



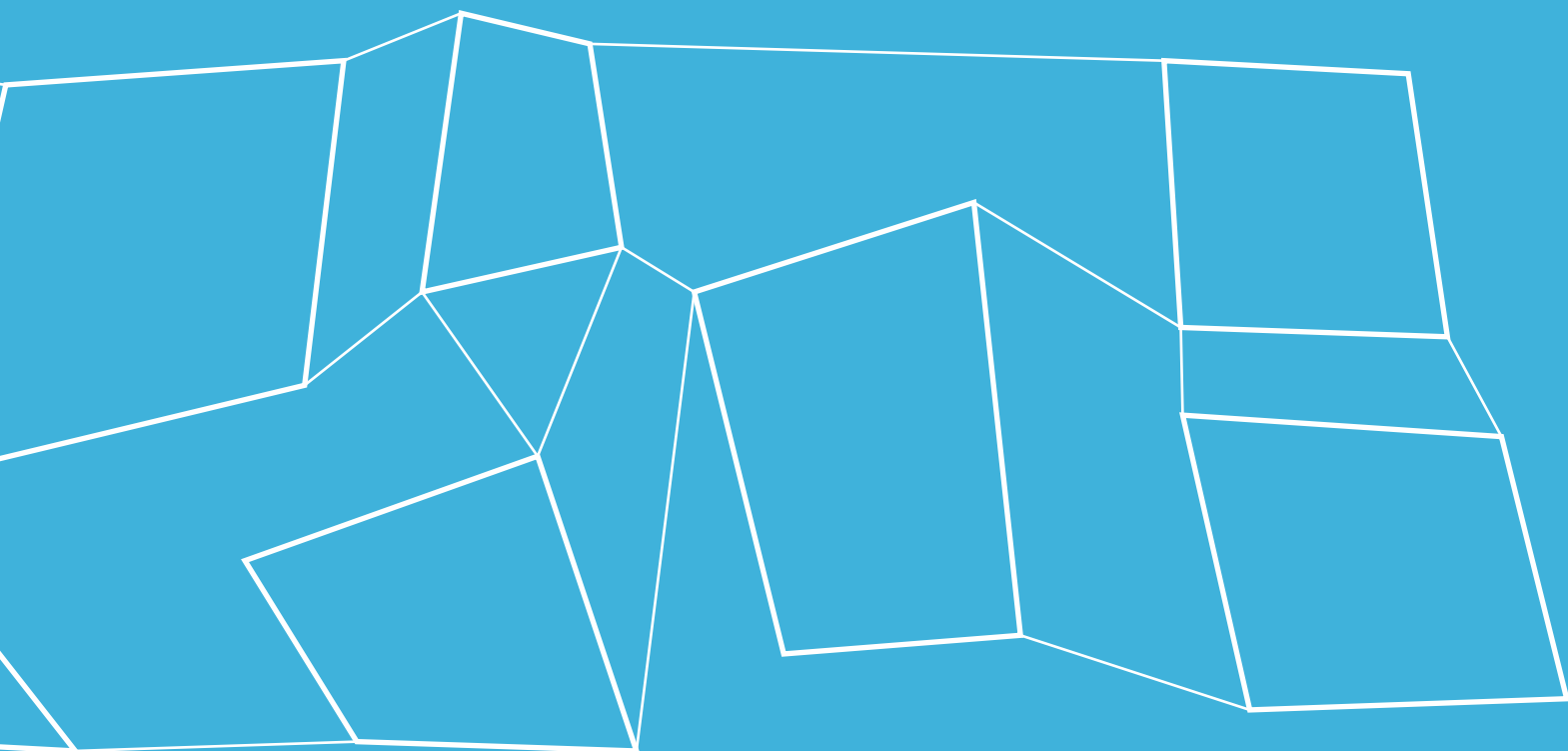
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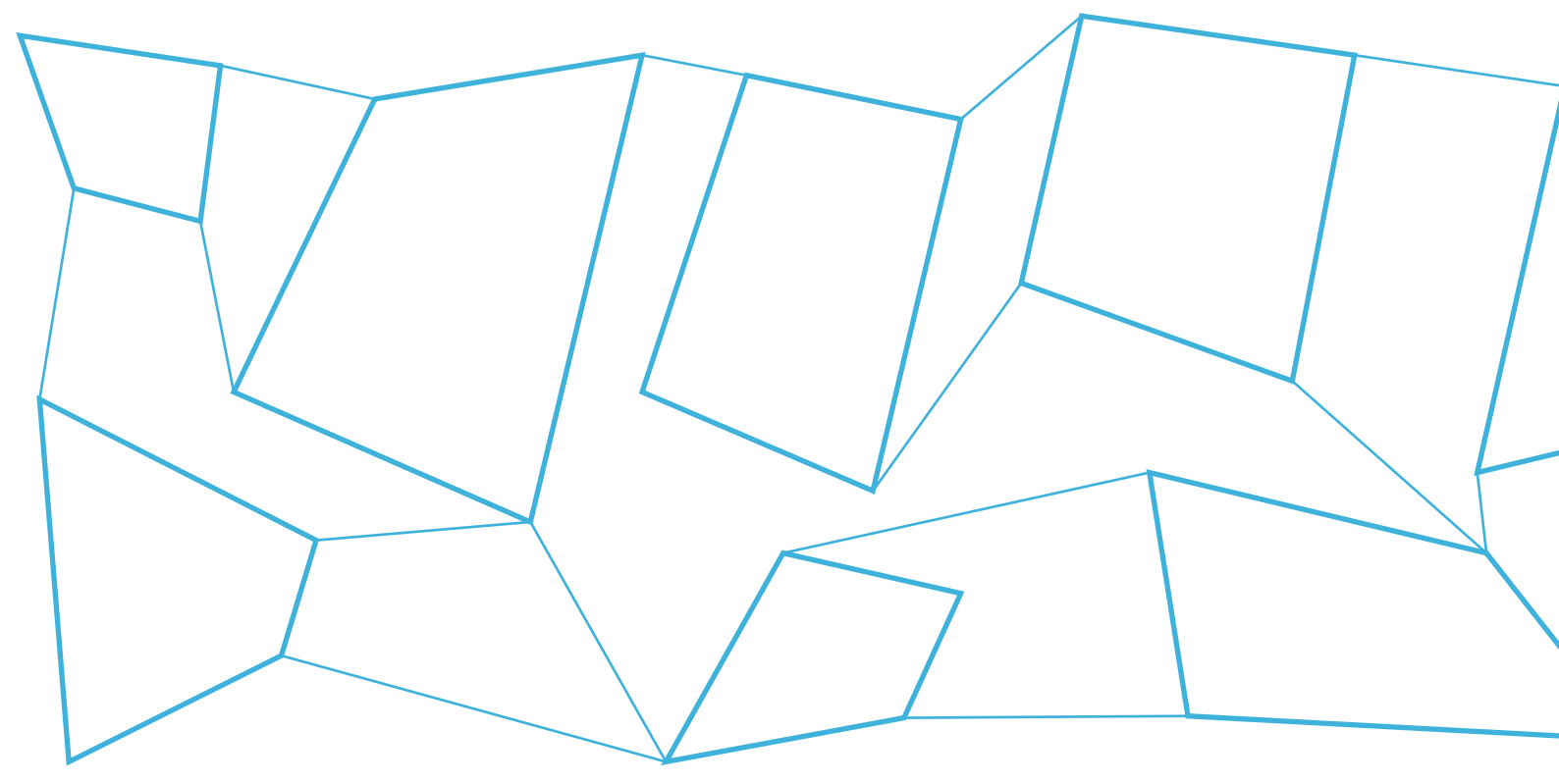
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# Meeting report of the First High-level Meeting of Small Countries

Implementing the Health 2020 vision in  
countries with small populations

San Marino, 3–4 July 2014

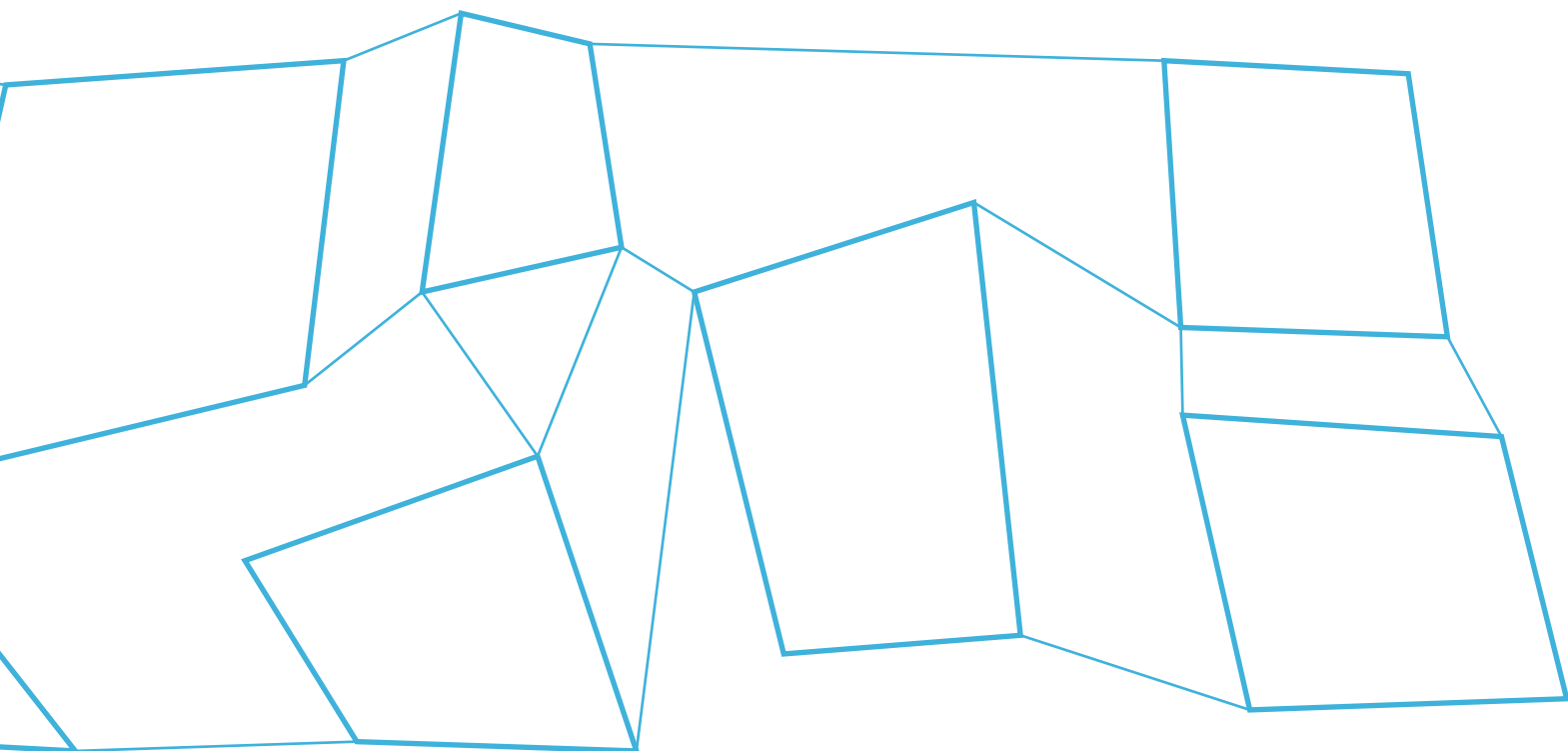




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Implementing the Health 2020 vision in  
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## Abstract

The Small Countries project focuses on the strategic objectives of Health 2020, and its values and principles for action to improve population health and well-being, reduce health inequities and build more equitable, cohesive and sustainable societies in countries with small populations. The First High-level Meeting of Small Countries served as a forum to share information on small countries' experiences, lessons learnt and plans related to Health 2020 implementation, and to discuss how to advance the collaboration among small countries. Experiences shared showed that small countries have advantages, such as strong social cohesion, as well as disadvantages, such as facing the same challenges as large countries, but with less capacity. Solutions for such challenges are highlighted in this report. Additionally, the meeting stressed the importance of documenting how to align national health policies to Health 2020; the benefits of joint capacity-building events and structures between the Regional Office and small countries; how better engagement of the media leads to a supportive environment for Health 2020; and the need for a platform to share experiences and mutual learning about Health 2020 implementation.

## Keywords

EUROPE

HEALTH POLICY

NATIONAL HEALTH PROGRAMS

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## Abbreviations

CARINFONET	Central Asian Republics Information Network
CCS	country cooperation strategy
EPHOs	essential public health operations
NCDs	noncommunicable diseases
OECD	Organisation for Economic Co-operation and Development
RC64	64th session of the Regional Committee

## Executive summary

The First High-level Meeting of Small Countries aimed to foster political commitment and develop good practice to implement Health 2020, focusing on how small-population countries are addressing its strategic objectives. The Small Countries project focuses on the strategic objectives of Health 2020; and its values and principles for action to improve population health and well-being, to reduce health inequities and to build more equitable, cohesive and sustainable societies in the context of countries with small populations.

The meeting served as a forum to share information on small countries' experiences, lessons learnt and plans related to Health 2020 implementation, and to discuss how to advance the collaboration among small countries around the main deliverables of the project.

Experiences shared showed that small countries have advantages, such as strong social cohesion, as well as disadvantages, such as facing the same challenges as large countries, but with less capacity.

Meeting highlights are grouped under Health 2020's two strategic objectives.

### **Strategic objective 1: improving health for all and reducing health inequalities**

**Reducing the health divide calls for the creation of conditions favourable for health, development and well-being.** Operationalizing the synergy between health and other sectors requires: innovative thinking; dynamic and new governance; health authority capacity to take up new roles promoting health and well-being; health services targeting users and focusing on health promotion and disease prevention; and the availability of a sufficient number and the proper mix of professionals within and outside the health sector.

**Entry points for intersectoral work are numerous.** The health sector can play an instrumental role in helping other ministries identify goals and targets that are mutually beneficial.

**Health information systems that reveal inequity are critical to small countries** due to their size, population fluctuations and particular needs. Health information systems are intersectoral, with data stored in different ministries and registries, and collected by means of numerous surveys. Mechanisms to integrate information need to be identified so that data are available at all times for anyone.

**Data collection challenges** in small countries, though numerous and unique, can be met. Mechanisms include: identification of country-specific data needs; identification of good practice that can be used/adapted for countries not meeting reporting needs; horizontal cooperation approaches among countries; identification of a common set of indicators to address country needs; preparation of a joint publication on health indicators from small countries; and reports on the progress of health information development in countries.

**Countries are keen to move forward with Health 2020 implementation** but need to repackage data for different audiences and convene around common agendas. Some mechanisms could be the use of live policy learning exchanges and Health 2020 leadership events where experiences, know-how and learning tools could be exchanged.

**Promising practices should be documented**, showing the co-production of health, reductions in the health divide, challenges encountered and lessons learnt. Such an exercise builds up

a valuable repository of know-how for the coming years. This information is valuable for the implementing country, as well as to other countries, to reflect on what worked and what could be improved.

**Health policy learning tools are available** to help implement lessons learnt to reduce inequity gaps. The *Review of social determinants and the health divide in the WHO European Region* and companion products<sup>1</sup> provide evidence on what works and a synthesis of promising practices.

## **Strategic objective 2: improving leadership and participatory governance for health**

**Linking the social determinants of health and the post-2015 development agenda are crucial.** Putting equity and the social determinants of health on the development agenda of small countries are of paramount importance. The time was deemed ripe for exploring and expanding political and institutional arrangements for this.

**It is important to mainstream equity into WHO programmes** and networks to help advance work on this issue. While there are action plans and workplans, a review of how to better support small countries in areas with limited capacity is warranted.

**Mechanisms to promote intersectoral work are available** and include ministerial committees and intersectoral working groups. Guidance on how to set up these committees and groups would be a valuable tool for Member States in the process of implementing Health 2020's strategic objectives.

**Supportive environments for implementing Health 2020 can be created** through better engagement of the media. The media can play a key part in creating better engagement of policy-makers and communities. A platform for sharing experiences and mutual learning about Health 2020 implementation should be set up.

Four key actions came out of the meeting.

1. Document how to align national health policies to Health 2020.
2. Develop joint capacity-building events and structures between the Regional Office and small countries to promote health and reduce health inequities.
3. Create a supportive environment for Health 2020 through better engagement of the media as an implementation partner.
4. Create a platform for sharing experiences and mutual learning about Health 2020 implementation.

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<sup>1</sup> Companion products are tools and documents that provide guidance on how to put the recommendations from the Review into practice.



## Introduction

The First High-level Meeting of Small Countries was held in San Marino on 3–4 July 2014. The participating countries, with a population of one million or less in the WHO European Region, were Andorra, Cyprus, Iceland, Luxembourg, Malta, Monaco, Montenegro, and San Marino. Forty participants representing five government sectors attended, including eight ministers, one Parliamentary Secretary for Health, three Directors-General and one Ambassador (Annex 4).

The main aims of the Small Countries project are to foster political commitment and develop good practice to implement Health 2020 (1) in the context of countries with small populations.

By participating in the project, countries will have the opportunity to:

- share Health 2020 implementation-related knowledge, processes and promising practices;
- strengthen technical capacity in countries in accelerating the implementation of innovative Health 2020 approaches such as whole-of-government and whole-of-society approaches, documenting their outcomes and process of adoption;
- receive, if needed, dedicated technical assistance on Health 2020 implementation; and
- contribute to fill the gap in the European policy-making literature in health policy development in the contexts of small countries.

The purpose of the meeting was to provide an overview of the implementation of Health 2020 in the Region and to review the latest developments in the eight participating countries. In particular:

- to provide an overview on the rationale of the project, its main objectives and expected deliverables;
- to share information on the experiences, lessons learnt and plans related to Health 2020 of the countries participating in the project; and
- to discuss how to advance the collaboration among small countries around the main deliverables of the project.

Erio Ziglio, Head of the WHO European Office for Investment for Health and Development of the WHO Regional Office for Europe, welcomed participants and thanked San Marino for hosting the meeting and supporting this project.

Francesco Mussoni, Minister of Health and Social Security of San Marino, thanked participants for accepting the invitation and expressed gratitude to WHO for their guidance and fruitful cooperation. Pasquale Valentini, Minister of Foreign Affairs of San Marino, also extended a welcome to participants and expressed sincere gratitude to Zsuzsanna Jakab, WHO Regional Director for Europe, for making this event her first visit to San Marino and for her presence for the duration of the meeting. He stated that this meeting confirms commitments to health and sustainable development, and provides a mechanism, within the context of Health 2020, for small states to keep abreast with larger countries, share good practices and establish objectives like those of larger countries. The cooperative agreement underlying this project shows shared health objectives and commitment to Health 2020 among small states.

The Regional Director welcomed participants, and extended gratitude and appreciation to the Government of San Marino, the Ministry of Health and Social Security, the Health Authority of

San Marino and others who worked on this initiative. This meeting kicked-off what is hoped to be a long and relevant collaboration in the coming years. Small countries have great potential to become know-how generators and catalysers to promote health, reduce inequities and achieve Health 2020 strategic objectives, thereby inspiring larger countries.

The meeting participants adopted the programme (Annex 3).

## Implementing Health 2020 in countries with small populations

### Moving Health 2020 Forward: more equitable and sustainable societies

The Regional Director provided an extensive overview of Health 2020 and the relevance of this Small Countries project for the Region. She emphasized that the project, with its eight country partners, can quickly become a unique forum for Health 2020 implementation and exchange. Three major themes, all relevant to the current and future development of this project were presented:

1. why Health 2020;
2. the rationale of Health 2020, and
3. current economic opportunities and threats, and the need to champion public health values and approaches.

Significant improvements in health and wealth have occurred in the Region, but in an uneven and unequal fashion. In all European countries, including small ones, good health is not equitably distributed across society. As evidenced by the *Review of social determinants and the health divide in the WHO European Region (2)*, commissioned in 2010 to inform Health 2020, there is a social gradient of health in all countries, and a need to know more about this distribution in small countries.

Countries need a framework for making changes since Europe's evolving health is marked by new demands, challenges and opportunities. The Health 2020 framework captures this need (Fig. 1). The second reason supporting Health 2020 is the need for the framework to help Member States consistently and coherently make progress in their health agendas given the fast changing European context. The Health 2020 framework allows for a re-thinking of priorities, a new focus on key determinants, strengthened leadership and a renewed approach to current governance mechanisms across all sectors and society. Thirdly, the unfolding economic crisis may indeed pose an additional threat to public health. Such a threat should be met by identifying opportunities to invest in health promotion and disease prevention that are not sufficiently addressed in most European countries.

Fig. 1. Health 2020 framework



Source: Health 2020. A European policy framework and strategy for the 21st century (1).

Health 2020 offers a way forward to improve health outcomes, but still address health inequalities. It addresses all the health determinants simultaneously, strengthening leadership for public health, as well as people-centred health systems, and horizontal and participatory governance for health.

## **Policy priorities for health**

**Use a life-course approach.** A life-course approach leads to better learning, longer and more productive lives, and more life satisfaction. It means putting health on the agenda of non-health sectors. The Small Countries project provides an opportunity to exchange practices on how small countries are using upstream intersectoral actions and identifying health goals across government policy sectors.

**Tackle noncommunicable diseases (NCDs).** NCDs account for the largest proportion of mortality, approximately 80% of deaths, and make up the largest health burden in the Region. All-age mortality from cardiovascular diseases accounts for nearly 50% of deaths, varying across the Region from 35% in the 15 countries belonging to the European Union before May 2004, to 65% in the countries of the Commonwealth of Independent States. Much NCD-related premature mortality is avoidable. Estimates indicate that at least 80% of all heart disease, stroke and type 2 diabetes and at least one third of cancer cases are preventable (1). Inequalities in the burden of NCDs within and between countries demonstrate that the potential for health gain is still very large. NCDs share risk factors, such as tobacco use, alcohol abuse and a lack of physical activity, that are complex to tackle but changeable due to the solid evidence of effective policies and interventions. Addressing these risk factors reduces not only the disease burden but also the social gradient.

**Strengthen health systems.** Work is needed to increase the sustainability of health investments and transform service delivery. A number of ministerial conferences have renewed commitments to strengthening health systems. Health systems can contribute greatly to promote, protect and maintain the health of people, and promote societal well-being. Universal health coverage is crucial. All should have access to quality care without financial ruin, to good quality health services and to health equity.

**Minimize the effects of the economic crisis.** Many countries have implemented austerity measures, but health budgets need to be defended. The economic crisis provides an opportunity to advocate and give evidence that investments in health are good investments and necessary to enable countries to move out of the current crisis. There is more knowledge than ever before supporting the sound economic argument of investing in health, in addition to considering the human rights aspect of it. Governments in Organisation for Economic Co-operation and Development (OECD) countries spend on average around 3% of their health budgets on prevention; in the eastern part of the Region, this figure is about 1% (3).

The Regional Director reported on the outcome from the 2013 conference on “Health systems in times of global economic crisis: an update of the situation in the WHO European Region” held in Oslo, Norway. Ten policy lessons and messages support and empower health ministers in negotiations with finance ministers and governments (4). They may also be relevant to countries participating in the Small Countries project.

1. Be consistent with long-term health system goals.
2. Factor health impact into fiscal policy.

3. Safety nets can mitigate many negative health effects.
4. Health policy responses influence the health effects of economic crises.
5. Protect funding for cost-effective public health services.
6. Avoid prolonged and excessive cuts in health budgets.
7. High-performing health systems may be more resilient.
8. Structural reforms require time to deliver savings.
9. Safeguarding access requires reliable information and monitoring system.
10. Good governance is necessary for prepared, resilient systems.

Opportunities to improve health and effectively address the challenges with new forms of governance for health include a strengthened and strategic role of health ministries, the involvement of all stakeholders and the empowerment of the population.

She concluded that the Health 2020 framework can guide the development of small country national health plans by helping put health at a higher level of societal and governmental action than it has ever been.

## **Discussion**

The Representative of the Ministry of Health and Welfare of Andorra acknowledged this particular historical moment of transition in Europe, and that despite differences in country health systems, Health 2020 can respond to the challenges faced.

The representative of Luxembourg stated that the Ministry of Health is not solely responsible for reducing inequities and in fact, the Ministry of Social Security takes the lead on this issue. Luxembourg reaffirmed that other ministries are involved in implementing the strategic objectives of Health 2020.

The Parliamentary Secretary for Health of Malta stated that due to size, small countries cannot excel in everything nor be self-contained. Often patients need to be sent abroad for interventions.

Malta proposed the identification of centres of excellence specializing in the diagnosis and treatment of and research for specific conditions in the small population Member States. These centres of excellence might be able to receive patients from other Member States and promote the mobility of expertise and knowledge. Should such centres meet the required characteristics, they could become WHO collaborating centres.

The Regional Director stated that was the first time small countries met to discuss these issues to attract the attention of governments, and to acknowledge the strength in this network of countries. Small countries have advantages, such as strong social cohesion, as well as disadvantages, such as facing the same challenges as large countries but with less capacity.

The cooperative agreement between the Regional Office; its WHO European Office for Investment for Health and Development, Venice, Italy; and San Marino offers a unique chance for small countries. It paves the way to document how to align national health policies to Health 2020 in the specific contexts of countries with small populations. Yet it also offers the opportunity to constitute a platform for knowledge and practice exchange, and to jointly

strengthen country capacity around key themes of Health 2020. It could also strengthen the skills and know-how needed to sustainably promote health and reduce health inequalities, by developing a critical mass of professionals in each country (e.g. 20 people/country) who can promote and produce policy changes.

## Using Health 2020 to forge health and development plans in countries with small populations

### San Marino: intersectoral perspectives on Health 2020

#### **Ministry of Health and Social Security**

San Marino has a long history of viewing health as a fundamental right and a common good. Since 1955, its health system has been based on the principles of solidarity, universalism and equity. In 1995, the Institute for Social Security was created, which put people at the centre of the support system. The health and social system has undergone reform culminating with approval of the first health and social plan in 2006. This plan is still in use and focuses on context analysis using demographic, economic, social and health data to better identify the health-related needs of the population, and indicators to observe health-related events in non-health sectors. San Marino plans to base its next health and social plan on Health 2020 objectives (1).

San Marino faces a number of obstacles. Revenues have decreased due to the economic and financial crisis, leading to growing unemployment rates. Life expectancy is very high (Annex 1), which leads to the need to further promote strategies for healthy and active aging. Young citizens are moving abroad to take better jobs. For this reason, inter-generational solidarity is critical. These challenges call for the identification of shared solutions among all sectors. Examples of intersectoral action include education, road safety, the elimination of violence against women, the benefits system and the solidarity pact for the insurance sector. The next health plan identifies six strategic macro-objectives:

1. reduction of health inequities through interventions on the social determinants of health;
2. reduction of risk factors of illness and death for the population;
3. better integration between health, social services and the different levels within the sector;
4. economic and organizational sustainability of the system;
5. proactive interaction with the countries outside the territories of San Marino to avoid isolation and foster innovation and knowledge, and
6. greater value given to human resources within the health and social system.

San Marino's experience in developing its social security system has shown that every government sector needs to work together. At the same time, society needs to play an active role by participating in the formulation of medium- to long-term strategies for health. Whole-of-government and whole-of-society approaches can ensure the long-term well-being of the population. As a small state, it is possible to put in place a short-term, complex, intersectoral endeavour involving all of society.

#### **Ministry of Territory and Environment**

San Marino considers the environmental system as a fundamental determinant of health, and has adopted legislative instruments and policies to protect the environment and safeguard human health. The 2012 Environmental Code is a key element of this legal framework, as it

brings together and updates past decrees and laws in order to promote the quality of human life by protecting the environment and using natural resources rationally. The Code involves a wide number of stakeholders, including commissions and technical offices reporting to different ministries, which all work together to implement integrated policies.

A result of these integrated policies is the “Observatory for integrated and sustainable management of waste”, which established a dialogue in the field of waste management among various stakeholders ranging from institutions, the Public Utilities State Corporation, offices competent in this field, and professional and environmental associations. Information and awareness-raising campaigns are also being developed to actively involve citizens to share the goals of environmental sustainability. The environmental sector also promotes health in relation to road safety by means of an ad hoc working group involving many government departments. The working group has collaborated with the Ministry of Health and Social Security, and the Health Authority to set up the “Observatory on road accidents”, an interdisciplinary body involving social, health and structural interventions related to road safety.

San Marino established a working group on climate change in order to define the policies and measures necessary to adapt to changing environmental conditions, and identify long-term solutions through educational and cultural awareness-raising among all population groups. Furthermore, a programme of monitoring and intervention for soil reclamation and conservation was recently started, and an ad hoc permanent working group was established to monitor the fragile territory of San Marino. Both are crucial for multisectoral action and are important determinants of health.



## Ministry of Finance and Budget

Health is a primary asset and a community heritage. The Institute for Social Security is a public welfare system financed by the State budget. In times of serious economic difficulty and high unemployment among young people, many countries revert to budgetary cuts leading to decreases in social protection. Indiscriminate cuts are not justifiable in San Marino. Although San Marino is still in the midst of the crisis, the quality of and transparency in public spending



are key to ensure efficient systems. Any restructuring of expenditure needs to be oriented towards improving the quality of public services, such as health and social services.

Transformation of these services calls for governance through empowerment of all users and operators. Health and social systems should be analysed to identify priorities for physical and mental health and well-being. Resources should be shifted from dedicated curative services to disease prevention and health promotion services. This discussion cannot remain just with experts and health professionals but should involve the entire community. The health of the population of San Marino is crucial for the economic health of the nation, so this should not be viewed as an unnecessary economic expenditure but rather an investment.

## Cyprus

Cyprus has high life expectancy at birth, a low infant mortality rate and a low incidence of communicable diseases (Annex 1). The country ranks high in regional and international comparisons in terms of population health status indicators. Health care equity is a main priority. National health policies, strategies and actions of the Ministry of Health play an essential role in defining the country's vision, priorities and course of action for improving and maintaining the health of the population. A country cooperation strategy (CCS) is being developed with WHO to be finalized before the end of 2014. The Cyprus national health strategy is based on Health 2020. The CCS mechanism will help Cyprus implement Health 2020, and achieve multisectoral action and intersectoral cooperation at national level, for health and non-health sectors.

In Cyprus, life expectancy is high so adapting a life-course approach to healthy aging and early life is an essential part of the CCS. For children, the promotion of breastfeeding, prevention of childhood injuries and protection of children from environmental risks, by means of the *Children's environment and health action plan for Europe* (5), are already actively underway as is the reduction of children's exposure to environmental chemicals.

NCDs account for over 85% of death at all ages. Cardiovascular diseases account for 38% of total mortality (6). Prostate cancer is the most common cancer in men; breast cancer is the most frequent cancer among women (7). Major risk factors such as smoking, alcohol consumption and unhealthy diets have a detrimental impact on health status; more than 30% of the population aged 15 years and over smokes, 34.4% are overweight and 14.8% are obese (8). Smoking indoors and in public places was prohibited in 2010 (9). Obesity is a significant health problem with 15% of the population obese; the prevalence of child obesity is 10.3% for males and 9.1% for females (10,11).

Special attention is paid to child health and well-being to tackle determinants of health, such as smoking, injury prevention and the promotion of healthy eating. These actions set the foundation for a holistic approach to tackling NCDs, which will be reinforced by the Cyprus CCS. Cyprus will collaborate with WHO in improving and promoting health equity, sharing experiences and best practices and in collaborating in cross-border health care.

## Discussion

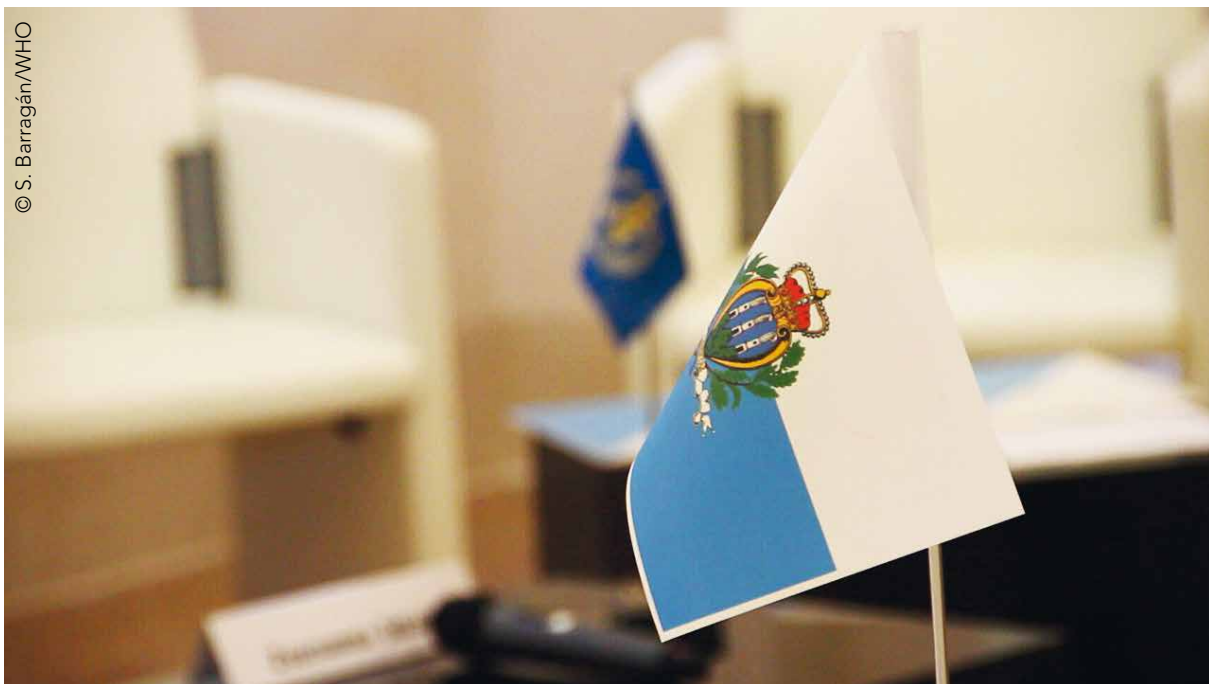
The Representative of the Ministry of Health and Welfare of Andorra asked how Cyprus and San Marino face challenges in their health information systems. Cyprus has a unit that collects health data, and a national committee monitors it; however, the country faces major financial difficulties with a more than 20% reduction in budgets and an overloaded public health

system. National health reforms are underway with restructuring of hospitals, but macro level and national health plan reform cannot be neglected. San Marino has centralized data, which are analysed, and include information from the health and social security systems.

The Small Countries project is trying to achieve reductions in inequities, as well as improved leadership for health. In this context, a representative of San Marino reiterated that indiscriminate cuts to health care should be avoided. A number of examples showed the importance of co-production of health. Documenting this project's process – case studies of Health 2020 implementation – is essential to make the experience available to countries and to build up a repository of know-how.

The challenge of how to achieve equity and avoid budget cuts during a time of crisis was paramount. San Marino faced health cuts with the economic crisis but maintained the same level of health services, which remain free of charge for all. Despite spending cuts, social protection measures and education are always maintained.

The Regional Director congratulated the ministers from San Marino for their whole-of-government approach, and the move towards a better system where curative care are complemented by increased health promotion, and a focus on preventing obesity and road traffic accidents. Good governance is sought in San Marino, as well as in the other countries, and the whole community should be involved since buy-in from society is necessary. Exploring how to share resources and capacities in the context of this project will be necessary.



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## Whole-of-government and whole-of-society approaches in countries with small populations

### Iceland

The Icelandic health system is characterized by easy and equal access to health services by all citizens. It is a universal health system paid for mainly by taxes and partially out of pocket. Health centres provide primary care and are responsible for general practice, home care and preventive health care. Patients need referrals for hospital care unless in case of emergency. Iceland has one of the highest life expectancies in the world (Annex 1). It also has low maternal mortality and high fertility. Overweight and obesity persists. In recent years, there has been increased attention to social determinants of health. Unemployment is currently low compared to other countries but historically high for Iceland at 4.5%.

Iceland has used whole-of-government and whole-of-society approaches for public health work in general, and to develop the national health plan in particular. Work on development of the first Icelandic national health plan started in 1980. That plan and the subsequent one were built on WHO policy, *Global Strategy for Health for All by the Year 2000* (17). The health plan under development is built on Health 2020. Development of that plan was guided by a wide consultation process. It includes a life-course approach, considers the importance of people-centred health systems, and aims to create supportive environments and resilient communities. Health plan components fall under three major pillars: equity in health and well-being, prevention and risk factors; and secure and comprehensive health care service.

To formulate objectives for the plan, a national meeting of 220 participants, working in 29 teams, took place with representatives of ministries, municipalities, health and social service organizations, universities, NGOs, and associations of health professionals, police and others. Once the plan was developed, it was disseminated and made available for comment on the web site of the Ministry of Welfare, and sent to approximately 600 individuals and organizations. Input was received, and the final draft of the national health plan will be submitted to Parliament.

Iceland has also used whole-of-government and whole-of-society approaches when cooperating with other ministries, local authorities and NGOs on topics such as nutrition labelling, food taxes and surcharges, health-promoting communities, physical activity and the national cancer action plan. The Ministerial Committee on Public Health was established in March 2014, consisting of the Prime Minister who leads the committee; the Minister of Health; the Minister of Social Affairs and Housing; the Minister of Education, Science and Culture; and other ministers who participate as needed. The aim is to make a comprehensive public health policy and action plan. In recent years, the increased willingness and flexibility of different sectors in promoting health and well-being has become evident in Iceland.

### Andorra

Andorra has a resident population of approximately 70 000 and a large influx of tourism. In Andorra, 60% of mortality is caused by chronic diseases such as cancer, circulatory diseases and respiratory diseases (Annex 1). Fertility is low; if the current trend persists, generational replacement is not guaranteed. Andorra faces a number of lifestyle-related risks. Overweight affects 3 out of 10 people over the age of 15. In children aged 11–12 years, the prevalence of overweight is 12% and the prevalence of obesity is 7%. Despite regulations creating smoke-free zones, tobacco use is still high. Alcohol consumption among 15–34-year-olds is also high (13,14). The population is physically active but there are opportunities to improve.

Since the Andorran health regulation system was developed in the 1960s, reform was needed to adapt to new challenges and the current economic environment, and to respond to social health expectations as people are more informed about health care. Public health expenditure has grown steadily at 37%. Direct public expenditure supported by citizens (co-payment) has increased nearly 50%. The national budgetary transfers to cover the deficit and investments of public providers have increased 267% (15). In light of this, there was a need to restructure to ensure the durability of the system, and to create a consolidated model based on solidarity, security and quality while being economically sustainable. A shift to look beyond disease management and to take into account education and prevention was called for.

The new Andorran Health care model, *Modelo Andorrano de Asistencia Sanitaria*, reflects this shift. It is a framework to integrate services such as the evaluation of primary health care; the use of a referring physician to access the best health care pathway; and a primary health care team that acts as a main health agent and coordinates with other health care levels. It will be implemented by means of the Horizon 2020 Initiative (16) and will create new capacities to implement a reorganization of health governance. The new model will prepare the system for a transition, including a new legal basis and financing mechanisms, and will build up a national health information system. Lastly, dialogue will be carried out with stakeholders, such as professional health care associations and bodies, and patient associations.



## Discussion

The Andorran experience showed that there can be different entry points to health care reform. It highlighted the importance of gatekeepers and skill development of health care workers. Governance and information were also stressed as important not only to provide evidence but also to give feedback to the population.

The Icelandic experience revealed that the whole government is involved in the Ministerial Committee on Public Health and is committed to maintain this approach. The smoking trend in younger age groups decreased over the past 20 years as did alcohol consumption. Regarding its health budget, Iceland has been more focused on treatment than prevention but is willing

to shift towards prevention. Some preparatory work is underway to provide personal health care services based on genetics. There is a database on all families in Iceland with information on who is related to whom called the "Book for Icelanders". Welfare Watch is an innovative project that started in the middle of the crisis (2009) to document how children are affected by it. It is supported by the Ministry of Welfare but includes representatives of many ministries. The project has been successful and shows good results.

The Regional Director said that the Ministerial Committee on Public Health in Iceland is an excellent example of working across government and involves many important ministries. Countries would welcome knowing how to set up ministerial committees and the challenges faced in doing this. Many countries are struggling to find the right mechanism to report data on health and well-being. The cost of prevention versus treatment was a topic of interest, as well as the use of existing social service budgets to pay for health prevention. A representative of Iceland emphasized that prevention is effective, and recent calculations indicate that spending just US\$ 4 per person on preventative health services would provide good returns on investment, which provides sound arguments to invest more in prevention.

## Creating synergies with other sectors

### Montenegro

Montenegro sees Health 2020 as a framework that creates synergy within health and with other sectors. Sustainable development and work towards a continuous long-term improvement of quality of life are strategic objectives of Montenegro and of its national strategy on sustainable development (17).

Although Montenegro has achieved progress in terms of improving population health, premature NCD-related mortality still accounts for 25% of deaths. The country's population is aging, which increases its need for comprehensive and more expensive health services and social care. Citizens are more informed and request new health technologies that put financial pressure on the health system. Montenegro is a country of natural and cultural diversity, but growing social and economic disparities are resulting in considerable health inequalities, which have added complexity to existing circumstances.

Faced with these challenges, Montenegro is focusing on further primary health care revitalization and strengthening, governed by a desire to make a paradigm shift in health care service delivery from acute care to preventive programmes and services. Efforts are underway to promote integrated and coordinated service delivery as an effective response to chronic disease conditions. Improving the performance of health systems by enhanced use of financial and human resources, appropriate use of technology, community empowerment and good governance will help advance the sustainable development strategy.

Montenegro is revising its national strategy on sustainable development (2014–2020). The process will be guided by the results of the post-2015 development agenda consultations (18) and by the principles and values enshrined in Health 2020. The strategy will promote synergies and partnerships that align actions across sectors for better health outcomes. Health will be key to this strategy and an integral element of every sectoral policy. The strategy will maximize health and well-being at all ages through universal health coverage and pro-health policies in all sectors. Universal health coverage will deliver substantial developmental benefits both in terms of better health indicators and improved economic performance, including a reduction of poverty level.

Traditionally, health facilities were the sole gatekeepers to health. But important stakeholders of health maintenance and improvement are in other sectors that influence social and economic health determinants through their sectoral policies. In order for a population to be and remain healthy, it needs to live in healthy conditions – many of which are determined outside of the health sector. Therefore smart, green, healthy policies for transport, energy, agriculture and tourism are imperative. Implementation of these smart policies is aimed at creating/enabling social and environmental conditions that promote the health of populations, and help individuals make healthy and sustainable decisions.

Montenegro is a service-oriented country and is highly dependent on tourism, which accounts for 20% of national gross domestic product. Promoting and developing synergy between the tourism and health sectors are needed. Montenegro aims to promote this synergy as a platform for further progress and development of healthier and stronger communities. Health 2020 will be used to reposition health as a crucial element of overall national development.

The health sector needs to become more active in working with other sectors to create conditions for health, development and well-being. Operationalizing the synergy between

health and other sectors requires: innovative thinking; dynamic and new governance; health authority capacity to take up new roles promoting health and well-being; health services targeting users and focusing on health promotion and disease prevention; and the availability of a sufficient number and the proper mix of health care workers.

## Malta

Small countries, compared with larger countries, traditionally perform well in terms of health system performance. Malta is a small country with the largest population density in Europe. In small countries, people vote not only on national issues but also on personal issues. In Malta, health is a very important political issue.

Small countries present opportunities to promote intersectoral work. Malta has several good practice examples of intersectoral work. These include interministerial task forces, advocacy through membership in working groups, joint publications with other ministries, sharing of data sources, and safety and emergency preparedness, which often go beyond the health sector alone. All ministers meet at the Cabinet of Ministers meeting, held on a weekly basis. Furthermore, a Social Cabinet meets once a month. Ministers from health, education, social services, sports and youth attend these Social Cabinet meetings. Close proximity makes working easier and allows ministers to get involved in both major and minor issues in the country.

Due to its geographical location, Malta has relatively high numbers of migrants and expatriates. Small states with open economies are vulnerable to global consumer trends, and subject to asymmetric power relationships and little negotiation power. The provision of health care to migrants and the strain on the health capacity of small nations – relatively high health care costs per capita due to lack of scale benefits and purchasing power found in larger nations – are very relevant for Malta.

All (non-health) ministries, civil society and the private sector including industry need to be on board to advance the health agenda within the context of Health 2020. The cost of new medicines places a big burden on the Maltese health system. Recently, Malta signed a joint procurement agreement for vaccines in case of a pandemic. With a network of small countries, joint procurement to get better prices for other groups of medicines might be a way forward. A pool of resources that small countries can tap into on a given topic might also work. From a small country perspective, health systems need to be transnational. An e-health resource facility could be a valuable tool to empower people and help carry out health services nationally and beyond.

## Discussion

The Regional Director reiterated how the link between health and sustainable development is very important also for the post-2015 development agenda (18), which is related to environment and health. In order to link health to sustainable development, intersectoral work is essential. The Regional Director commented on the need to include finance ministers in discussions of intersectorality, as San Marino does. Future meetings should ensure that this project truly exemplifies intersectoral work, and the Regional Director requested the commitment of the eight participating countries to include finance ministers. Malta supports this proposal and it was accepted.

The Regional Director also mentioned that another entry point to encourage intersectoral work in some countries could be the topic of migration and health. The Montenegro experience illustrated the important links between health and economic growth, and between health and sustainable development. The experience of Malta showed how intersectoral work is easier in smaller states, due to their size, and served as encouragement for other countries to promote their successes as examples for larger states.



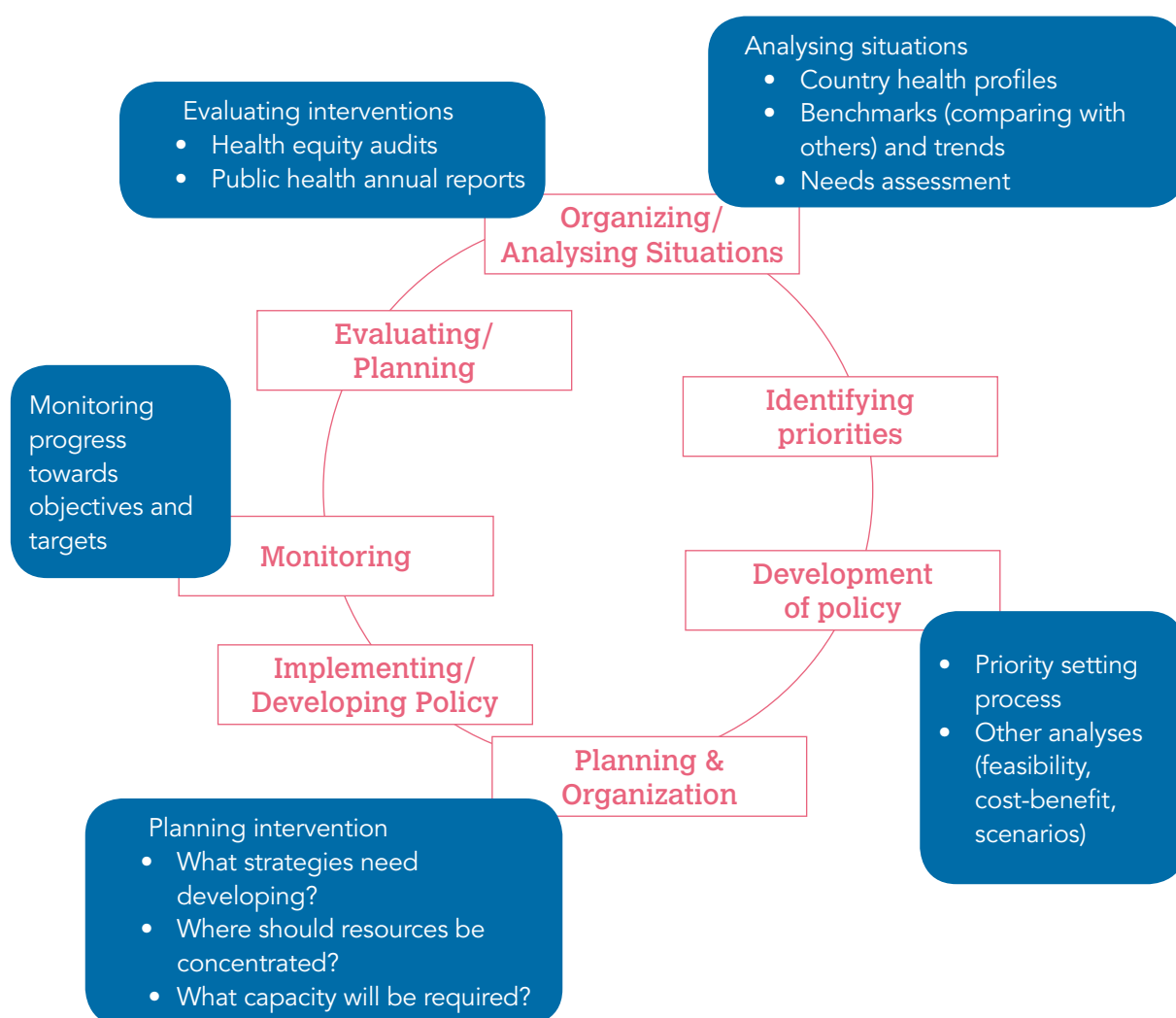


## Health information and data collection in countries with small populations

### Health 2020 indicators and targets

When policy-makers begin to implement Health 2020, they will need evidence to help identify the main priorities; the basis for a national NCD strategy; cost-effective changes needed for local services; the allocation of resources, the achievement of objectives and targets; and initiatives to promote. The policy cycle (Fig. 2) shows various entry points where health information plays a critical role.

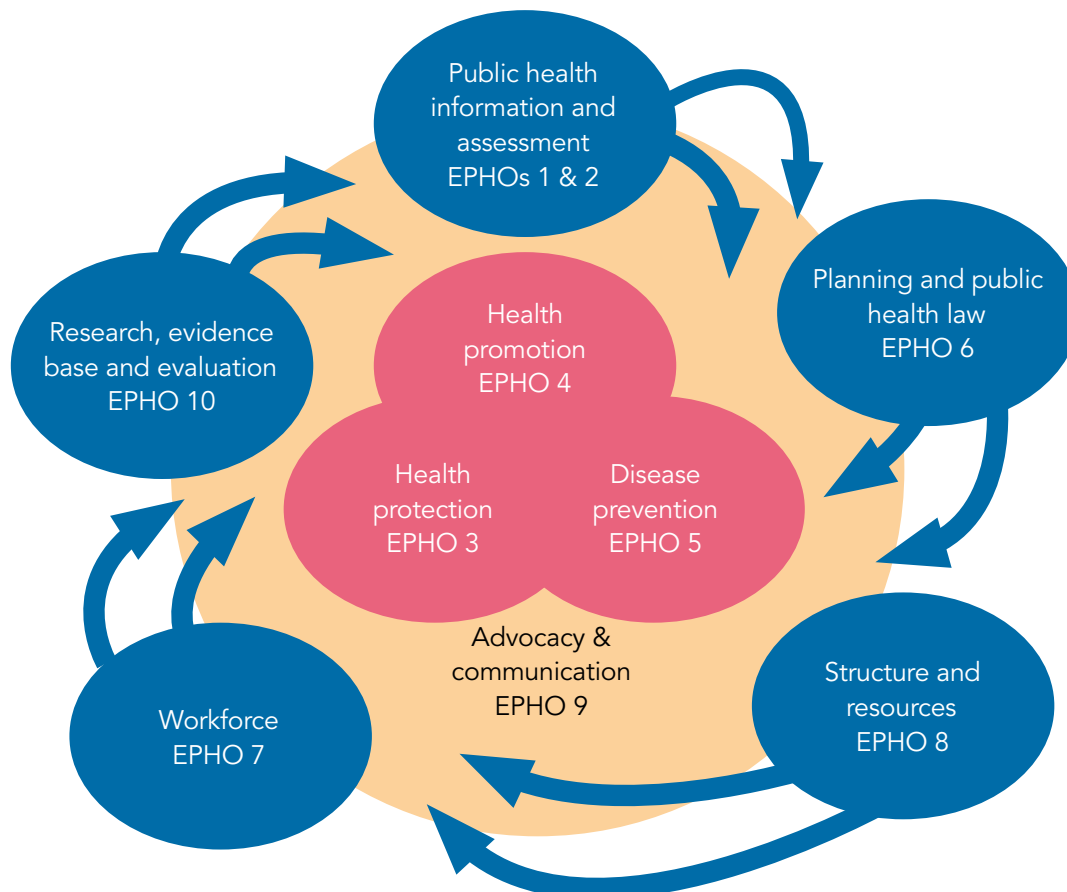
Fig. 2. Policy cycle: role of health information and evidence



Firstly, the health profile and trends in the country need to be known, as well as where health problems are most prominent and where to intervene to put relevant resources. Secondly, priorities should be identified; information on the feasibility of different interventions and cost-benefit scenarios are critical for prioritization. Planning interventions call for the development of strategies, knowing where to concentrate resources and what capacity will be required. Progress towards objectives and targets should be monitored and interventions evaluated to know if any changes took place using mechanisms, such as health equity audits and public health annual reports.

Strengthening public health functions is key for implementation of Health 2020. There are 10 essential public health operations (EPHOs) that, with WHO leadership and support, countries can adapt and work on together, to assess and plan for stronger public health services and capacities (19). Data defines each of these operations, which centre around three main areas of service delivery – health protection, health promotion and disease prevention – and are informed by robust public health intelligence and data (Fig. 3).

Fig. 3. Strengthening public health functions: key for implementing Health 2020



Health information systems are intersectoral, with data stored in different ministries and registries, and collected by means of numerous surveys. In the past, death and vital statistics were heavily relied upon but do not inform about non-fatal events, which are just as important. Linking patient information from different health systems allows for cross-system analyses and could provide knowledge on, for example, the causes of non-fatal ill health. Common challenges for health information systems in Europe range from regulatory to legislative aspects and include inadequate infrastructure for data collection; the need to identify identification of a mechanism for regular integration of information; improvement of human resource capacity; and other barriers such as excessive data collection with little analysis, insufficient incentives for reporting and multiple demands from United Nations agencies.

Mechanisms need to be identified to integrate information so that data are available at all times for anyone (Box 1). Some countries have national identification numbers to connect data from different sectors and perform cross-sectoral analyses, but robust legislation, informatics and confidentiality are needed to implement this in a country. Data also need to be disaggregated into smaller units in order to analyse regions and cities in order to identify where health inequalities occur. E-health creates many opportunities for integrated care continuity across

the health system, and can help countries provide services to people living in remote areas. The small countries in the Region could analyse these examples and build upon them.

#### Box 1. Ingredients to improve health information to respond to policy needs

- Comparable quality data and indicators (use of standards)
- Information representing different health dimensions
- Benchmark options
- Capacity to determine change over time
- More data disaggregation to allow further analysis
- User-friendly and open access
- Integrated “one-stop-shop” for data and information
- Different ways to visualize data and convey information
- Possibility to expand use of data with analytical tools
- Added value beyond indicators

In the Region, a number of policies and mandates provide valuable information and could be used to form a policy framework. Core health indicators were approved by the WHO Regional Committee for Europe in 2013; the indicators are identified by policy area (20). For example, they provide data on traditional risk factors, school enrolment or the inequality in income distribution. Enhancing well-being is being incorporated into the indicators. Some are subjective measures, such as life satisfaction, and others relate to social and physical living conditions, such as the availability of social support and the percentage of the population with improved sanitation facilities.

Many countries have already aligned their health plans with Health 2020, but new indicators are needed for some small country health statistics. Data on trends such as a decrease in mortality are also needed, and should be disaggregated at regional level to show, for example, how higher income can lead to lower mortality. Twenty core Health 2020 indicators are reported to or may be estimated by WHO (20), but gaps caused by a delay in reporting mortality need to be addressed.

The next steps for addressing these challenges in small countries could be: identification of country-specific data needs; identification of good practice that can be used/adapted for countries not meeting reporting needs; horizontal cooperation approaches among countries; identification of a common set of indicators to address country needs; preparation of a joint publication on health indicators from small countries; and reports on the progress of health information development in countries.

#### Monaco

As a small country, Monaco faces a number of data collection challenges. Often, the data requested for some topics does not fit the size scale of the country. One example is a report to certify the eradication of poliomyelitis where the country is requested to record the names of the specialized hospital department and the reference laboratory. Monaco has not had any cases of poliomyelitis for a number of years. Therefore the country has no specialized hospital department or reference laboratory for this disease. Data are often adjusted to answer a specific data request, which led Monaco to be ranked in the category of least developed

countries. In other cases, some data are not reported, such as the agreement Monaco has with France to provide medical care to children in certain cases.

Coherence is also a problem. Any data reported on mental health reflect the resident population alone while medical plan questionnaires take into consideration a larger population group. The result is that the communicated data are incoherent. For example, the number of beds in the psychiatric department – taking into account the average length of stay – does not match the number of hospitalized patients, and are much higher than the calculated results. The figures reveal a false overcapacity.

Monaco also has a large population flow from frontier workers and tourists. Due to the latter, consumption of alcohol seems very high but reflects consumption of people coming from abroad. Monaco lacks data on epidemiological surveys since the size of the data does not reach the required level to be statistically significant. Often Monaco needs to go to neighbouring countries to get data, as is the case with the 35% of schoolchildren who come from France and make up an important part of Monaco's population. Data standards are very important, but the definition of the data standards often does not match the size of a small country population.

## Luxembourg

The population of Luxembourg is growing, with at least 45% comprised of foreign nationals. Its population doubles during the day, as workers commute to Luxembourg to work. Health data are available in Luxembourg due to the collaboration between the Ministry of Social Security, the National Health Directorate, the National Institute of Statistics and Economic Studies, and the National Health Laboratory.

A wide range of morbidity and mortality data are collected. Morbidity data on, for example, diseases of obligatory declaration, cancer data and data from the national health care system are available. There are also morbidity data reflecting hospital medical activities as per the tenth revision of the International Classification of Diseases (ICD-10). Mortality data comes from the accident database and from surveys on population health and health behaviour, and mothers and young children. Other data available are vaccination coverage in 25–30-month-old children; nosocomial infections in the hospital sector; road traffic accidents; breast and uterine cancer screening data; hearing and vision data; narcotic substitution data from the methadone register; occupational data; and ophthalmology and hearing data for schoolchildren.

Luxembourg faces many challenges in data collection. Being a rich, small country does not facilitate data collection. There is much reliance on personal connections and knowledge about facilitators for data collection. Luxembourg has reduced staff and budget for data collection in the Ministry of Health. However, it has the same needs (and requests) for data as larger countries. Precision in international surveys is often too high for small countries where sample size is inadequate despite adjustments. Furthermore, over-surveying often takes place since there is the impression that surveys are easy to carry out in small countries. As Luxembourg is a high-migration country with a multilingual population, surveys need to be available in three to four languages. Finally the country has a strict data protection policy in place.

The main challenges in providing data to international organizations are the frequency of requests with short deadlines; similar but not identical requests that burden the system; strict standardization for comparability that leads to incoherent data presentation; and the fact that small countries are not considered internationally comparable.

Data requests by international organizations should be reduced or more joint questionnaires or raw data should be used. Database harmonization between organizations could ease the burden of data requests to small countries. There is also an imminent need for survey streamlining to avoid double data collection by secondary data use, as well as survey harmonization. Collection modes and sampling for small countries should be more flexible and consider small country data specificities, possibly allowing expert comment when data are presented.



## Discussion

The Parliamentary Secretary for Health of Malta spoke about how delicate the issue of data is. If politicians are not prepared and journalists get data, the response is often reactive instead of proactive. For this reason, it is important to focus on what data are gathered to translate it to action.

The Minister of Health of Montenegro reiterated the importance of accountable and transparent governance supported by evidence and data to advocate for changes. Politicians need to be smart leaders that guide non-health sectors to make strong investments in interventions. Increased capacity is needed to implement whole-of-government and whole-of-society approaches in the country. One of the advantages in small countries is that everyone knows each other making it easier to get data relatively quickly. Nevertheless, a well-functioning information system cannot be based only on personal relations. It would help if WHO would consider consulting with other agencies, such as the European Centre for Disease Prevention and Control and the OECD, to harmonize data collection pressure.

A representative from the WHO Regions for Health Network spoke about a health behavioural risk factor surveillance system run by a local health unit and based on local health data collection. In the Trento Region, for example, data are collected by means of an ongoing survey carried out by health nurses. Surveillance is one of the core issues of public health, and this system has been operational since 2007. Presently 123 local units have joined, with an 85% response rate. The system allows for obtaining prevalence rates in one year.

The Regional Director stated the long-term aim is to have a unified reporting system, but that time is needed to unify health information systems. This issue is on the agenda of the 64th session of the Regional Committee (RC64). Ideally there should be a common list of core indicators and a common data set (from OECD, the European Centre for Disease Prevention and Control, the Directorate-General for Health and Consumers). The WHO Director-General has issued a call to reduce the number of data requests from countries as some countries receive up to 78 requests per year. There is a push to carry out a single data collection exercise and joint analysis of data. The importance of governance issues and the need to have independent bodies that collect and monitor data (e.g. an observatory in Monaco) were also acknowledged.



In reply, Enrique Loyola mentioned that a core set of indicators for small countries may be published as part of the core health indicators for the Region (20), a suggestion that was well received. With regards to promoting networking, the Division of Information, Evidence, Research and Innovation of the Regional Office has provided support to members of the South-eastern Europe Health Network. It is also developing a subregional effort on health information with countries of central Asia through a forum called the Central Asian Republics Information Network (CARINFONET), which aims to improve health information through shared resources, knowledge and experience.

In addition, to increase technical capacity on health information, the Regional Office also offers the annual WHO Autumn School on Health Information and Evidence for Policy-making, which addresses key elements of the health information cycle from data collection to quality assessment to analysis and translation of evidence into policy. This course may provide an opportunity for small countries to increase the cadres of skilled professionals in this area of work. Both the Autumn School and CARINFONET are elements of the European Health Information Initiative coordinated by the Regional Office, with various Member States contributing to its development. The Regional Office will share more information about this initiative at RC64.

## Update from subregional launch of the European review of social determinants

Health 2020 has been informed by a number of scientific studies, including the *Review of social determinants and the health divide in the WHO European Region (2)*. The subregional launch of the European review of social determinants was a policy dialogue among Nordic and Baltic countries. Countries shared progress and lessons learnt in reducing health inequalities and in understanding the risks and consequences of ill health. Key issues discussed were what is working in terms of addressing health inequities in these countries; initiating and sustaining engagement of other sectors in health; addressing health over the life course; and optimizing ways to work together across countries.

Health policy learning tools are available to help implement lessons learnt to reduce inequity gaps. The European review and companion products provide evidence on what works and a synthesis of promising practices. Companion products are tools and documents that provide guidance on how to put the recommendations from the Review into practice.

Valuable learning from implementation was also shared. As many country services are organized and delivered at subnational level, addressing problems at this level are important since it is connected to key parts of service delivery. Central governments should enable partnerships to take place at subnational level and better vertical governance mechanisms are needed.

The issues of co-production and champions needing capacity were also highlighted. Systematic work based on legislation and permanent structures is needed and could take the form of equity architecture (e.g. a mix of instruments, laws, data, training, advocacy, contracts, incentives, common goals) and focus on equity of outcomes. A Health Equity in All Policies approach (21) with health equity as one measure of success would be effective, as would monitoring of external drivers to assess the impact on social determinants and health distribution, such as the Icelandic Welfare Watch.

Implementation gaps identified centred on how to move forward, and the need to repackage data for different audiences and convene around common agendas. Some mechanisms could be the use of live policy learning exchanges and Health 2020 leadership events where experiences, know-how and learning tools could be exchanged. A portal for promising practices, emerging research and new methods would also provide a useful forum for know-how exchange. The Regional Office could also formally support country reviews and assessments, and foster inter-institutional alliances to bridge and build capacity.

Countries encouraged the Regional Office to maintain equity and social determinants of health on European and global agendas, and to help mainstream equity across Regional Office health programmes and action plans and in the technical assistance they provide. They also reported the usefulness of keeping equity on agendas, since it encouraged other neighbouring countries to do the same. The importance of establishing inter-institutional alliances and the need to include equity in the post-2015 development agenda (18) were highlighted.

A number of take home messages arose from the subregional launch. Countries agreed that, despite differences, they faced the same challenges, and this was an opportunity to co-create solutions through joint exchanges. They also felt better equipped to talk to colleagues and other stakeholders about social determinants of health and equity. The idea of bringing a multisectoral delegation to the subregional launch was useful since it brought home a wider understanding of health inequities and determinants. Countries felt motivated to keep up the momentum of having equity high on the agenda at home and in Europe.

## Discussion

The subregional launch highlighted the link from evidence to policy. The Regional Director stated that, thanks to evidence from the Review and other valuable studies, there is substantial evidence on social determinants, and it is time to move to the next stage and understand the policy implications of this evidence. Several launches are planned to take place in the Region to share experiences and challenges. The Regional Director proposed that one of the next meetings of the Small Country project should focus on the policy know-how related to the social determinants of health, as the need to share these types of experiences and intelligence is great. Support is needed from countries to keep social determinants of health and health inequalities on local agendas and to make links within the country.

Two key messages stood out: the importance of making the link between social determinants of health and the post-2015 development agenda (18); and the need to mainstream equity aspects into all public health programmes in WHO and in countries. Due to the size of small-population countries, it can often be a challenge to distinguish health development from general development. Therefore it is important to identify specific issues and assets shared by small countries. The subregional launch reaffirmed support for and the usefulness of mechanisms to assess implementations and to share experiences and challenges. Countries were interested in the portal and supported the idea of setting up a platform where ideas could be shared.





## The Small Countries project: the way forward

Small countries demonstrated a common willingness to strengthen their role, visibility and cooperation in implementing Health 2020. Inserting equity and the social determinants of health into the development agenda of small countries are of paramount importance. The time was deemed ripe for exploring the best ways to expand political and institutional arrangements to accomplish this.

Several participants mentioned that small countries can use available resources and experiences to work together on the project. One resource is the cooperative agreement between San Marino and the Regional Office, through its WHO European Office for Investment for Health and Development. This agreement provides an excellent basis to rapidly advance the project.

The Regional Director suggested that countries nominate one national counterpart and one technical counterpart to act as specific entry points for different health topics. She suggested that other ministers, such as finance, should be invited to the next meeting. A meeting of small countries should be planned every 6 months.

The Regional Committee is a key event that provides an opportunity for small countries to speak with one voice on common, shared small country experiences that could help Health 2020 implementation. Health ministers were encouraged to attend Regional Committee meetings where most policy issues are discussed and decided upon.

The Regional Director encouraged small countries to apply for membership of governing bodies, such as the WHO Executive Board and the Standing Committee of the Regional Committee. Small countries were also encouraged to get involved in ministerial conferences, which are often intersectoral.

A number of political and institutional arrangements to further the project in a coherent and cooperative way were mentioned, such as CCS, biennial collaborative agreements and an exchange of letters. WHO country offices, when feasible, could also lend a hand in taking this work forward.

Countries were encouraged to expand their use of existing networks, such as the WHO European Healthy Cities Network and the Regions for Health Network, and WHO collaborating centres.

The Regional Director pointed out that more countries are working together in groups (e.g. the South-eastern Europe Health Network) and called for more informal exchange. Key messages from this meeting should be taken back to the Regional Committee. Therefore small countries will present the San Marino Manifesto (Annex 3) and make a joint statement at RC64 to let other countries know about their work and cooperation.

One important aspect in the implementation of the CCS between the Regional Office, its WHO European Office for Investment for Health and Development and San Marino is to document how to align national health policies to Health 2020. The project requires deep understanding of current capacities to implement Health 2020 in the specific context of small countries. In many instances, this country capacity can be developed jointly, such as the skills and know-how needed to sustainably promote health and reduce health inequalities, forming a critical mass of professionals in each country (e.g. 20 people/country).

More supportive environments for implementing Health 2020 are needed, and the media plays a key role in fostering engagement at both political and community levels. For this reason, a platform for sharing experiences and mutual learning about Health 2020 implementation would be desirable, and engagement of the media is a necessity and an opportunity.

Small countries are interested in health information systems and their challenges, particularly the low capacity in most small countries to meet all the information requests from international organizations including WHO. The Regional Director reassured small countries that their needs would be understood, and that future data requests would be more appropriate and better coordinated internationally.

After this concluding session, a number of participants made additional comments.

Andorra was grateful for the presence of the Region Director for two full days and the forum provided by this meeting. Andorra proposed that there should be continued meetings among the eight countries to see how best to work and keep the trust and momentum going. There was agreement in the value of joining the Standing Committee of the Regional Committee, since it provides countries with a good experience and understanding of how WHO works from the inside. RC64 provides an excellent opportunity to take time to discuss further implementation of this project.

Luxembourg also supported the idea of having an informal gathering at the Regional Committee for future collaborations.

Monaco saw great value in the informal group exchanges among small countries.

San Marino took the floor and thanked the Regional Director and all the participating countries, and stated that this first meeting was a great success, with the in-depth discussions on Health 2020 and its vision for the future, and the growing commitment to Health 2020 implementation.

Health 2020 was adopted during the 66nd session of the Regional Committee meeting in 2012 in Malta. To continue this link, the Parliamentary Secretary of Health of Malta read the text of the San Marino Manifesto (Annex 2).

## Highlights

Small countries have advantages, such as strong social cohesion, as well as disadvantages such as facing the same challenges large countries but with less capacity. The following highlights arose from the First High-level Meeting of Small Countries as possible areas to move forward and focus on. They are grouped under Health 2020's two strategic objectives.

### Strategic objective 1: working to improve health for all and reducing the health divide

**Reducing the health divide calls for the creation of conditions favourable for health, development and well-being.** Operationalizing the synergy between health and other sectors requires: innovative thinking; dynamic and new governance; health authority capacity to take up new roles promoting health and well-being; health services targeting users and focusing on health promotion and disease prevention; and the availability of a sufficient number and the proper mix of professionals within and outside the health sector.

**Entry points for intersectoral work are numerous.** The health sector can play an instrumental role in helping other ministries identify goals and targets that are mutually beneficial. Migration and health are possible entry points where the issue of health inequalities could be integrated and maintained. This issue also provides an opportunity for intersectoral work, since many ministries are already involved in migration and health. Some countries have reformed their health systems in collaboration with other ministries, such as social security, which is an example of another possible entry point. Other sectors may be motivated when they see that they can also contribute to improvements in health. The insertion of health as a priority in national strategies for sustainable development, another entry point, promotes synergies and partnerships that align actions across sectors for better health outcomes.

**Health information systems that reveal inequity are critical to small countries** due to their size, population fluctuations and particular needs. Health information systems are intersectoral with data stored in different ministries and registries, and collected by means of numerous surveys. Mechanisms to integrate information need to be identified so that data are available at all times for anyone. Common challenges for health information systems in Europe range from regulatory to legislative aspects and include inadequate infrastructure for data collection; the need to identify identification of a mechanism for regular integration of information; improvement of human resource capacity; and other barriers such as excessive data collection with little analysis, insufficient incentives for reporting and multiple demands from United Nations agencies.

**Data collection challenges** in small countries, though numerous and unique, **can be met.** Often the data requested does not fit the size scale of the country. Data are often adjusted to answer a specific data request, resulting in incoherence. Lack of data from epidemiological surveys due to the mismatch between data size and required levels to reach significance are also common. Precision in international surveys is also often too high for small countries where sample size is inadequate despite adjustments. Furthermore, over-surveying often takes place, since there is the impression that surveys are easy to carry out in small countries. The main challenges in providing data to international organizations are the frequency of requests with short deadlines; similar but not identical requests that burden the system; strict standardization for comparability that leads to incoherent data presentation; and the fact that small countries are not considered internationally comparable.

Data challenges in small countries could be met by certain mechanisms: identification of country-specific data needs; identification of good practice that can be used/adapted for countries not meeting reporting needs; horizontal cooperation approaches among countries; identification of a common set of indicators to address country needs; preparation of a joint publication on health indicators from small countries; and reports on the progress of health information development in countries.

**Countries are keen to move forward with Health 2020 implementation** but need to repackage data for different audiences and convene around common agendas. Some mechanisms could be the use of live policy learning exchanges and Health 2020 leadership events where experiences, know-how and learning tools could be exchanged. A portal for promising practices, emerging research and new methods would also provide a useful forum for know-how exchange. The Regional Office could also formally support country reviews and assessments, and foster inter-institutional alliances to bridge and build capacity. Despite differences, countries face the same challenges, which provide an opportunity to co-create solutions through joint exchanges. Bringing a multisectoral delegation to meetings such as this one, could bring home a wider understanding of health inequities and determinants. The Regional Committee is a key event, providing an opportunity for small countries to speak with one voice on common, shared small country experiences that could help Health 2020 implementation.

**Promising practices should be documented**, showing the co-production of health, reductions in the health divide, challenges encountered, and lessons learnt. Such an exercise builds up a valuable repository of know-how for the coming years. This information is valuable for the implementing country, as well as to other countries, to reflect on what worked and what could be improved. Case studies that document Health 2020 implementation should be explored.

**Health policy learning tools are available** to help implement lessons learnt to reduce inequity gaps. *The Review of social determinants and the health divide in the WHO European Region (2)* and companion products provide evidence on what works and a synthesis of promising practices. Valuable learning opportunities, such as the subregional launch of the European Review, could be encouraged.

## Strategic objective 2: improving leadership and participatory governance for health

**Linking the social determinants of health and the post-2015 development agenda are crucial.** Putting equity and the social determinants of health on the development agenda of small countries are of paramount importance. The time was deemed ripe for exploring and expanding political and institutional arrangements for this. Due to the size of small-population countries, it can often be a challenge to distinguish health development from general development. Therefore it is important for small countries to meet in order to share their policies and experiences, and have an opportunity to work in cross-sectoral teams.

**It is important to mainstream equity into WHO programmes** and networks to help advance work on this issue. Networks – such as the WHO European Healthy Cities Network and the Regions for Health Network – WHO collaborating centres and centres of excellence are active in many small countries. While there are action plans and work plans, a review of how to better support small countries in areas with limited capacity is warranted. A number of political and institutional arrangements to further this work, such as CCS, biennial collaborative agreements and an exchange of letters, are also in place. National counterparts could also be valuable focal points at country level.

**Mechanisms to promote intersectoral work are available** and include ministerial committees and intersectoral working groups. Guidance on how to set up such committees and groups would be a valuable tool for Member States in the process of implementing Health 2020's strategic objectives.

**Supportive environments for implementing Health 2020 can be created** through better engagement of the media. The media can play a key part in creating better engagement of policy-makers and communities. A platform for sharing experiences and mutual learning about Health 2020 implementation should be set up.

## Conclusions

Four key actions came out of this meeting.

1. Document how to align national health policies to Health 2020.
2. Develop joint capacity-building events and structures between the Regional Office and small countries to promote health and reduce health inequities.
3. Create a supportive environment for Health 2020 through better engagement of the media as an implementation partner.
4. Create a platform for sharing experiences and mutual learning about Health 2020 implementation.



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## Annex 1. Country profiles

# ANDORRA



## Statistics

Total population (/000) (2012)	<b>77<sup>a</sup></b>
Area km <sup>2</sup>	<b>468</b>
Life expectancy at birth m/f (years, 2012)	<b>79.0/86.0<sup>b</sup></b>
Probability of dying under five (per 1 000 live births, 2012)	<b>3.00<sup>b</sup></b>
GNI per capita, Atlas method (current US \$, 2012)	<b>43 110<sup>c</sup></b>
Total expenditure on health per capita (Int\$, 2012)	<b>3 499<sup>d</sup></b>
Total expenditure on health as % of GDP (2011)	<b>7.2<sup>b</sup></b>

a: European health for all database (HFA-DB) (1)  
b: World Health Statistics 2014 (2)

c: World Development Indicators (3)  
d: WHO Global Health Observatory (4)

The General Health Act of 1989 is the legal document, which sets the regulations for the health system in Andorra. After analysing its current situation, the Government selected an approach that involves all stakeholders and developed an action plan for the next 10 years.

The Government's approach to health issues is interdisciplinary, interdepartmental and interministerial, and includes the principle of *Health in All Policies* (5). Taking into account guidelines provided by WHO (6), the action plan emphasizes cooperation and continuous learning in the field of public health, and collaborates with the Governments of France and Spain in view of their territorial proximity.

Recent programmes implemented at local level address environmental issues, children's rights, and family and housing problems.

### What are the health strategies implemented?

National Health Policy Strategy and Plan (2008–2018)

### What stands out?

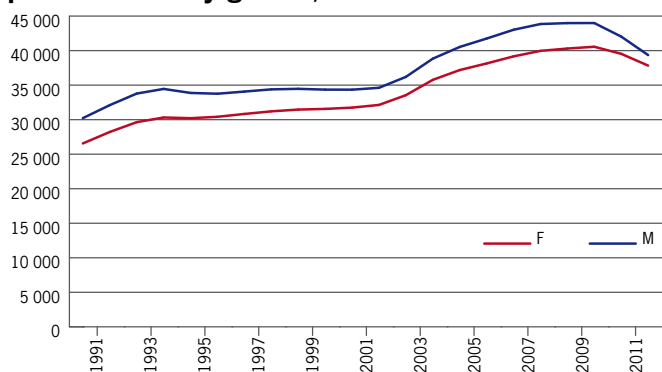
Andorra has placed great focus on providing health services with the highest possible standard of quality.

### Link to the national health ministry's website:

<http://www.salut.ad/> (English version not available)

## DEMOGRAPHIC indicators

### Population trend by gender, 1990–2012



Source: HFA-DB, April 2014 (1)

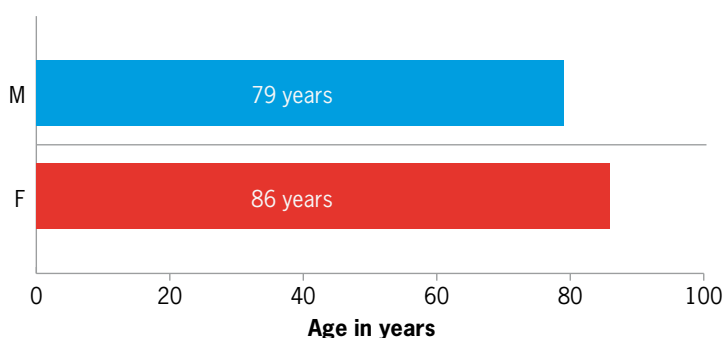
### Structure of the population by age groups

No data available

Source:

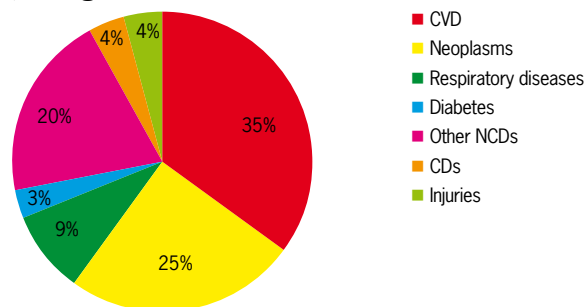
## HEALTH indicators

### Life expectancy at birth by gender, 2012



Source: World Health Statistics 2014 (2)

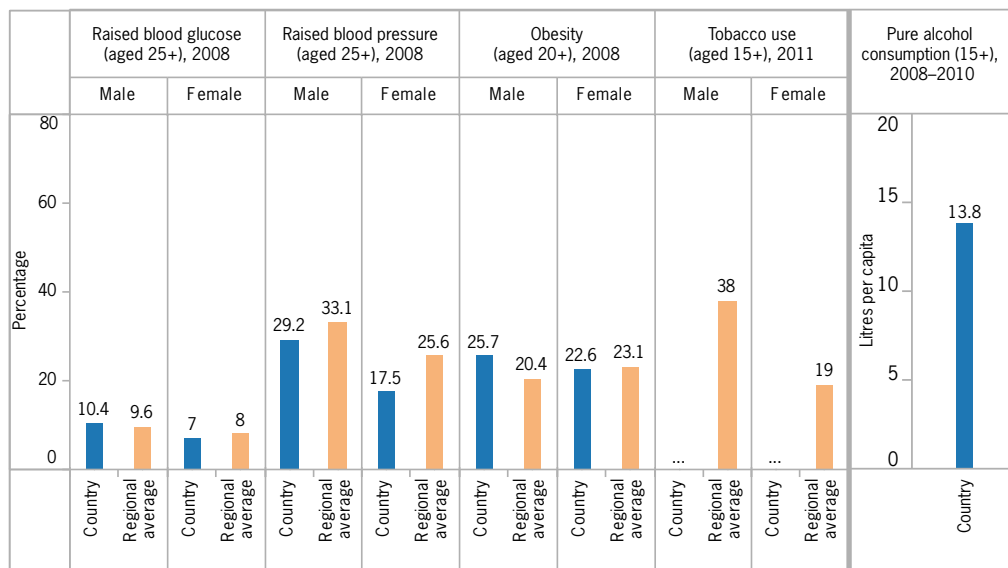
### Distribution of mortality by main groups of causes of death, all ages



Source: Noncommunicable diseases country profiles 2011 (7)

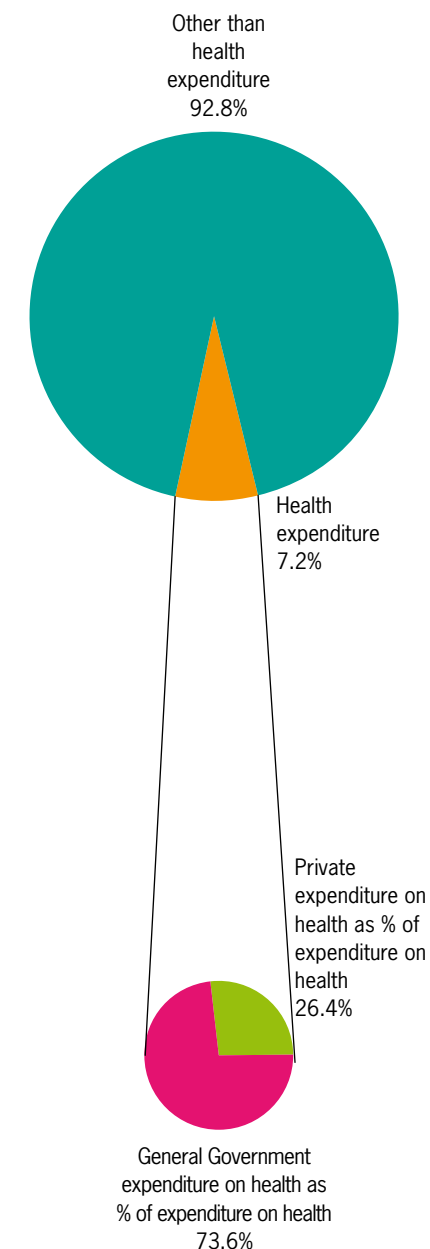
# HEALTH indicators

## Selected adult risk factors



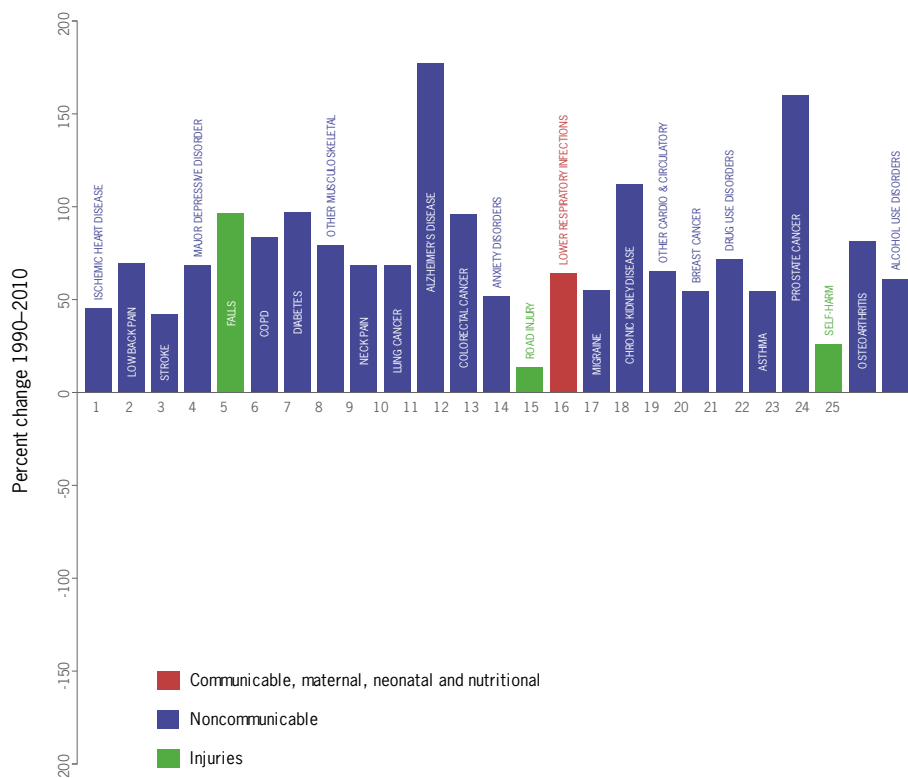
Source: WHO Global Health Observatory (4); Global Status Report on Alcohol and Health 2014 (14)

## Health expenditure as percentage of GDP, 2011



Source: World Health Statistics 2014 (2)

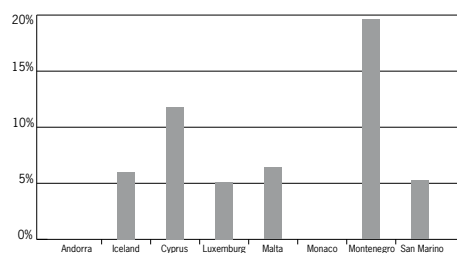
## Leading causes of DALY's and percent change, 1990 to 2010



Source: Global Burden of Disease Study 2010 (8)

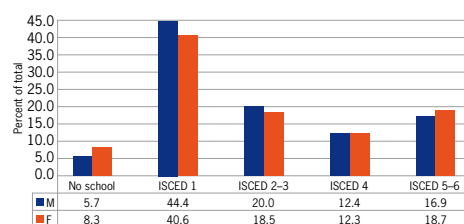
## SOCIODEMOGRAPHIC indicators

### Unemployment, percentage of total labor force, 2012



Source: Estimates modelled by the International Labour Organization (9); Bollettino di Statistica San Marino (12)

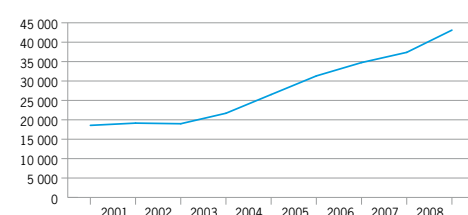
### Education attainment on population aged > 25, 2006



Source: UNESCO Institute for Statistics (10)

Note: No school/Unknown, ISCED 1 = Primary, ISCED 2 = Lower secondary, ISCED 3 = Upper secondary, ISCED 4 = Post secondary, ISCED 5-6 = Tertiary

### GNI per capita, Atlas method (current US\$)



Source: World Development Indicators (3)

# CYPRUS



## Statistics

Total population (/000) (2012)	<b>864<sup>a</sup></b>
Area km <sup>2</sup>	<b>9 251 km<sup>2</sup></b>
Life expectancy at birth m/f (years, 2011)	<b>80.1/83.9<sup>a</sup></b>
Probability of dying under five (per 1 000 live births, 2011)	<b>3.63<sup>a</sup></b>
GNI per capita, Atlas method (current US \$, 2012)	<b>26 110<sup>b</sup></b>
Total expenditure on health per capita (Int\$, 2012)	<b>2 266<sup>c</sup></b>
Total expenditure on health as % of GDP (2011)	<b>7.4<sup>d</sup></b>

a: European health for all database (HFA-DB) (1)  
b: World Development Indicators (3)

c: WHO Global Health Observatory (4)  
d: World Health Statistics 2014 (2)

Accession to the European Union (EU) led to many reforms in the Cyprus health system, particularly in terms of policy, regulation, legislative harmonization and the provision of services. With the re-launch of the Lisbon Strategy in 2005, the EU and its Member States committed themselves to a new partnership and to undertake reforms in a coordinated manner.

Many initiatives in Cyprus tackle health issues like maternal and child health; food and water safety; substances abuse - with the National Health Strategy for illicit substances and alcohol (2013-2016); mental health; nutrition; national immunization.

Together with Greece, Italy, Malta, Portugal and Spain, Cyprus has been collaborating with WHO on health and migration policies.

## What are the health strategies implemented?

“Strategic Plan for 2007–2013”.

## What stands out?

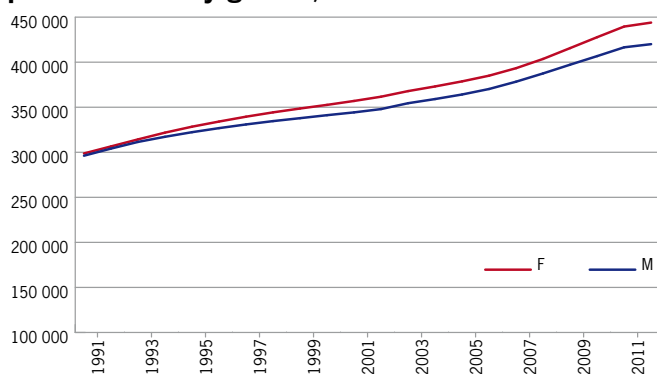
Children’s rights to health are emphasized, which are addressed in multiple ways in national policies (for example, in nutrition, housing and access to health care).

## Link to the national health ministry’s website:

[http://www.moh.gov.cy/MOH/MOH.nsf/index\\_en/index\\_en?OpenDocument](http://www.moh.gov.cy/MOH/MOH.nsf/index_en/index_en?OpenDocument) (English version)

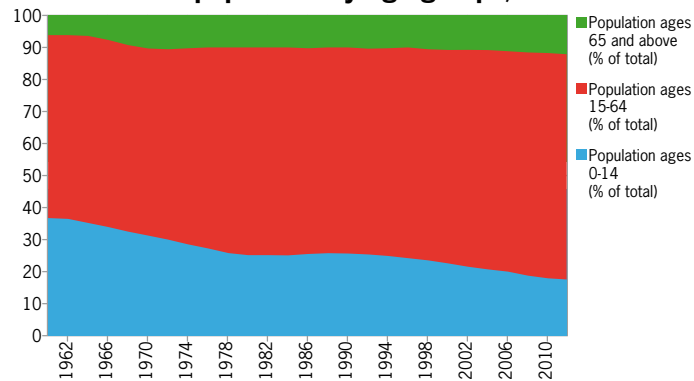
## DEMOGRAPHIC indicators

### Population trend by gender, 1990–2012



Source: HFA-DB, April 2014 (1)

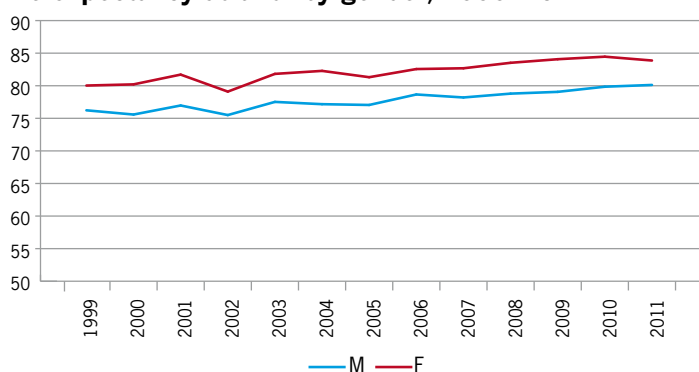
### Structure of the population by age groups, 1960–2012



Source: World Development Indicators (3)

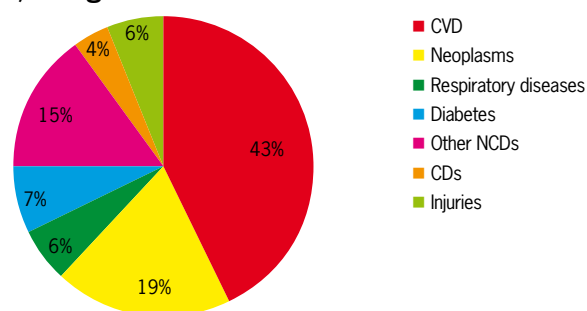
## HEALTH indicators

### Life expectancy at birth by gender, 1999–2011



Source: HFA-DB, April 2014 (1)

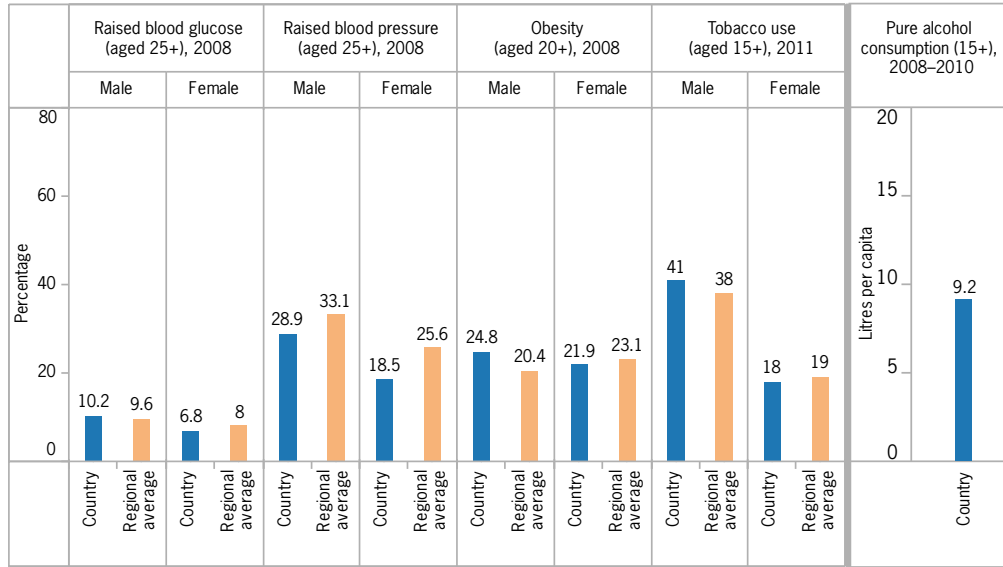
### Distribution of mortality by main groups of causes of death, all ages



Source: Noncommunicable diseases country profiles 2011 (7)

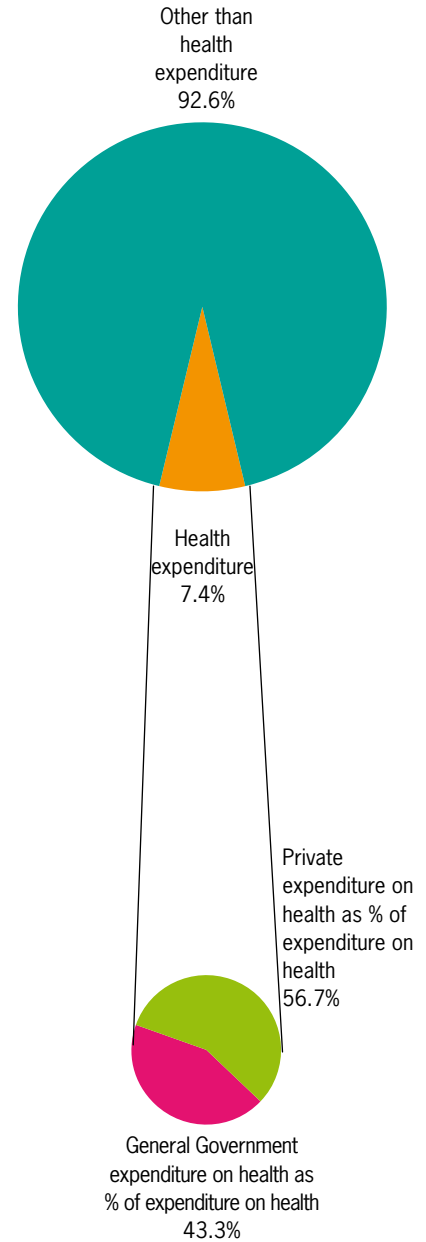
# HEALTH indicators

## Selected adult risk factors



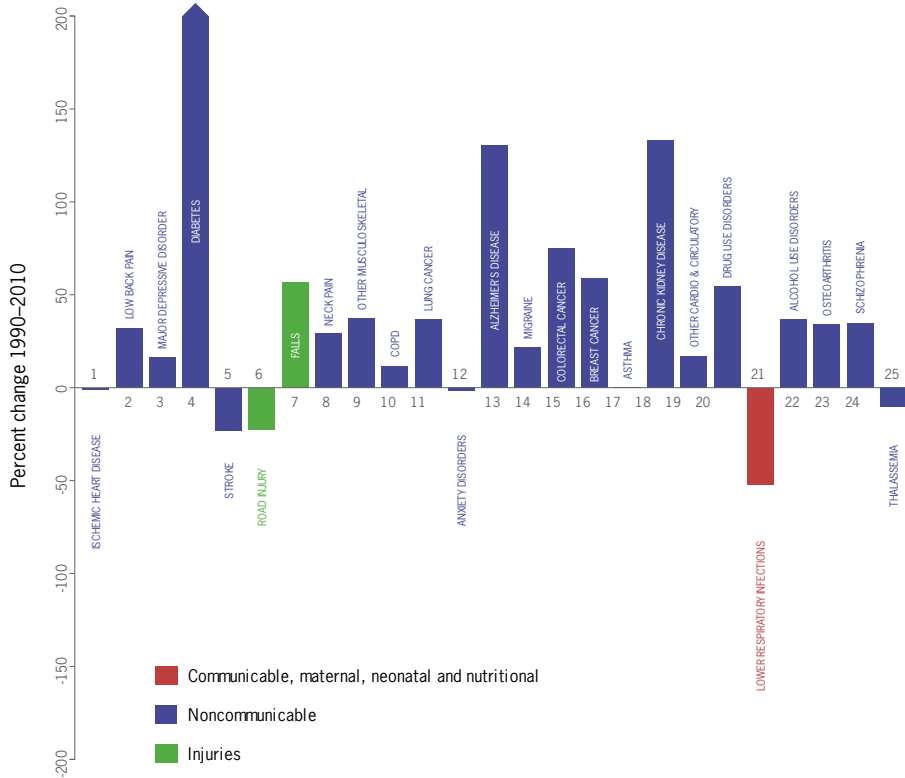
Source: WHO Global Health Observatory (4); Global Status Report on Alcohol and Health 2014 (14)

## Health expenditure as percentage of GDP, 2011



Source: World Health Statistics 2014 (2)

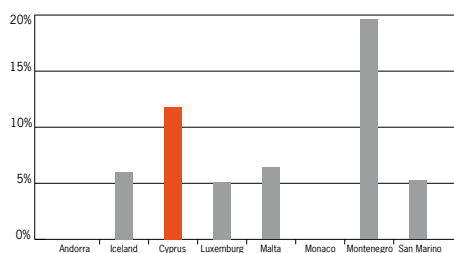
## Leading causes of DALY's and percent change, 1990 to 2010



Source: Global Burden of Disease Study 2010 (8)

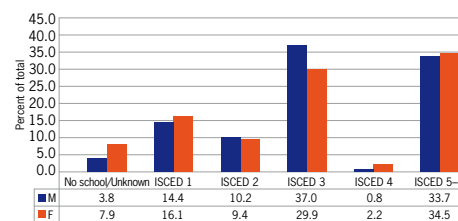
# SOCIODEMOGRAPHIC indicators

## Unemployment, percentage of total labor force, 2012



Source: Estimates modelled by the International Labour Organization (9); Bollettino di Statistica San Marino (12)

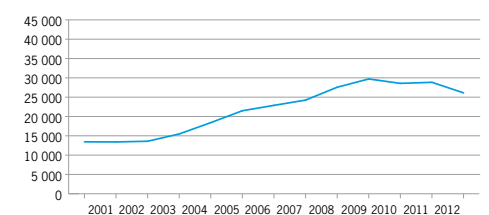
## Education attainment on population aged > 25, 2012



Source: UNESCO Institute for Statistics (10)

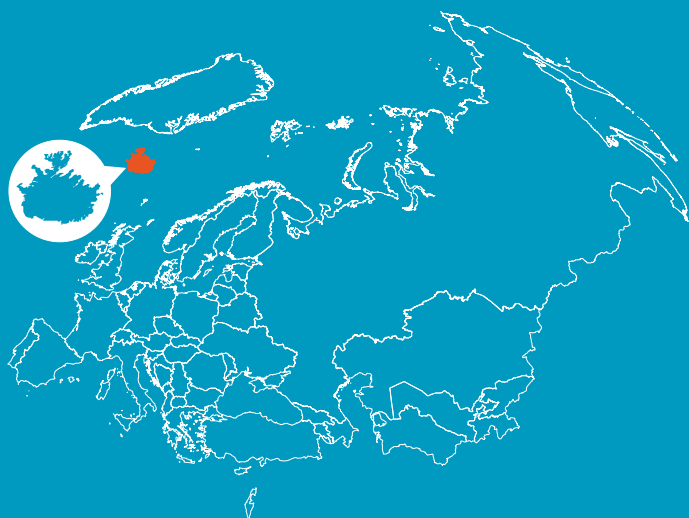
Note: No school/Unknown, ISCED 1 = Primary, ISCED 2 = Lower secondary, ISCED 3 = Upper secondary, ISCED 4 = Post secondary, ISCED 5-6 = Tertiary

## GNI per capita, Atlas method (current US\$)



Source: World Development Indicators (3)

# ICELAND



## Statistics

Total population (/000) (2012)	<b>321<sup>a</sup></b>
Area km <sup>2</sup>	<b>103 000</b>
Life expectancy at birth m/f (years, 2009)	<b>79.9/83.9<sup>a</sup></b>
Probability of dying under five (per 1 000 live births, 2012)	<b>2.23<sup>a</sup></b>
GNI per capita, Atlas method (current US \$, 2012)	<b>38 270<sup>b</sup></b>
Total expenditure on health per capita (Int\$, 2012)	<b>3 436<sup>c</sup></b>
Total expenditure on health as % of GDP (2011)	<b>9.2<sup>d</sup></b>

a: European health for all database (HFA-DB) (1)  
b: World Development Indicators (3)

c: WHO Global Health Observatory (4)  
d: World Health Statistics 2014 (2)

The foundation of the Icelandic Health Care System was laid in the middle of last century. Iceland has a long history of health planning, with the work on the first National Health Plan starting in 1980. The first National Health Plan to the year 2000 was built on the WHO strategy "Health for all by the year 2000" and the second plan, The Icelandic National Health Plan to the year 2010, was also built on the WHO policy "Health for All". Iceland is now working on its third National Health Plan to the year 2020 built on Health 2020. Health strategies and policies of Iceland can also be found as prescribed by law, regulations and other directives. In 2010 the government agreed on a policy statement "Iceland 2020" whose pillars are knowledge, sustainability and welfare.

These policies and legislative tools combine health, social and economic targets and give priority to: prevention of alcohol, drug and tobacco use; children and youth health; senior citizens' health; mental health; improving gender equality; people with disabilities; patients' rights; and a focus on well-being and improved equality for all sectors in society.

## What are the health strategies implemented?

The Icelandic National Health Plan to the Year 2010; Iceland 2020

## What stands out?

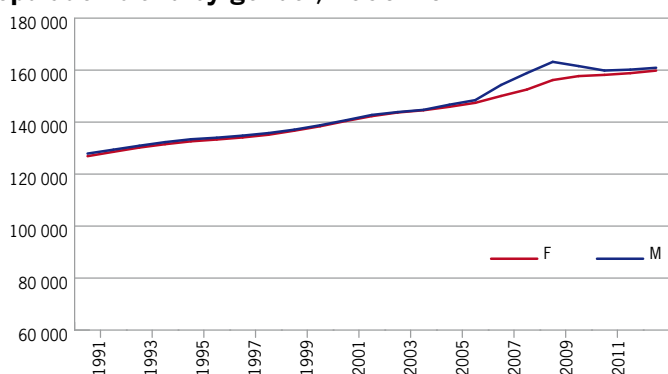
Iceland has made improving gender equality a high priority. A basic principle for Health Care Services in Iceland is easy and equal access to services and patients' rights.

## Link to the national health ministry's website:

<http://eng.velferdarraduneyti.is/> (English version)

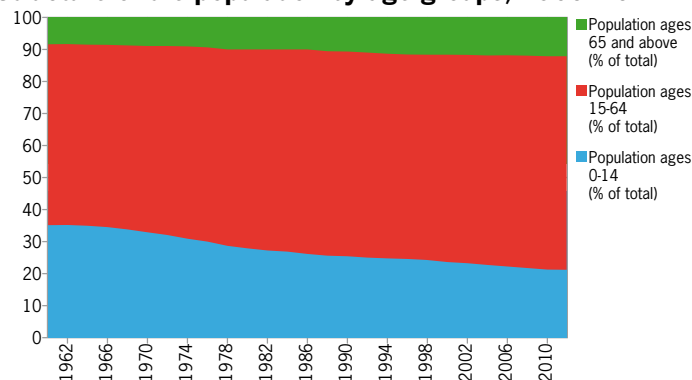
## DEMOGRAPHIC indicators

### Population trend by gender, 1990–2012



Source: HFA-DB, April 2014 (1)

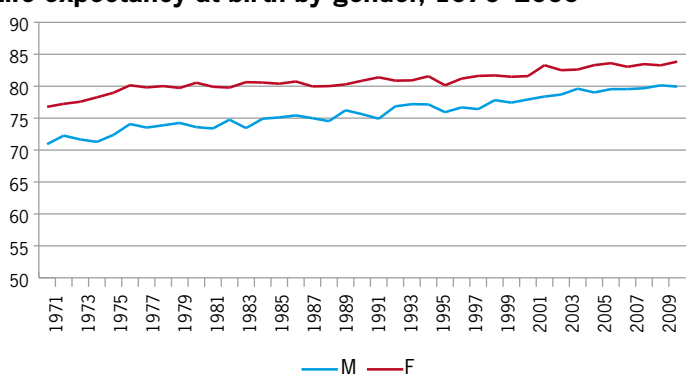
### Structure of the population by age groups, 1960–2012



Source: World Development Indicators (3)

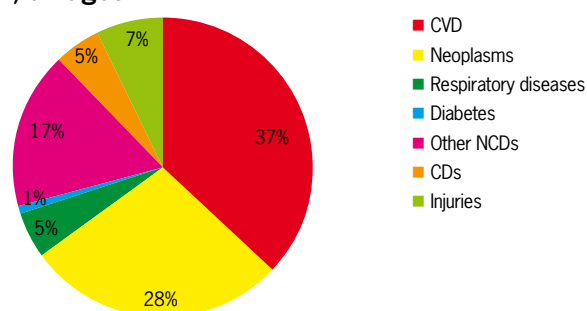
## HEALTH indicators

### Life expectancy at birth by gender, 1970–2009



Source: HFA-DB, April 2014 (1)

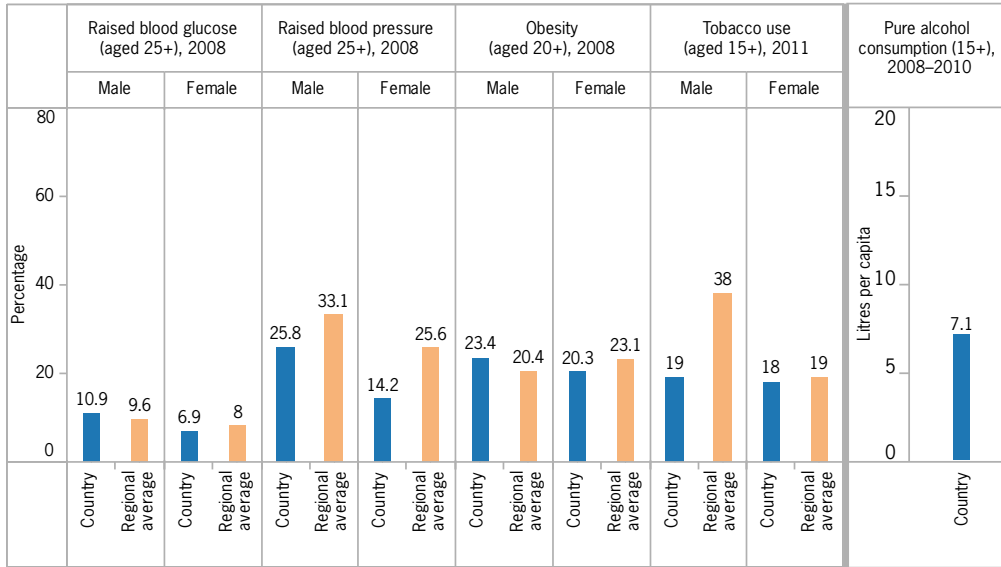
### Distribution of mortality by main groups of causes of death, all ages



Source: Noncommunicable diseases country profiles 2011 (7)

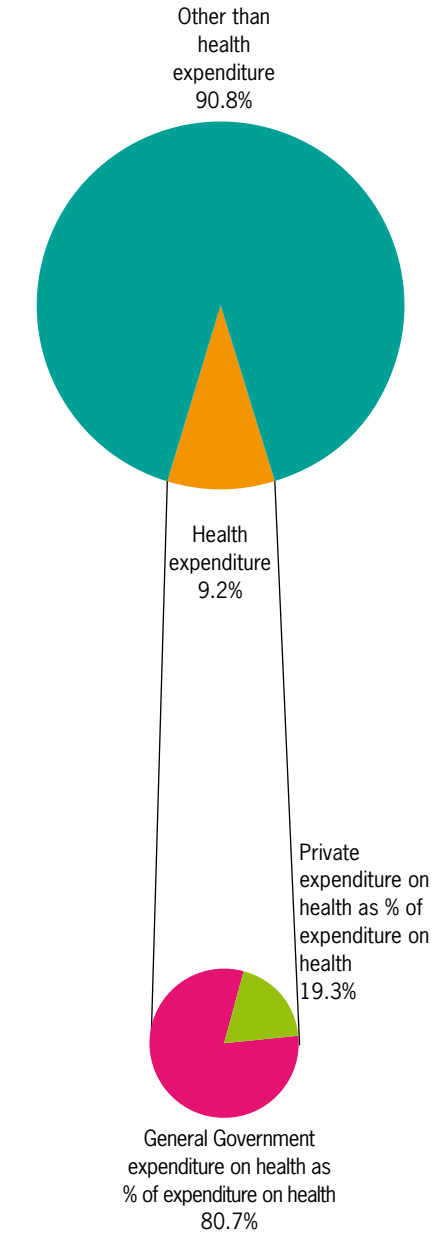
# HEALTH indicators

## Selected adult risk factors



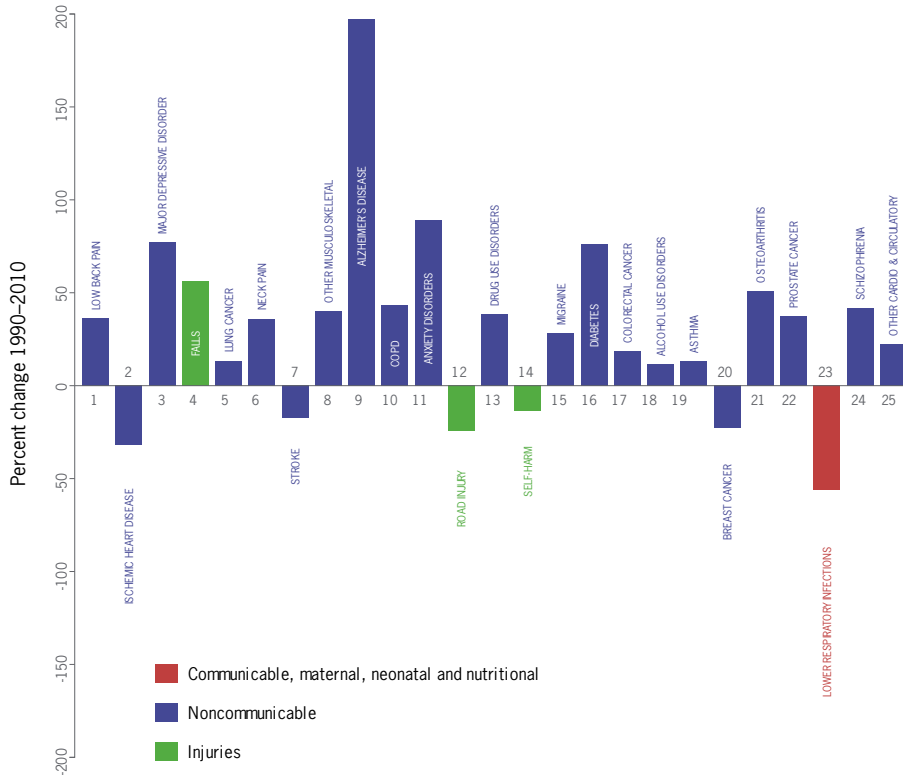
Source: WHO Global Health Observatory (4); Global Status Report on Alcohol and Health 2014 (14)

## Health expenditure as percentage of GDP, 2011



Source: World Health Statistics 2014 (2)

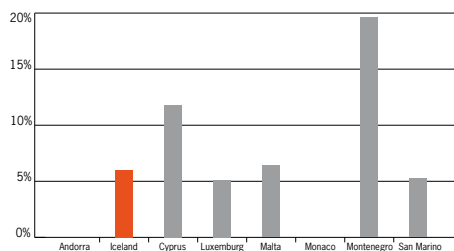
## Leading causes of DALY's and percent change, 1990 to 2010



Source: Global Burden of Disease Study 2010 (8)

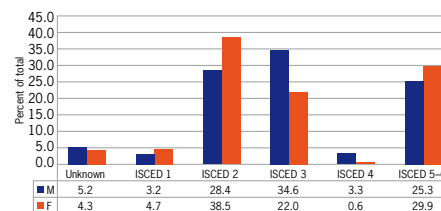
## SOCIODEMOGRAPHIC indicators

### Unemployment, percentage of total labor force, 2012



Source: Estimates modelled by the International Labour Organization (9); Bollettino di Statistica San Marino (12)

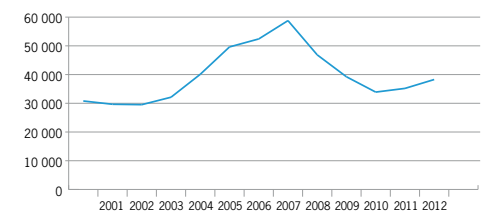
### Education attainment on population aged > 25, 2005



Source: UNESCO Institute for Statistics (10)

Note: No school/Unknown, ISCED 1 = Primary, ISCED 2 = Lower secondary, ISCED 3 = Upper secondary, ISCED 4 = Post secondary, ISCED 5-6 = Tertiary

### GNI per capita, Atlas method (current US\$)



Source: World Development Indicators (3)

# LUXEMBOURG



## Statistics

Total population (/000) (2012)	531 <sup>a</sup>
Area km <sup>2</sup>	2 586
Life expectancy at birth m/f (years, 2011)	79.1/83.9 <sup>a</sup>
Probability of dying under five (per 1 000 live births, 2012)	3.34 <sup>a</sup>
GNI per capita, Atlas method (current US \$, 2012)	71 810 <sup>b</sup>
Total expenditure on health per capita (Int\$, 2012)	6 341 <sup>c</sup>
Total expenditure on health as % of GDP (2011)	6.7 <sup>d</sup>

a: European health for all database (HFA-DB) (1)  
b: World Development Indicators (3)

c: WHO Global Health Observatory (4)  
d: World Health Statistics 2014 (2)

The Luxembourg health care system is one of the most comprehensive systems in the world offering virtually unrestricted access to the Luxembourg population. Notable facts of the Luxembourg health care system are: universal coverage of the population by health insurance; global supervision and planning of hospital and pharmaceutical sectors; and equal treatment of providers (legal entities or physical persons), regardless of their status.

Recent health strategies that have been implemented include the 2006-2010 HIV/Aids Plan and the Policies of Psychiatry and Mental Health in Luxembourg (2005). Luxembourg's approach is comprehensive and takes into account a number of factors including environmental issues; child health; nutrition; elderly citizens; family and integration matters; noncommunicable disease prevention in line with the WHO standards; health and safety at work.

### What are the health strategies implemented?

Programme gouvernemental 2013 du Luxembourg – Sante

### What stands out?

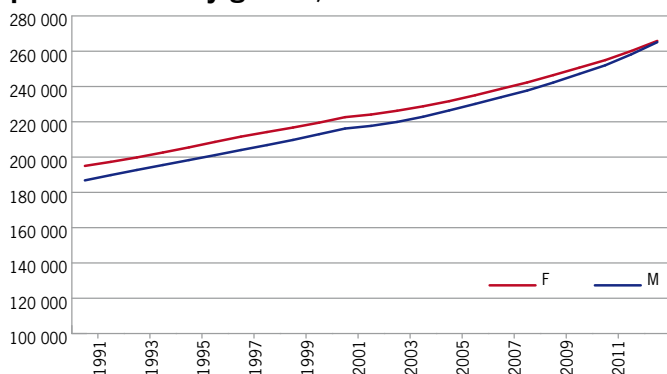
Luxembourg has recently adopted (January 2014) an anti-smoking bill, which bans smoking in public places.

### Link to the national health ministry's website:

<http://www.ms.public.lu/fr/index.html> (English version not available)

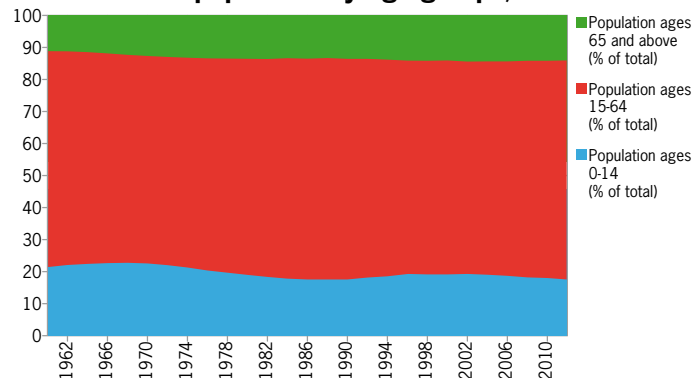
## DEMOGRAPHIC indicators

### Population trend by gender, 1990–2012



Source: HFA-DB, April 2014 (1)

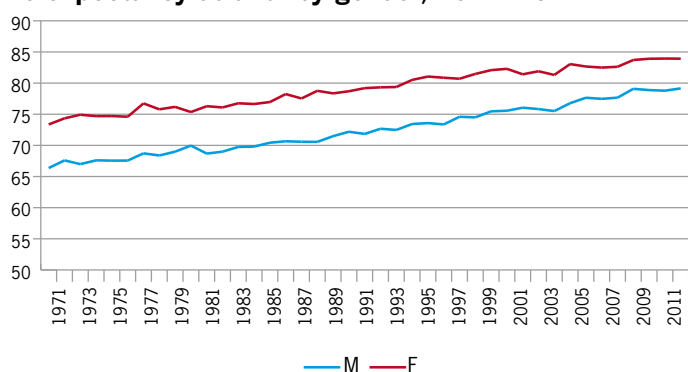
### Structure of the population by age groups, 1960–2012



Source: World Development Indicators (3)

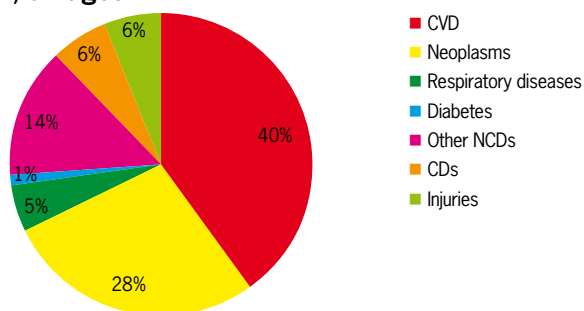
## HEALTH indicators

### Life expectancy at birth by gender, 1971–2011



Source: HFA-DB, April 2014 (1)

### Distribution of mortality by main groups of causes of death, all ages

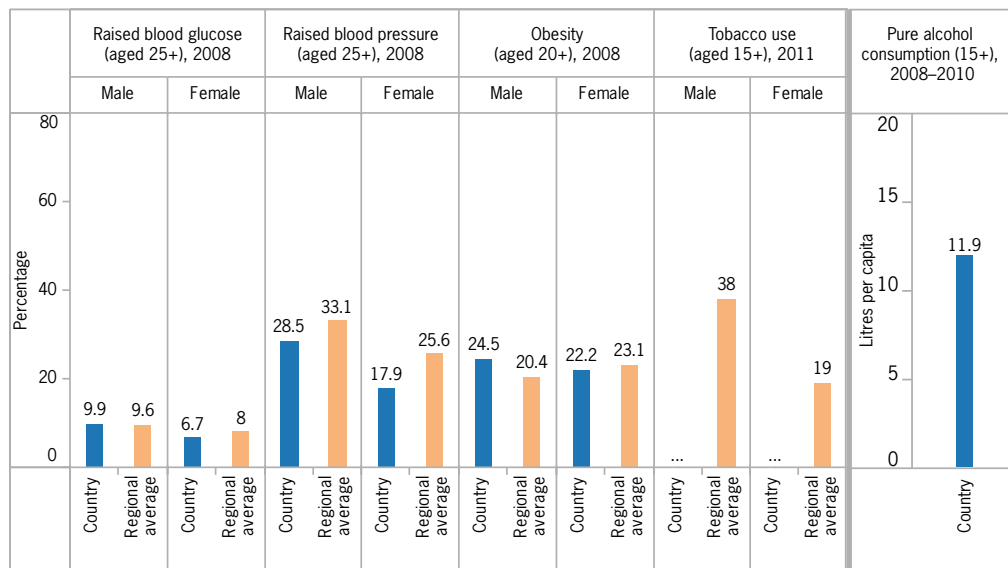


Source: Noncommunicable diseases country profiles 2011 (7)



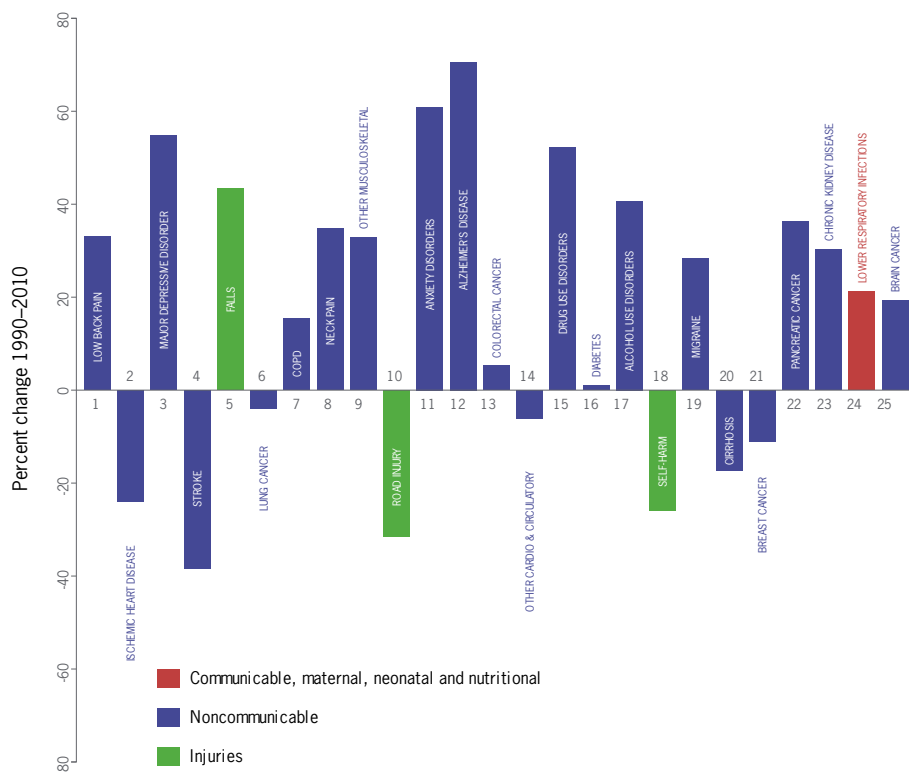
# HEALTH indicators

## Selected adult risk factors



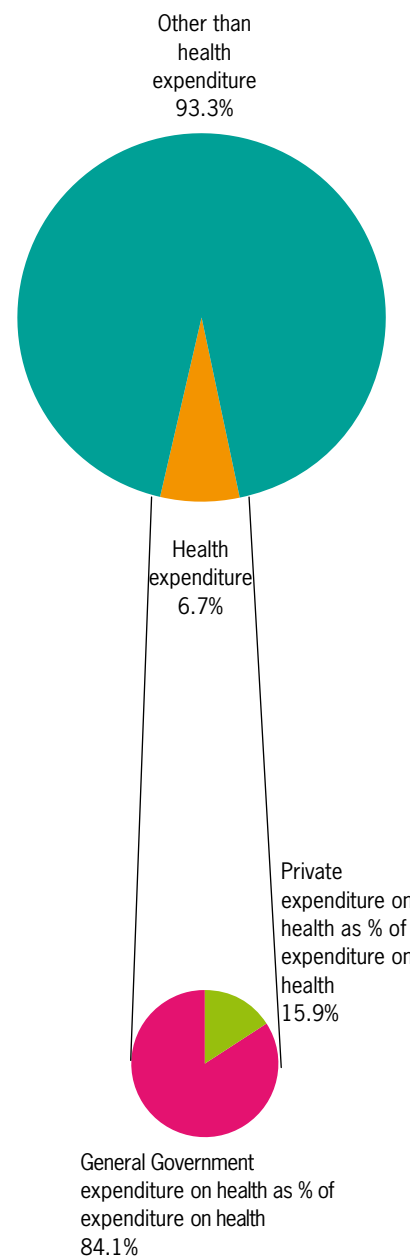
Source: WHO Global Health Observatory (4); Global Status Report on Alcohol and Health 2014 (14)

## Leading causes of DALY's and percent change, 1990 to 2010



Source: Global Burden of Disease Study 2010 (8)

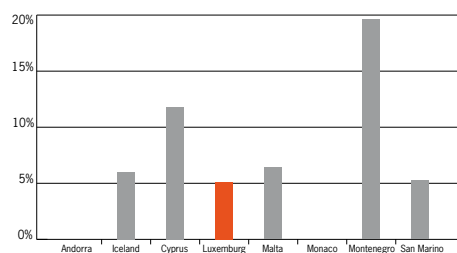
## Health expenditure as percentage of GDP, 2011



Source: World Health Statistics 2014 (2)

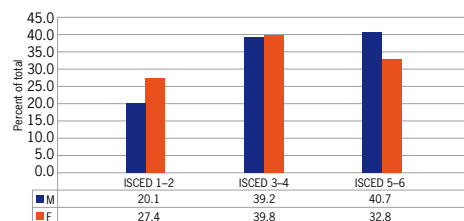
# SOCIODEMOGRAPHIC indicators

## Unemployment, percentage of total labor force, 2012



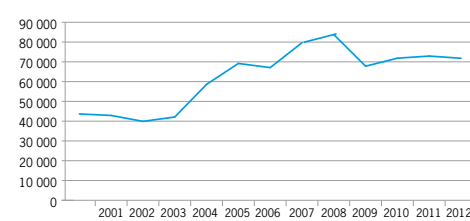
Source: Estimates modelled by the International Labour Organization (9); Bollettino di Statistica San Marino (12)

## Education attainment on population aged > 25, 2012

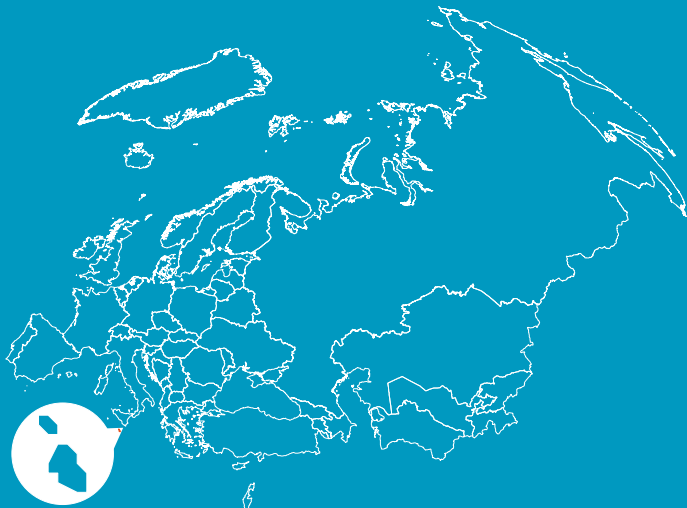


Source: UNESCO Institute for Statistics (10)  
 Note: No school/Unknown, ISCED 1 = Primary, ISCED 2 = Lower secondary, ISCED 3 = Upper secondary, ISCED 4 = Post secondary, ISCED 5-6 = Tertiary

## GNI per capita, Atlas method (current US\$)



Source: World Development Indicators (3)



## Statistics

Total population (/000) (2012)	<b>428<sup>a</sup></b>
Area km <sup>2</sup>	<b>316</b>
Life expectancy at birth m/f (years, 2011)	<b>78.8/83.1<sup>a</sup></b>
Probability of dying under five (per 1 000 live births, 2011)	<b>7.06<sup>a</sup></b>
GNI per capita, Atlas method (current US \$, 2012)	<b>19 730<sup>b</sup></b>
Total expenditure on health per capita (Int\$, 2012)	<b>2 548<sup>c</sup></b>
Total expenditure on health as % of GDP (2011)	<b>8.7<sup>d</sup></b>

a: European health for all database (HFA-DB) (1)  
b: World Development Indicators (3)

c: WHO Global Health Observatory (4)  
d: World Health Statistics 2014 (2)

Over the past few years a number of policies and strategies relating to health have been finalized and are being implemented. Below are a number of policies and strategies and other significant milestones:

**2007:** restructuring to separate Regulatory and Service Provider Functions; commissioning of the new Mater Dei hospital and migration to the new hospital.

**2008:** introduction of the Pharmacy of Your Choice Scheme (POYC); foundation Programme and Post Graduate Medical training centre.

**2009:** launch of the national breast cancer screening programme; consultation on a primary health care reform.

**2010:** faculty for Health Sciences within the University of Malta; Non-communicable Disease Strategy; Sexual Health Policy.

**2011:** National Cancer Plan 2011–2015; Sexual Health Strategy; commissioners for Health, for Mental Health and for Elderly Persons.

**2012:** Embryo Protection Bill (2012); Mental Health Act (2012); launch of national colorectal cancer screening programme.

**2013:** launch of the Human Papilloma Virus (HPV) vaccination programme; Health Act (2013); structures (including the National Contact Point) for cross border healthcare.

**2014:** launch of the Food and Nutrition Policy and Action Plan 2014–2020; launch of the National Health Systems Strategy for Malta 2014–2020.

## What stands out?

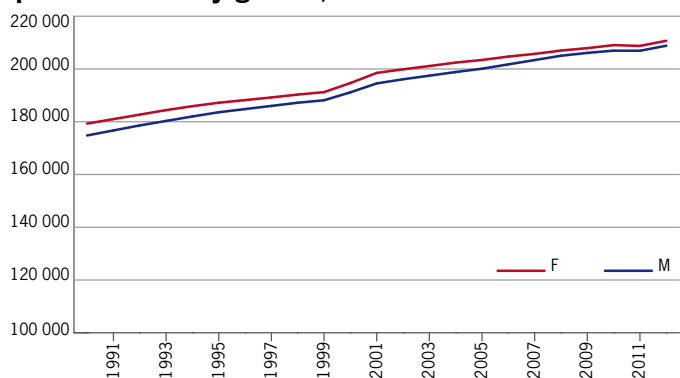
The health systems in Malta is being guided by the principle that every individual is provided with the opportunity to lead a healthy and active life and can benefit from equitable access to sustainable quality health care.

**Link to the national health ministry's website:**

[www.health.gov.mt](http://www.health.gov.mt)

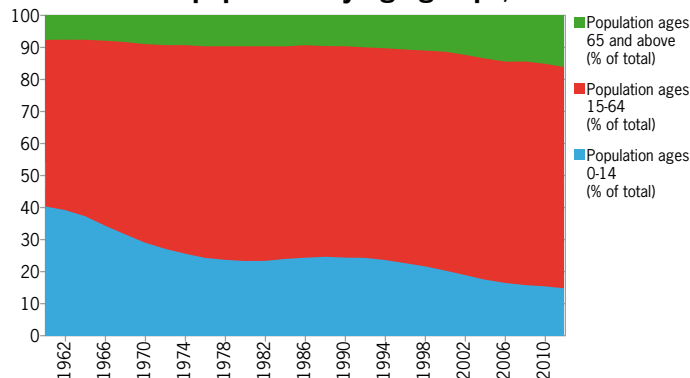
## DEMOGRAPHIC indicators

### Population trend by gender, 1990–2012



Source: HFA-DB, April 2014 (1)

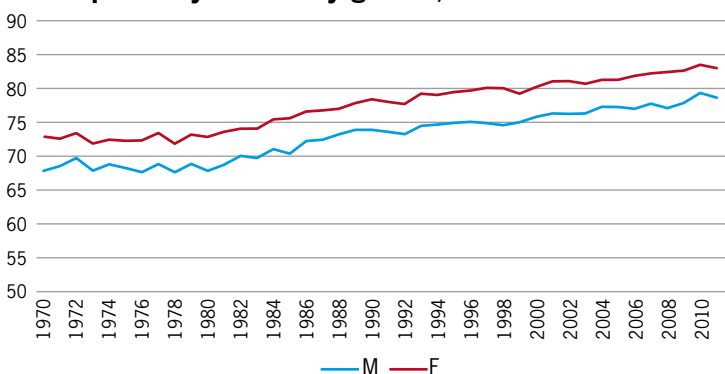
### Structure of the population by age groups, 1960–2012



Source: World Development Indicators (3)

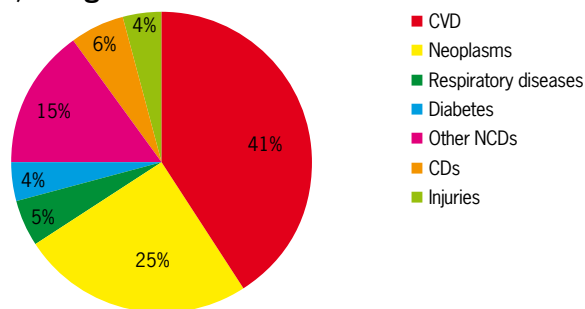
## HEALTH indicators

### Life expectancy at birth by gender, 1970–2011



Source: HFA-DB, April 2014 (1)

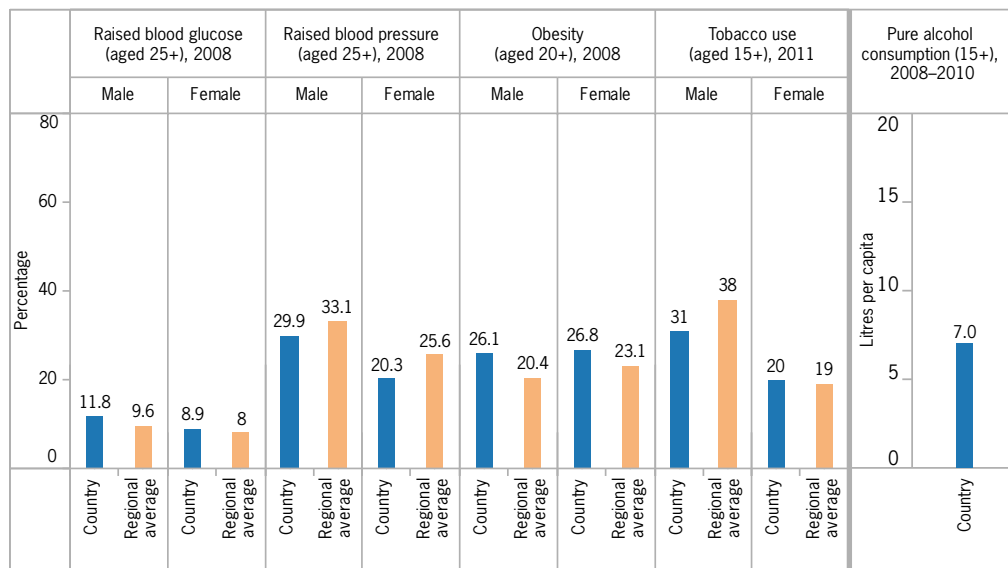
### Distribution of mortality by main groups of causes of death, all ages



Source: Noncommunicable diseases country profiles 2011 (7)

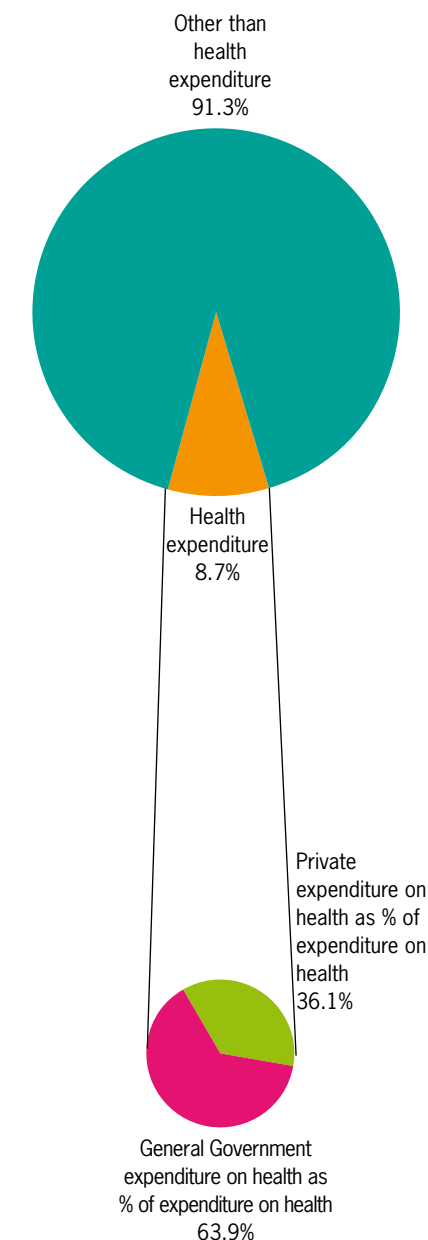
# HEALTH indicators

## Selected adult risk factors



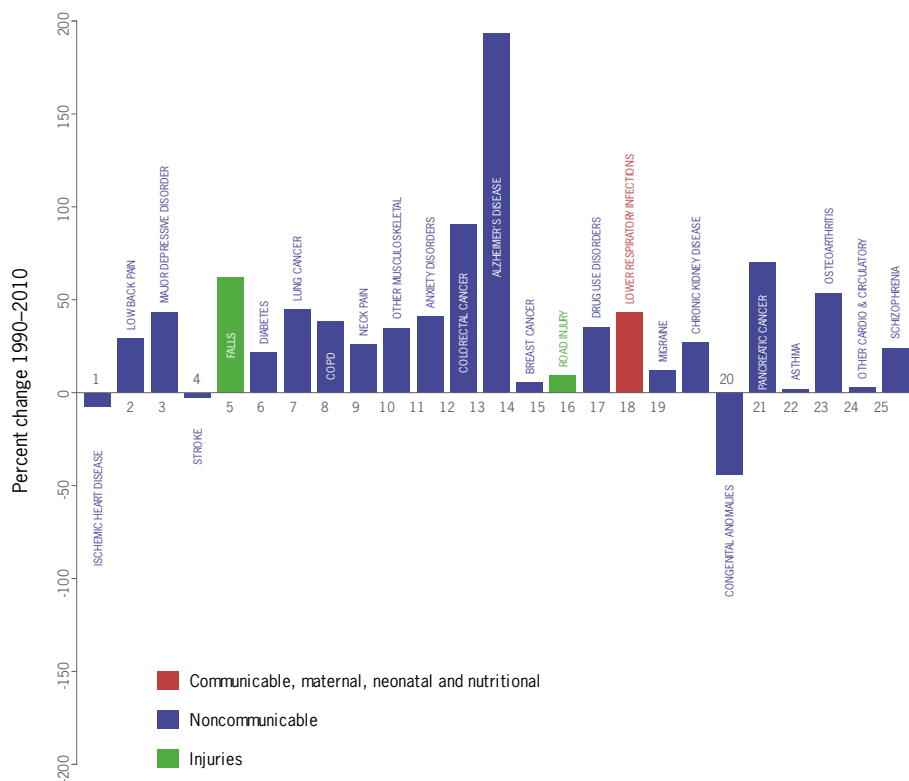
Source: WHO Global Health Observatory (4); Global Status Report on Alcohol and Health 2014 (14)

## Health expenditure as percentage of GDP, 2011



Source: World Health Statistics 2014 (2)

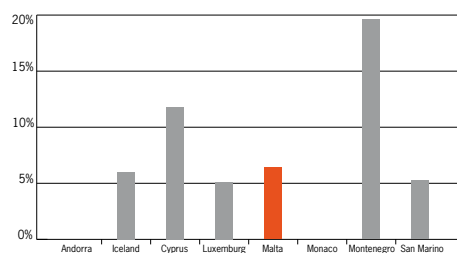
## Leading causes of DALY's and percent change, 1990 to 2010



Source: Global Burden of Disease Study 2010 (8)

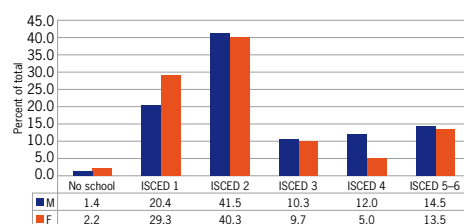
# SOCIODEMOGRAPHIC indicators

## Unemployment, percentage of total labor force, 2012



Source: Estimates modelled by the International Labour Organization (9); Bollettino di Statistica San Marino (12)

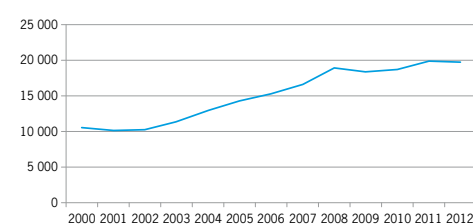
## Education attainment on population aged > 25, 2012



Source: UNESCO Institute for Statistics (10)

Note: No school/Unknown, ISCED 1 = Primary, ISCED 2 = Lower secondary, ISCED 3 = Upper secondary, ISCED 4 = Post secondary, ISCED 5-6 = Tertiary

## GNI per capita, Atlas method (current US\$)



Source: World Development Indicators (3)

# MONACO



## Statistics

Total population (/000) (2012)	<b>36<sup>a</sup></b>
Area km <sup>2</sup>	<b>2</b>
Life expectancy at birth m/f (years, 2012)	<b>79.0/86.0<sup>b</sup></b>
Probability of dying under five (per 1 000 live births, 2012)	<b>4.00<sup>b</sup></b>
GNI per capita, Atlas method (current US \$, 2012)	<b>186 950<sup>c</sup></b>
Total expenditure on health per capita (Int\$, 2012)	<b>6 026<sup>d</sup></b>
Total expenditure on health as % of GDP (2011)	<b>4.4<sup>b</sup></b>

a: European health for all database (HFA-DB) (1)  
b: World Health Statistics 2014 (2)

c: World Development Indicators (3)  
d: WHO Global Health Observatory (4)

The field of health is a major focus of the Government's activity under the aegis of the Ministry of Health and Social Affairs. Health statistics place the Principality among the top ranking countries of the Organisation for Economic Co-operation and Development countries, but Monaco is continuing its efforts in the area of prevention, health monitoring and the quality of its health care system.

The mission and strategies of Monaco's health sector focus on: families; early childhood; senior citizens; disability; social work; social security; health and safety at work and the alignment with international agreements about social protection. Prevention and screening are key elements of the public health policy developed over several years by the Government.

Paramount importance is given to health education, especially for young people: the aim is to promote a high-quality environment, improve lifestyles and prevent early risk behaviour (including smoking, addictions and sexually transmitted diseases).

### What stands out?

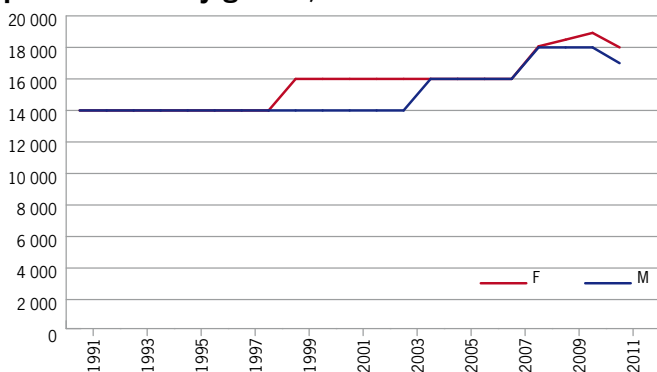
Monaco is especially committed and consistent in the field of prevention and diagnosis of HIV/AIDS with a number of initiatives and the action of its Health Screening Centre.

### Link to the national health ministry's website:

<http://en.gouv.mc/Policy-Practice/Social-Affairs-and-Health/An-exemplary-Public-Health-system>

## DEMOGRAPHIC indicators

### Population trend by gender, 1990–2012



Source: HFA-DB, April 2014 (1)

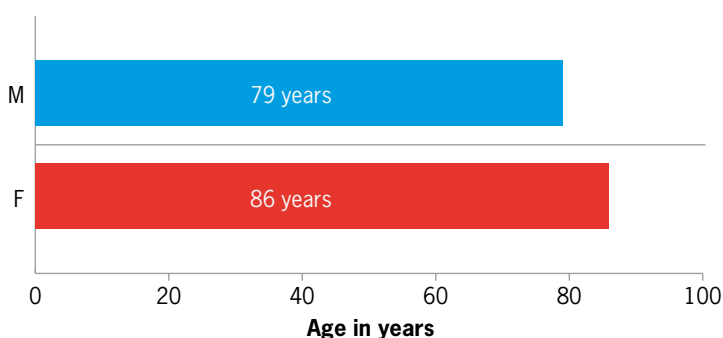
### Structure of the population by age groups

No data available

Source:

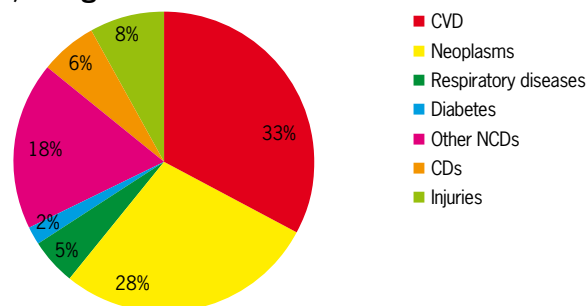
## HEALTH indicators

### Life expectancy at birth by gender, 2012



Source: World Health Statistics 2014 (2)

### Distribution of mortality by main groups of causes of death, all ages



Source: Noncommunicable diseases country profiles 2011 (7)

# HEALTH indicators

## Selected adult risk factors

	Raised blood glucose (aged 25+), 2008		Raised blood pressure (aged 25+), 2008		Obesity (aged 20+), 2008		Tobacco use (aged 15+), 2011		Pure alcohol consumption (15+), 2008-2010
	Male	Female	Male	Female	Male	Female	Male	Female	
Country	..	..	..	..	..	..	..	..	0
Regional average	9.6	8	33.1	25.6	20.4	23.1	38	19	-

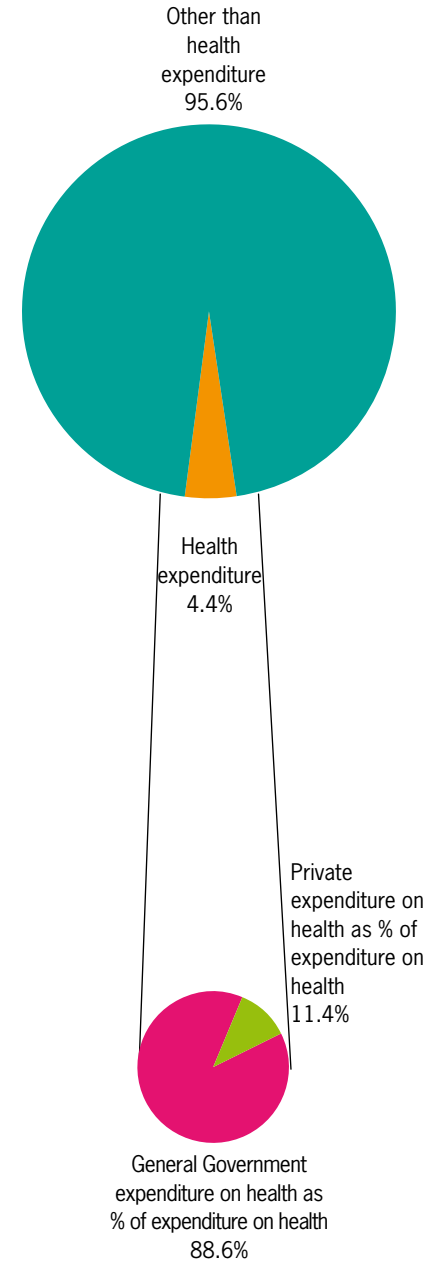
Source: WHO Global Health Observatory (4); Global Status Report on Alcohol and Health 2014 (14)

## Leading causes of DALY's and percent change

No data available

Source:

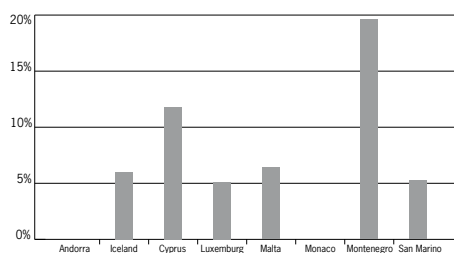
## Health expenditure as percentage of GDP, 2011



Source: World Health Statistics 2014 (2)

# SOCIODEMOGRAPHIC indicators

## Unemployment, percentage of total labor force, 2012



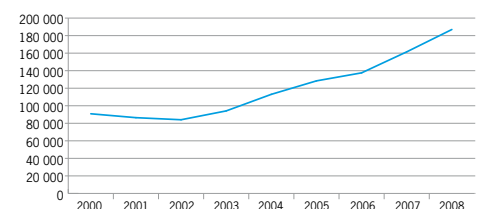
Source: Estimates modelled by the International Labour Organization (9); Bollettino di Statistica San Marino (12)

## Education attainment on population aged > 25

No data available

Source:

## GNI per capita, Atlas method (current US\$)



Source: World Development Indicators (3)

# MONTENEGRO



## Statistics

Total population (/000) (2012)	<b>622<sup>a</sup></b>
Area km <sup>2</sup>	<b>13 812</b>
Life expectancy at birth m/f (years, 2009)	<b>73.3/78.0<sup>a</sup></b>
Probability of dying under five (per 1 000 live births, 2009)	<b>6.17<sup>a</sup></b>
GNI per capita, Atlas method (current US \$, 2012)	<b>7 220<sup>b</sup></b>
Total expenditure on health per capita (Int\$, 2012)	<b>1 019<sup>c</sup></b>
Total expenditure on health as % of GDP (2011)	<b>7.2<sup>d</sup></b>

a: European health for all database (HFA-DB) (1)  
b: World Development Indicators (3)

c: WHO Global Health Observatory (4)  
d: World Health Statistics 2014 (2)

By adopting a health policy until 2020, Montenegro has joined a unique international process implementing the HEALTH21 policy framework (5). Montenegro's health care strategies are founded on improving the quality of health of the population, and by adapting and improving the health care system in harmony with financial factors.

The *Health policy in the Republic of Montenegro until 2020* represents the foundation for legislative, platform and action programmes, with the objective to make health care more efficient and to align Montenegro with European and world health standards. It defines some general objectives: extending life expectancy; improving quality of life; decreasing health inequities and improving financial protection related to health expenses.

In addition, a number of policies and laws have been approved and are currently implemented in terms of child protection; domestic violence reduction; safeguards to protect the rights of the disabled and social protection for the elderly. Also a number of grants and plans are available to tackle diseases like tuberculosis and HIV.

## What are the health strategies implemented?

Health Services Policy in the Republic of Montenegro Up to the Year 2020 (2001)

Strategy for Health Care Development in Montenegro (2003)  
Master plan on development of healthcare system of Montenegro for the period 2010 – 2013

## What stands out?

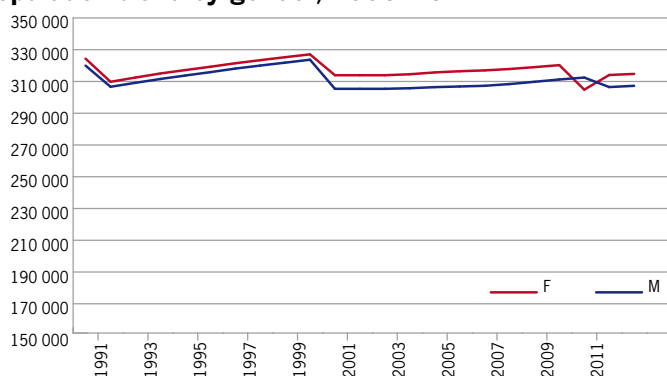
Montenegro has a dynamic and modern approach to health care that respects international standards and guidelines.

## Link to the national health ministry's website:

<http://www.mzdravlja.gov.me/en/ministry> (English version)

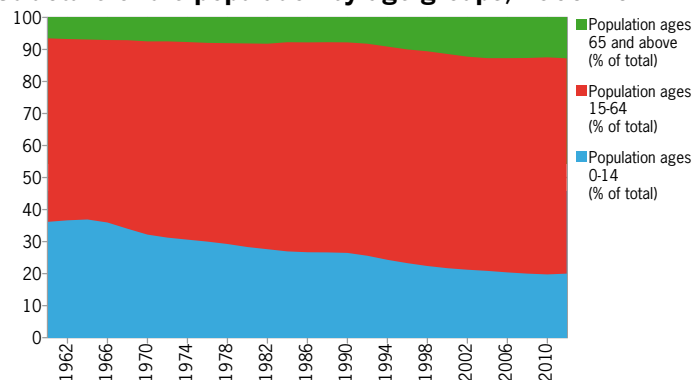
## DEMOGRAPHIC indicators

### Population trend by gender, 1990–2012



Source: HFA-DB, April 2014 (1)

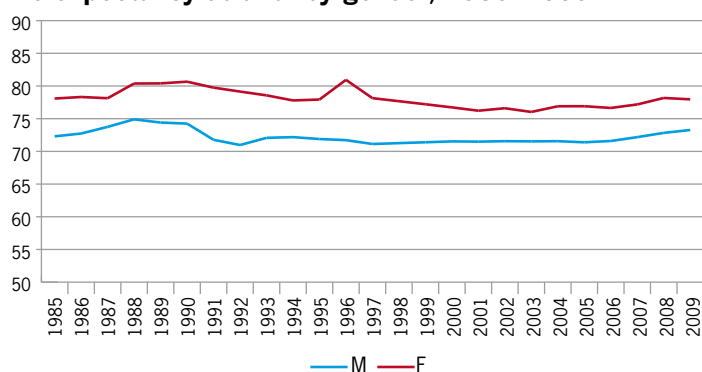
### Structure of the population by age groups, 1960–2012



Source: World Development Indicators (3)

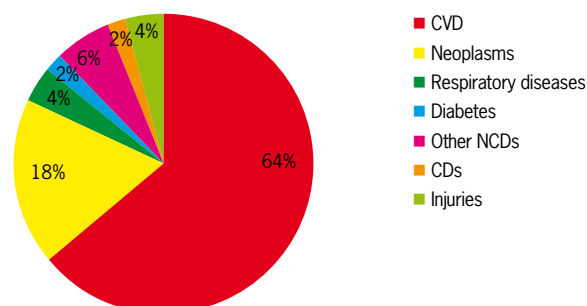
## HEALTH indicators

### Life expectancy at birth by gender, 1985–2009



Source: HFA-DB, April 2014 (1)

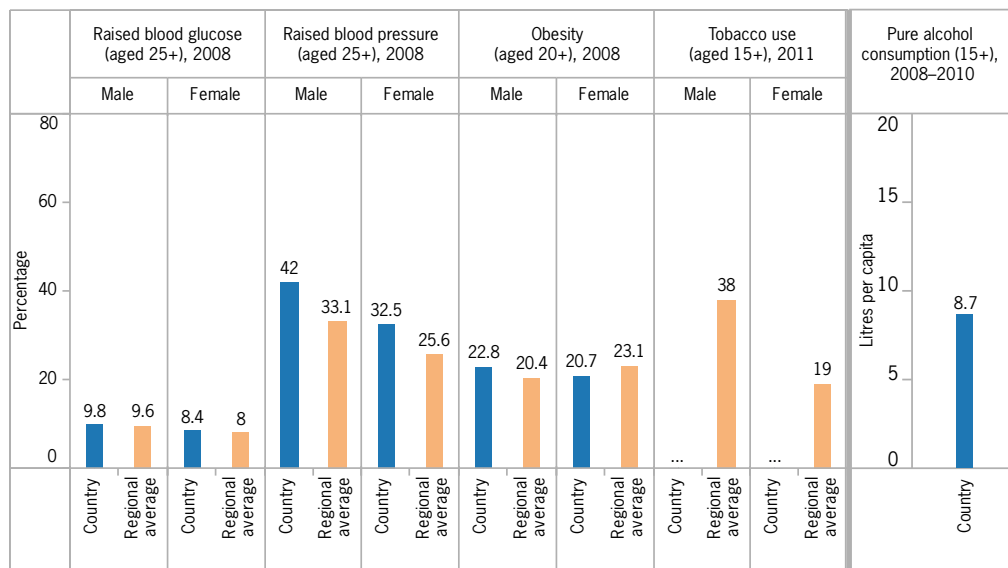
### Distribution of mortality by main groups of causes of death, all ages



Source: Noncommunicable diseases country profiles 2011 (7)

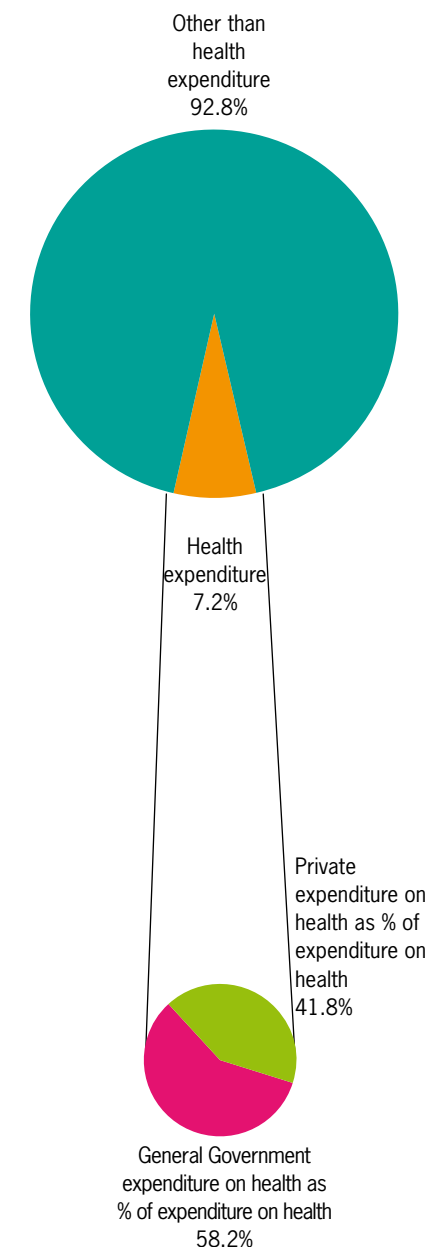
# HEALTH indicators

## Selected adult risk factors



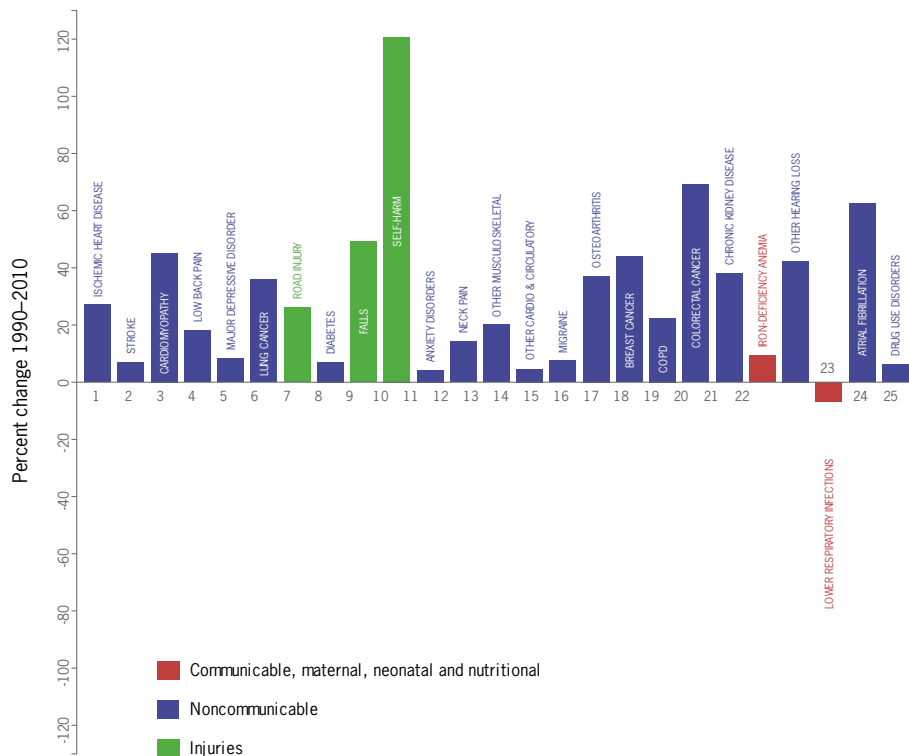
Source: WHO Global Health Observatory (4); Global Status Report on Alcohol and Health 2014 (14)

## Health expenditure as percentage of GDP, 2011



Source: World Health Statistics 2014 (2)

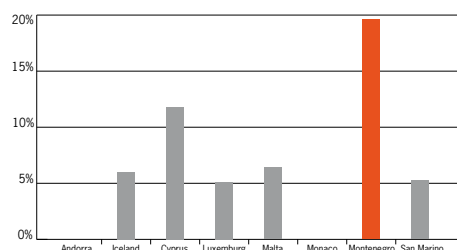
## Leading causes of DALY's and percent change, 1990 to 2010



Source: Global Burden of Disease Study 2010 (8)

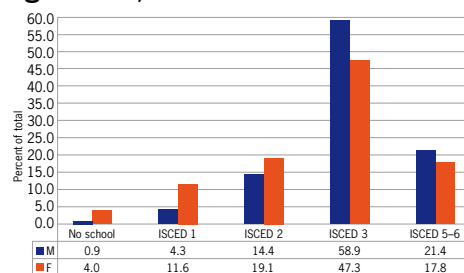
## SOCIODEMOGRAPHIC indicators

### Unemployment, percentage of total labor force, 2012



Source: Estimates modelled by the International Labour Organization (9); Bollettino di Statistica San Marino (12)

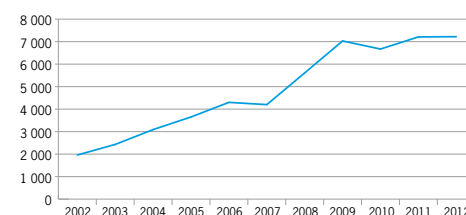
### Education attainment on population aged > 25, 2011



UNESCO Institute for Statistics (10)

Note: No school/Unknown, ISCED 1 = Primary, ISCED 2 = Lower Secondary, ISCED 3 = Upper Secondary, ISCED 4 = Post Secondary, ISCED 5-6 = Tertiary

### GNI per capita, Atlas method (current US\$)



Source: World Development Indicators (3)

# SAN MARINO



## Statistics

Total population (/000) (2012)	<b>30<sup>a</sup></b>
Area km <sup>2</sup>	<b>61</b>
Life expectancy at birth m/f (years, 2012)	<b>82.0/84.0<sup>b</sup></b>
Probability of dying under five (per 1 000 live births, 2012)	<b>3.00<sup>b</sup></b>
GNI per capita, Atlas method (current US \$, 2012)	<b>51 470<sup>c</sup></b>
Total expenditure on health per capita (Int\$, 2012)	<b>3 736<sup>d</sup></b>
Total expenditure on health as % of GDP (2011)	<b>5.5<sup>b</sup></b>

a: European health for all database (HFA-DB) (1)  
b: World Health Statistics 2014 (2)

c: World Development Indicators (3)  
d: WHO Global Health Observatory (4)

The key document to integrate social and health issues in San Marino is the *National Health Policy Strategy and Plan 2006–2008*. It aims to ensure the continuity of care and rehabilitation services including long-term care.

The 2006–2008 Plan provided the foundation for the legislative measures that followed (particularly the *National Health Policy Strategy and Plan 2011–2013*). The current strategies of San Marino's health policy are: to reduce risk factors of mortality; to implement an intersectoral approach; to promote sustainability; to avoid isolation in order to foster innovation and to maximize human resources.

The general objectives for health in San Marino include: prevention and health promotion; smoking, alcohol and illegal substances prevention; HIV programmes; better environmental standards; maternal and child health; elderly care; care for disabled and vulnerable citizens; noncommunicable disease prevention; and mental health.

## What are the health strategies implemented?

National Health Policy Strategy and Plan (2011-2013)

## What stands out?

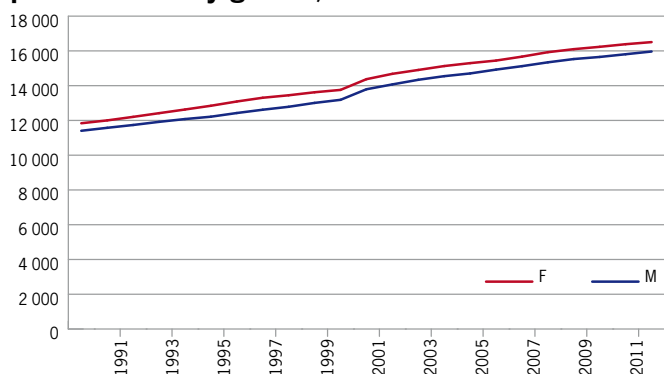
The importance given to keeping in contact with international and WHO changes in order to avoid (as a smaller country) any form of isolation.

## Link to the national health ministry's website:

<http://www.sanita.sm/on-line/home.html> (English version not available)

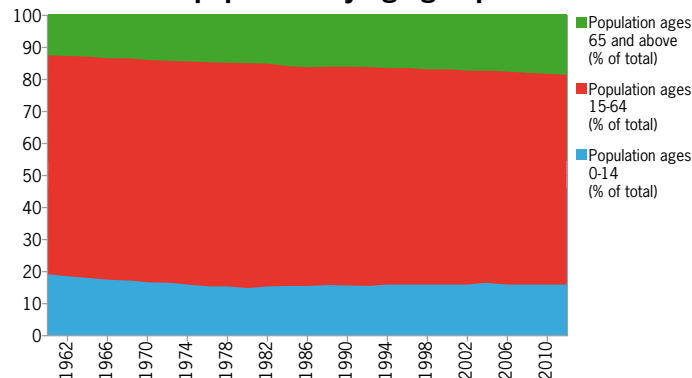
## DEMOGRAPHIC indicators

### Population trend by gender, 1990–2012



Source: Bollettino di Statistica San Marino (12)

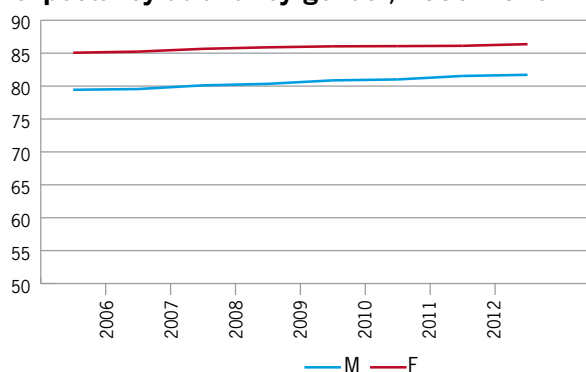
### Structure of the population by age groups



Source: Bollettino di Statistica San Marino (12)

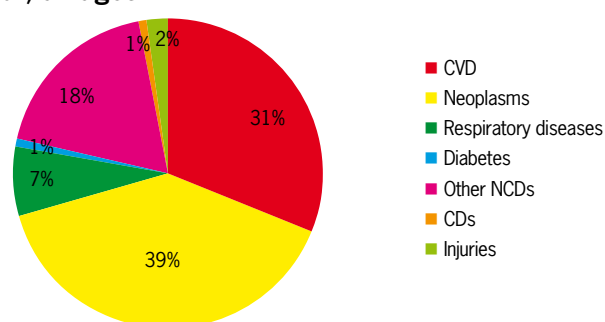
## HEALTH indicators

### Life expectancy at birth by gender, 2006–2013



Source: Bollettino di Statistica San Marino (12)

### Distribution of mortality by main groups of causes of death, all ages

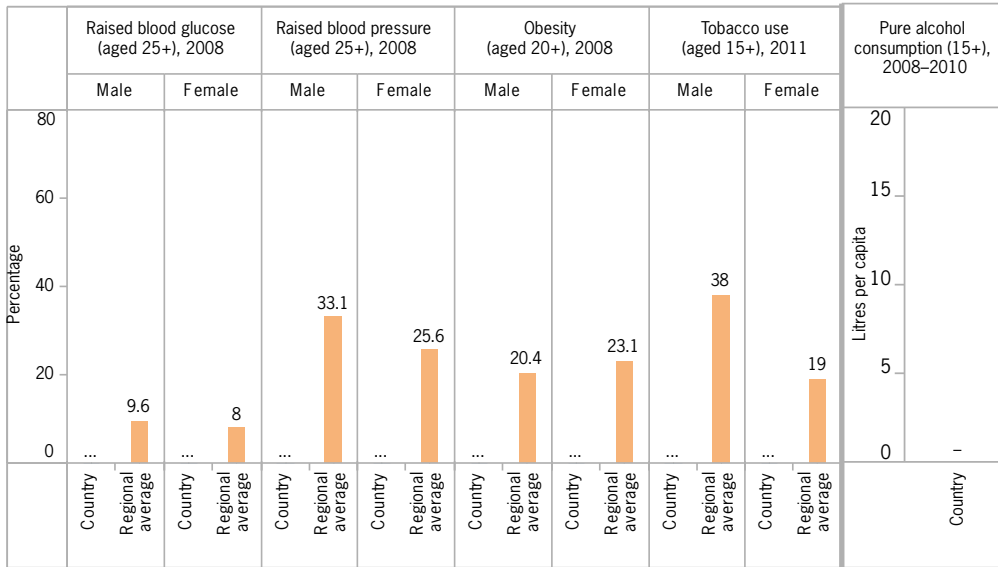


Source: Bollettino di Statistica San Marino (12)



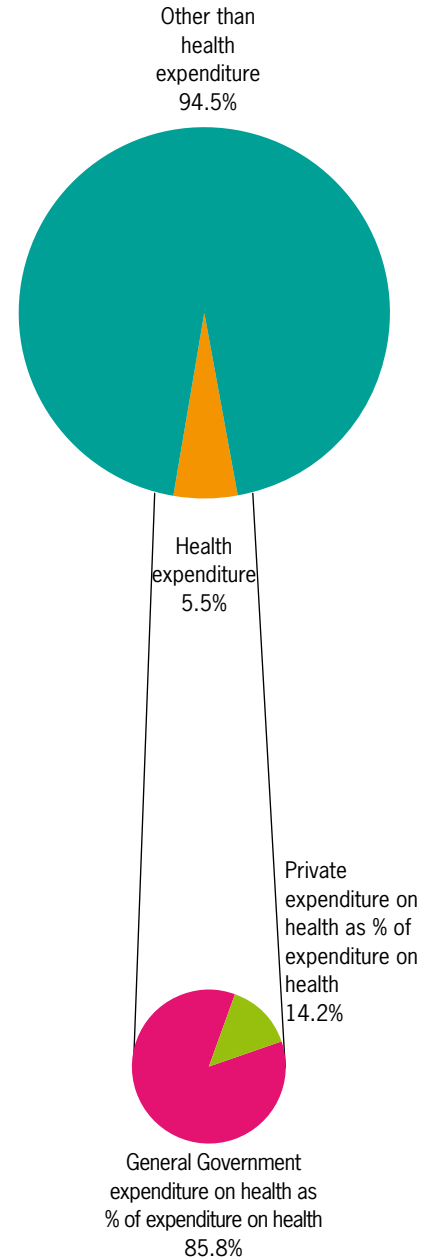
# HEALTH indicators

## Selected adult risk factors



Source: WHO Global Health Observatory (4); Global Status Report on Alcohol and Health 2014 (14)

## Health expenditure as percentage of GDP, 2011



Source: World Health Statistics 2014 (2)

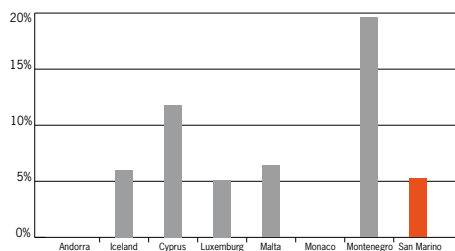
## Leading causes of DALY's and percent change, 1990 to 2010

No data available

Source:

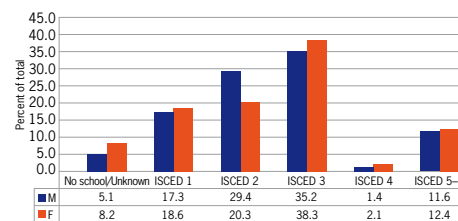
# SOCIODEMOGRAPHIC indicators

## Unemployment, percentage of total labor force, 2012



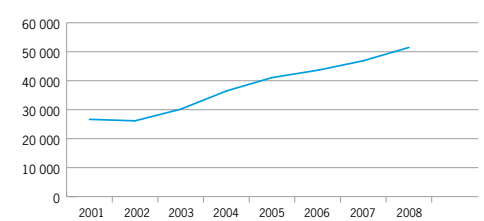
Source: Estimates modelled by the International Labour Organization (9); Bollettino di Statistica San Marino (12)

## Education attainment on population aged > 25



Source: Sixth National Population Census of San Marino (13)

## GNI per capita, Atlas method (current US\$)



Source: World Development Indicators (3)

# ACRONYMS

CDs	communicable diseases
COPD	chronic obstructive pulmonary disease
CVD	cardiovascular disease
DALY	disability-adjusted life-year
EU	European Union
GDP	gross domestic product
GNI	gross national income
HFA-DB	European health for all database
ILO	International Labour Organization
ISCED	International Standard Classification of Education
NCDs	noncommunicable diseases
UNESCO	United Nations Educational, Scientific and Cultural Organization

1. European Health for All database [online database]. Copenhagen: WHO Regional Office for Europe; 2014 (<http://www.euro.who.int/en/data-and-evidence/databases/european-health-for-all-database-hfa-db>).
2. World Health Statistics 2014. Geneva: World Health Organization; 2014 ([http://apps.who.int/iris/bitstream/10665/112738/1/9789240692671\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/112738/1/9789240692671_eng.pdf?ua=1)).
3. World Development Indicators [online database]. World Bank; 2014 (<http://data.worldbank.org/data-catalog/world-development-indicators>).
4. WHO Global Health Observatory [online database]. Geneva: World Health Organization; 2014 (<http://www.who.int/gho/countries/en/>).
5. Health for all in the 21st century. Copenhagen: WHO Regional Office for Europe; 1998 (European Health for All Series No. 5; <http://www.euro.who.int/en/publications/policy-documents/health21-health-for-all-in-the-21st-century>).
6. Health 2020: the new European policy framework for health and well-being. Copenhagen: WHO Regional Office for Europe; 2012 (<http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/about-health-2020>).
7. Noncommunicable diseases country profiles 2011. Geneva: World Health Organization; 2011 ([http://www.who.int/nmh/publications/ncd\\_profiles2011/en/](http://www.who.int/nmh/publications/ncd_profiles2011/en/)).
8. Global Burden of Disease Study 2010. Institute for Health Metrics and Evaluation; 2010 (<http://www.healthdata.org/gbd>).
9. World Bank Open Data [online database]. World Bank; 2014 (<http://data.worldbank.org/>).
10. UIS.Stat [online database]. Montreal: United Nations Educational, Scientific and Cultural Organization Institute for Statistics; 2014 (<http://data.uis.unesco.org/>).
11. Children's Environment and Health Action Plan for Europe. Copenhagen: WHO Regional Office for Europe; 2004 (EUR/04/5046267/7; <http://www.euro.who.int/en/health-topics/noncommunicable-diseases/chronic-respiratory-diseases/publications/pre-2011/childrens-environment-and-health-action-plan-for-europe>).
12. Bollettino di Statistica. San Marino: Ufficio Informatica, Tecnologia, Dati e Statistica; 2014 (<http://www.statistica.sm/>).
13. 6° Censimento Generale della Popolazione. San Marino: Ufficio Informatica, Tecnologia, Dati e Statistica; 2010 (<http://www.statistica.sm/on-line/home/censimento.html>).
14. Global Status Report on Alcohol and Health 2014. Geneva: World Health Organization; 2014 ([http://www.who.int/substance\\_abuse/publications/global\\_alcohol\\_report/en/](http://www.who.int/substance_abuse/publications/global_alcohol_report/en/)).

<sup>1</sup> All websites accessed on 12 June 2014.

## Annex 2. San Marino Manifesto

## Implementing the Health 2020 vision in countries with small populations

We the delegates of Member States in the European Region of the World Health Organization (WHO) with populations of less than 1 million have met in San Marino on 4 July 2014 to participate in the First High-level Meeting of Small Countries convened by the WHO Regional Office for Europe.

On 12 September 2012, the 53 Member States of the WHO European Region endorsed the new European policy framework for health and well-being – Health 2020.

We are aware that countries with smaller populations have a significant advantage to promote and implement policies and strategies for health and well-being that draw on the contribution of many sectors. The experiences of small countries can provide useful learning opportunities that can then be employed at regional level in more populous nations.

We are convinced that health – in addition to being a fundamental human right – is a key factor for sustainable national progress and prosperity. We recognize the importance of promoting health for all, with particular focus on disadvantaged groups, fostering equitable and sustainable development and reducing health inequities. We recognize that health is a whole-of-government responsibility. The protection and promotion of health and the tackling of today's health challenges cannot be solved by the health sector alone. Actions in all government sectors and in all of society, at any level – personal, institutional, community, municipal or national – are needed to nurture and improve the health and well-being of the population.

We find Health 2020 particularly helpful in aligning our policies with modern evidence-based, 21st century concepts, principles and approaches.

In particular, we value its emphasis on addressing the social determinants of health and health inequalities, on strengthening leadership and participatory management for health, on improving health throughout the life-course, on tackling the burden of noncommunicable diseases, on strengthening people-centred health care and public health systems, and on creating resilient communities that can withstand social and economic transitions.

Through our cooperation and commitment, we want to act as facilitators, catalysts and advocates of the right to the highest level of health for all as a key value embedded in Health 2020. We aim, on one hand, to amplify the voice of small countries in European and global health fora and, on the other, to share existing resources and maximize assets, innovating and applying solutions to increase capacity to improve health.

With this manifesto we commit ourselves to work:

- to align our national health policies to Health 2020;
- to strengthen our technical capacity on core Health 2020 aspects, with an emphasis on all determinants of health including the social determinants and using an intersectoral approach and sustainable actions to address the four priorities of Health 2020:
  - investing in health through a life-course approach and empowering people;
  - tackling the Region's major health challenges of noncommunicable and communicable diseases;
  - strengthening people-centred health systems, public health capacity and emergency preparedness, surveillance and response;
  - creating resilient communities and supportive environments; and
- to create a platform for sharing experiences and mutual learning about Health 2020 implementation and beyond.

We call on the WHO Regional Office for Europe to support us in meeting the above-mentioned commitments and to use the knowledge we generate as Health 2020 learning sites to accelerate the pace of Health 2020 implementation throughout the WHO European Region.



Andorra



Cyprus



Iceland



Luxembourg



Malta



Monaco



Montenegro



San Marino

## Annex 3. Programme

### Thursday, 3 July 2014

#### Opening

Dr Francesco Mussoni, Minister of Health and Social Security, San Marino

Dr Pasquale Valentini, Minister of Foreign Affairs, San Marino

Ms Zsuzsanna Jakab, WHO Regional Director for Europe

Dr Erio Ziglio, Head, WHO European Office for Investment for Health and Development

#### Session 1: implementing Health 2020 in countries with small populations

Introduction by Dr Ziglio

Keynote speech by Ms Jakab

Comments and feedback from participants

Moving Health 2020 forward: more equitable and sustainable societies in the WHO European Region by Ms Jakab

#### *Discussion*

#### Session 2: using Health 2020 to forge health and development plans in small countries

The experience of San Marino

Dr Francesco Mussoni, Minister of Health and Social Security, San Marino

Dr Antonella Mularoni, Minister of Territory and Environment, San Marino

Dr Claudio Felici, Minister of Finance and Budget, San Marino

San Marino team including other ministries

The experience of Cyprus

Professor Philippos Patsalis, Minister of Health, Cyprus

#### *Structured discussion*

#### Session 3: whole-of-government and whole-of-society approaches in countries with small populations

The experience of Iceland

Mr Kristjan Thor Juliusson, Minister of Health, Iceland

The experience of Andorra

Dr Josep M. Casals Alis, Director-General, Ministry of Health and Welfare, Andorra

#### *Structured discussion*

### Thursday, 3 July 2014 (contd)

#### Session 4: creating synergies with other sectors

The experience of Montenegro

Professor Miodrag Radunovic, Minister of Health, Montenegro

The experience of Malta

Hon. Chris Fearne, Parliamentary Secretary for Health, Ministry of Energy and Health, Malta

#### *Structured discussion*

## **Friday, 4 July 2014**

Session 5: health information and data collection in countries with small populations

Health 2020 indicators and targets: opportunities and challenges in countries with small populations

Dr Enrique Loyola, Programme Manager, Health Information Monitoring and Analysis, WHO Regional Office for Europe

The experience of Monaco

H.E. Robert Fillon, Ambassador, Permanent Representative of Monaco to the Food and Agriculture Organization of the United Nations, Ministry of Foreign Affairs

The experience of Luxembourg

Dr Robert Goerens, Medical Inspector, Luxembourg

*Structured discussion*

Session 6: update from the subregional Launch of the European review of social determinants of health and the health divide – Implementing the Health 2020 vision held on 16–17 June 2014 in Helsinki, Finland

Ms Chris Brown, Programme Manager, Social Determinants of Health, WHO European Office for Investment for Health and Development

Input from Iceland

Mr Kristjan Thor Juliusson, Minister of Health, Iceland

*Discussion*

## **Friday, 4 July 2014 (contd)**

Session 7: the Small Countries project: the way forward

Discussion:

- review the process and outcome of this first meeting of countries with small population;
- identify the main areas where the small-population countries would like to concentrate in their commitment and exchange; and
- agree on main deliverables and process of work for the small countries cooperation.

Ms Zsuzsanna Jakab, WHO Regional Director for Europe

Wrap-up of Day 2

The San Marino Manifesto

Closure of the meeting

Bilateral meetings, *if required by participants*

## Annex 4. List of participants

### **Andorra**

Dr Josep M. Casals Alis  
Director General of Health  
Ministry of Health and Welfare

### **Cyprus**

Professor Philippos C. Patsalis  
Minister of Health

Dr Demetris Efthymiou  
Medical Officer  
Ministry of Health

### **Iceland**

Mr Kristjan Thor Juliusson  
Minister of Health

Mrs Vilborg Ingolfsdottir  
Director General  
Ministry of Welfare

### **Luxembourg**

Dr Robert Goerens  
Medical Inspector, Ministry of Health

### **Malta**

The Honourable Chris Fearne  
Parliamentary Secretary for Health, National Parliament

Dr Miriam Dalmas  
Consultant, Public Health Medicine  
Ministry for Energy and Health

### **Monaco**

H. E. Robert Fillon  
Ambassador, Permanent Representative of Monaco to the Food and Agriculture  
Organization of the United Nations  
Ministry of Foreign Affairs

Mr Jean-Philippe Bertani  
Counsellor – Deputy Permanent Representative of Monaco to the Food and Agriculture  
Organization of the United Nations  
Ministry of Foreign Affairs

Ms Anne Negre  
Director, Directorate of Health and Social Work  
Department of Health and Social Affairs  
Ministry of State

Mr Tidiani Couma  
Secretary of External Relations  
Directorate of International Affairs  
Ministry of State



## **Montenegro**

Professor Miodrag Radunovic  
Minister of Health

Mr Drazen Ljumovic  
Chief of Cabinet of the Minister  
Ministry of Health

## **San Marino**

Dr Francesco Mussoni  
Minister of Health and Social Security

Dr Pasquale Valentini  
Minister of Foreign Affairs

Dr Claudio Felici  
Minister of Finance and Budget

Dr Antonella Mularoni  
Minister of Territory and Environment

Dr Paolo Pasini  
Director General  
Institute for Social Security

Dr Dario Manzaroli  
Director, Health and Social-Health Activities  
Institute for Social Security

Dr Lorenzo Venturini  
Director, Administration  
Institute for Social Security

Dr Andrea Gualtieri  
Director, Authority for Quality of Health  
Social-Health and Social-Education Services

## **World Health Organization**

### **WHO Regional Office for Europe**

Ms Zsuzsanna Jakab  
Regional Director

Dr Erio Ziglio  
Head, WHO European Office for Investment for Health and Development  
Division of Policy and Governance for Health and Well-being

Dr Thierry Mertens  
Senior Adviser  
Division of Policy and Governance for Health and Well-being

Dr Santino Severoni  
Coordinator, Public Health and Migration Project  
Division of Policy and Governance for Health and Well-being

Dr Enrique Loyola  
Programme Manager, Health Information Monitoring and Analysis,  
Division of Information, Evidence, Research and Innovation,

Ms Chris Brown  
Programme Manager, Social Determinants of Health Equity  
Division of Policy and Governance for Health and Well-being

Ms Mina Brajovic  
Head of Country Office  
WHO Country Office, Montenegro

Dr Francesco Zambon  
Policy Development Officer  
Division of Policy and Governance for Health and Well-being

Ms Simone Tetz  
Administrative Officer  
Division of Policy and Governance for Health and Well-being

Mr Lazar Nikolic  
Assistant  
Division of Policy and Governance for Health and Well-being

Ms Sara Barragan Montes  
Consultant, Communications  
Division of Policy and Governance for Health and Well-being

Ms Annalisa Buoro  
Secretary  
Division of Policy and Governance for Health and Well-being

Ms Leda Nemer  
Consultant (Rapporteur)  
Division of Policy and Governance for Health and Well-being

## **Guests**

Mr Maurizio Berardi  
Director, Prevention Department  
Institute for Social Security, San Marino

Ms Cinzia Cesarini  
Director, Social-Health Department  
Institute for Social Security, San Marino

Ms Francesca Masi  
Director, Hospital Services  
Institute for Social Security, San Marino

Dr Fateh Moghadam Pirous  
Trentino – Alto Adige Region, Italy  
Regions for Health Network

Dr Alberto Zanobini  
Tuscany Region, Italy  
Regions for Health Network



