanism for the policy community to learn from the experiences acquired in practice, and to adapt accordingly.

The way forward to the Sixty-fifth session of the Regional Committee in 2015

171. The WHO Regional Office for Europe will continue to support Member States in implementing the commitments made in the Tallinn Charter by strengthening their health systems. WHO will engage with Member States by providing technical input into the policy dialogue in a wide range of areas such as reducing the burden of particular diseases, improving health financing arrangements, strengthening public health services, improving the quality of medical services, generating the appropriate level and quantity of resources (human resources and medicines) and strengthening governance arrangements. In addition, the Regional Office has a number of intercountry products to offer such as guidelines on health system performance assessment, case studies that share know-how in a number of fields related to strengthening health systems, analytical work, courses, and other cross-country knowledge-sharing events. Finally, the new WHO initiative on national health plans will provide an opportunity for those Member States that are starting new planning cycles to adopt a systematic approach to health system strengthening.

172. The material reviewed in this interim report indicates that the principles and commitments affirmed in the Tallinn Charter are being implemented in policy environments characterized by complexity, uncertainty, high stakes and sometimes conflicting values. As a region-wide set of commitments focused on accountability for the performance of health systems, the Tallinn Charter represents an important political "experiment", and valuable lessons can be learned from the experience of Member States and the Regional Office in implementing it. In order to maximize the learning experience while remaining faithful to the adaptive policy-making paradigm outlined above, the planning for an evaluation that would aim to assess both lessons from country experience with reforms and the role played by this international political agreement should be initiated in the near future. The approach adopted in the present mid-term review could be bolstered to include individual interviews, focus groups and case studies, and selected Member States or an independent body could be invited to facilitate the evaluation. This would ensure that the wealth of experience gained in the process could be collected, appropriately analysed and synthesized in time for the sixty-fifth session of the Regional Committee in 2015.