

# SOUTH-EASTERN EUROPE HEALTH NETWORK (SEEHN)

## POLICY DIALOGUE ON HEALTH SYSTEM TRANSFORMATION



**Banja Luka, Bosnia and Herzegovina**  
**14 November 2017**



## ABSTRACT

The policy dialogue on health system transformation was held in Banja Luka, Bosnia and Herzegovina on 14 November 2017. Participants included members of the South-eastern Europe Health Network (SEEHN), subject matter experts and staff from WHO Regional Office for Europe. This report summarizes the key objectives and messages obtained from the policy dialogue, including the outcome of working-group sessions.

### Keywords

PUBLIC HEALTH  
PUBLIC HEALTH SERVICES  
HEALTH REFORM  
HEALTH SYSTEMS  
HEALTH POLICY  
EUROPE

Address requests about publications of the WHO Regional Office for Europe to:

Publications  
WHO Regional Office for Europe  
UN City, Marmorvej 51  
DK-2100 Copenhagen Ø, Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office website (<http://www.euro.who.int/pubrequest>).

© **World Health Organization 2018**

All rights reserved. The Regional Office for Europe of the World Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the World Health Organization.

# **South-eastern Europe Health Network (SEEHN)**

## **Policy Dialogue on Health System Transformation**

**Hosted by the health authorities in Bosnia and Herzegovina**

**Banja Luka, Bosnia and Herzegovina**

**14 November 2017**

**Dialogue Report**

### **Key messages from the Policy Dialogue**

Policy dialogue set out the following objectives:

- To discuss the vision and priority areas of action for Health Services Transformation in the specific context of the countries in the South East European Health Network;
- To obtain inspiration from international experts with experience in leading specific health system reforms in Europe;
- To understand practical steps that countries can take to build capacity in Public Health systems and support continued progress in transforming health services delivery;
- To generate priority options for mobilizing local, national and regional stakeholders around specific reforms;
- To discuss the support required by, and from, the countries within the South East European Health Network to accelerate the scale and pace of these reform.

Messages from the policy dialogue:

- The Policy Dialogue proved to be useful as a learning exercise about the concepts in framing public health interventions and management of change.
- There was fruitful exchange of practices in the participating countries and there is already existing evidence of examples of good practice in implementation of public health interventions.
- The model of earmarking taxes from tobacco for intervention purposes was well received and a design for the introduction of such a policy was proposed for Bosnia and Herzegovina.
- Concrete models of a developed set up for public health interventions were presented from several of the participating countries
- There is room for improvement on a better understanding of Kotter's steps when designing the transformational change
- Although inherent in the concept of modern public health, more efforts will be needed in strengthening intersectoral collaboration, especially on the implementation side of the transformational process

## **1. Background and Context**

This policy dialogue on health system transformation was the third in a series of events delivered in the scope of the project “Developing and Advancing Modern and Sustainable Public Health Strategies, Capacities and Services to Improve Population Health in Bosnia and Herzegovina (BIH)”, which has been developed and financially supported in partnership between the Swiss Government and the World Health Organization (WHO), and implemented by WHO Regional Office for Europe (WHO EURO)/WHO Country Office (CO) in BIH (2013-18). Component 1 of the project is concerned with the organisation and finance of public health services, for which the first conference was organised in 2015 in Sarajevo. In 2016, the second policy dialogue/conference took place in Banja Luka and focused on human resources in public health. The third and final event was intended to address the governance and reform of public health programmes and policies.

## **2. Objectives and Expected Outcomes**

Objectives of the policy dialogue were:

- To discuss the vision and priority areas of action for Health Services Transformation in the specific context of the countries in the South East European Health Network;
- To obtain inspiration from international experts with experience in leading specific health system reforms in Europe;
- To understand practical steps that countries can take to build capacity in Public Health systems and support continued progress in transforming health services delivery;
- To generate priority options for mobilising local, national and regional stakeholders around specific reforms;
- To discuss the support required by, and from, the countries within the South East European Health Network to accelerate the scale and pace of these reforms.

Expected outcomes were:

- Inspire public health leaders and build commitment and support for health system reforms in Bosnia-Herzegovina and across South East Europe;
- Identify practical steps for successful implementation of priority reforms in order to transform health and wellbeing;
- Strengthened capacity of public health leaders in SEEHN to implement reforms in their public health systems;
- Increased capacity and capability for transformational change within the SEEHN countries.

### **3. Programme Outline**

The workshop programme (**Annex 1**) was organised in four sessions, as follows:

**Session 1:** Health System Transformation in Europe – from why to how;

**Session 2:** Walking the Talk 1: Towards comprehensive screening and prevention;

**Session 3:** Walking the Talk 2: From tobacco reform to earmarking excise taxes;

**Session 4:** Influencing Policy; Building Your Case for Change; Shifting Investment.

Each session included time for delegates to contextualise presentation content to their country experience. Selected highlights from these discussions are presented in Annex 4.

### **4. Proceedings from the Meeting**

#### **4.1. Opening/Introduction**

The meeting was opened by the Ministry of Health and Social Protection of the Republic of Srpska, Dr Dragan Bogdanić. In the name of the Federal Ministry of Health of Bosnia and Herzegovina and on behalf of the absent minister, Dr Goran Čerkez greeted the meeting. On behalf of the Department of Health and Other Services of the District Brčko, Mr Sabrija Čandić expressed his greetings. Dr Hans Kluge, Director, Health Systems and Public Health from WHO-EURO welcomed all before Dr Victor Olsavszky, Head of WHO CO for BIH, greeted all the participants of the Dialogue, in particular the representatives from the SEEHN and from the Swiss Agency for Development and Cooperation, and expressed gratitude to the hosts and wished everyone a productive meeting.

#### **4.2. Session 1: Health System Transformation in Europe – from why to how**

In the introductory presentation, Dr Hans Kluge, Director, Health Systems and Public Health, from the WHO-EURO spoke of the important challenges and opportunities that lie ahead for the region. Every aspect of change is faced with challenges and, as the heading of Session 1 indicates, once it is agreed why we should introduce changes, we need to find ways of defining how we are going to carry them out.

He explained how the Sustainable Development Goals (SDGs) adopted by the UN include Goal 3 on good health and well-being, which reflects health in a broad context that bridges sectors, institutions and societal borders. SDG 3 includes the objective of Universal Health Coverage (UHC), which is at the core of the agenda of the new WHO Director General, Dr Tedros. For many countries in Europe, in particular in the SEE region, achieving UHC is still a challenge.

Three important events will mark the year 2018 for WHO-EURO:

1. The conference on HSS NCDs in Barcelona in April 2018, which culminates a five-year programme of WHO activities aiming to work with countries to overcome some of the main health system barriers impeding progress on the reduction of pre-mature mortality from NCDs;
2. The 10<sup>th</sup> anniversary of the Tallinn Charter celebrated with a new conference on Health Systems in Tallinn in June 2018 under the banner of Health Systems for Prosperity and Solidarity;
3. The 40<sup>th</sup> anniversary of the Alma-Ata declaration on primary care, where also a celebration event will take place in Almaty in October 2018.

All these events signal the need to be responding to the new challenges, while taking up new opportunities to improve population health and deliver person-centred, coordinated and integrated care.

The aligning of efforts through these three events will serve as the basis for future renewed work on health system strengthening through all three important and inter-related platforms. Dr Kluge reflected that new times bring about new challenges, which are also more complex. He urged us to be aware and to act concerning the health destroying industry, which has a negative impact on health and yields disability and direct and indirect mortality in many countries. SDGs may prove most instrumental in that respect. Another important challenge lies in the lobbying by the pharmaceutical and medical technology industries. While we need to recognise the important technological advances, we should be ready to tackle the widespread overuse of medicines and medical technologies. It is important to present this important challenge to politicians and stress that a careful balance is needed between increasing access to medicines and medical technologies and ensuring that their use is grounded in sound health technology assessments.

Dr Kluge went on to present some important examples of the scope and scale of the different reform processes in several European countries. Firstly, he highlighted the successful primary health care reform in Greece, which took place in the dire situation of the deep economic and social crisis in the country. This was an excellent example of a guiding coalition of actors who took forward a positive vision for change, instead of retreating into the negative framework of the austerity packages.

There were short term wins in reducing length of stay in hospitals through the urgent action plan in Turkey and another example of a quick win in Cyprus.

Going westwards, we can see service transformation in both England and Belgium, where in both countries the focus is on strengthening primary care and developing strategies to address the growing problem of health determinants and the resulting NCDs.

It is important, if not essential, that there is intrinsic motivation for reform within the MoH, such as the case of Kyrgyzstan that is currently in the midst of developing its fourth health sector strategy, with a strong emphasis on disease prevention and health promotion.

He concluded by stressing his key messages that successful change requires strong and persistent energy, the ability to mobilise and motivate people and distributed leadership, while establishing common values, which result in a higher level of trust, which is essential to any change or reform process. He invited delegates to read more about system transformation in

the reports of two WHO Europe meetings. (link to one of the reports, while the second is forthcoming: <http://www.euro.who.int/en/health-topics/Health-systems/health-services-delivery/publications/2016/health-system-transformation-making-it-happen-2016> )

The next speaker in this introductory session was Dr Anne Hendry from the International Centre for Integrated Care in Scotland, UK. She outlined the definitions and illustrated several frameworks for transformational change and large-scale change. These are summarised in a document on health system transformation provided for delegates in hardcopy.

As health systems are dynamic and complex adaptive ecosystems, their transformation involves multiple organisations and care providers. The main shared goals are improvements in the efficiency of health care delivery, the quality of patient care and population-level health outcomes. There are no magic bullets and there is a need for coordinated efforts across civic society, the whole of government and the whole health and care system.

Dr Hendry advised that each system needs to adopt a common framework for change, regardless of context, setting or geography. She cited *Kotter's eight steps* as a simple and useful example (Source: Kotter J (1996), *Leading Change*, Boston: Harvard Business School Press).

1. *Establish a sense of urgency*
2. *Pull together a 'powerful, guiding coalition'*
3. *Create a compelling vision*
4. *Communicate the vision*
5. *Empower and enable people to act*
6. *Plan and create short term wins*
7. *Don't let up*
8. *Make change stick*

The critical first steps are understanding the national and local context and readiness for change and creating a sense of urgency. Policy leaders have to create a compelling vision and a narrative about a better future. Relationships need to be nurtured, with time and attention given to understanding cultures and changing behaviours. Creative, flexible and resilient system leaders need to be cultivated at all levels in order to create supporting environments and networks that inspire and empower people to lead change and to shift power and control. There needs to be realistic conversations regarding the values and outcomes that matter to people and involvement of citizens and those using health services in order to co-design future systems and models of care. Both pace and resilience are needed but this does not preclude the need to evaluate and adapt as you implement changes.

Dr Hendry presented the case of Public Service Reform in Scotland, where the change process was based on a 3-step improvement framework: Creating a vision; Engaging and enabling the organisation; Implementing and sustaining local change. She shared other examples of successful system transformation across the globe: in Kinzigtal (Germany), the Basque Region (Spain), and Canterbury (New Zealand). She concluded that common to all are system

leadership; disruptive innovation; involvement, inclusion and co-production; continuous improvement, and a relentless focus on the outcomes that matter to people.

**Table Exercise 2** - Participants described an example of successful change in their country and used Kotter's 8 steps framework to explore what worked well.

### **4.3. Session 2: Walking the Talk 1: Towards comprehensive screening and prevention**

The introductory presentation in Session 2 was given by Dr Tit Albreht who spoke about the development of the prevention programmes in Slovenia. At the beginning, he described the historical development of preventative programmes in Slovenia, which were initially focusing on children and women of childbearing age but were gradually extended to include prevention of NCDs. This approach was strengthened after 2000, when the first comprehensive screening programme was launched by the MoH and the NIPH. It was the screening programme focusing on the early detection of risk factors for cardiovascular diseases, which got the priority, based on the gap identification and analysis of problems that triggered the need to develop new responses. As 1980s and 1990s were marked by the steep rise of NCDs, in particular of CVDs, it was essential to address from different levels and perspectives. From the public health point of view, lifestyles were not addressed sufficiently, especially not comprehensively by then. As a result, the MoH, with the collaboration and support by the NIPH, launched the National Programme for Early Detection of Risk Factors for CVDs. It started in 2002/2003 and it was developed jointly by both the GPs and the public health professionals. Dr Albreht went on to describe the main characteristics of the programme. Baseline assessment of CVD risk for men at 35 and for women at 40 years includes family history, BMI, blood pressure, blood cholesterol (HDL, LDL), triglycerides and blood glucose. If values are normal and the assessment of other risk factors is favourable, invited persons are called back every 5 years. Patients who show increased levels on any number of values, start with treatment and are referred to health promoting workshops at the primary health centres. Persons, who are not diagnosed with a disease yet but have risk factors in their current lifestyles, are referred to the health promoting workshops as well. The latter are a clear link between primary care and public health. The setting of the workshops is in primary care but the intervention is a public health one and the educators, registered nurses who are heads of health promoting and educational centres, received training by public health professionals. He then explained the key elements of each of the workshops organised along the individual health determinants. They have recently been upgraded with workshops addressing mental health, especially depression, anxiety and excessive alcohol consumption.

The main elements of these workshops are:

1. Intervention on lifestyle for persons at risk of developing NCDs and sick individuals tiered to their needs
2. Voluntary involvement and inclusion in workshop but on advice and recommendation of the GP or model practice nurse
3. Achieving reinforcement of effects through linking treatment and lifestyle modification

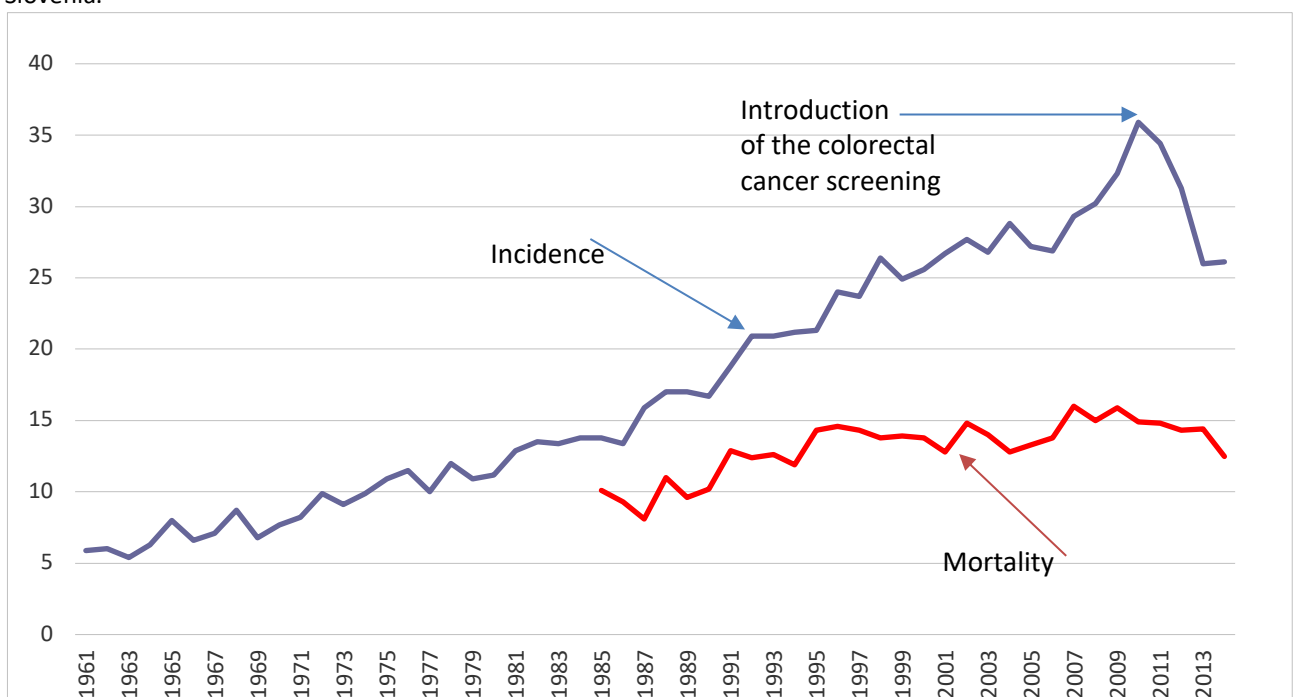


- Historic experience shows that generic advice on lifestyle modification is not enough, but organisation of person- or group-centred workshops shows much better outcomes in assisting the necessary lifestyle change in patients with NCDs.

Dr Albreht then described the development and the successes of the three cancer screening programmes in Slovenia, where greatest achievements can be seen in colorectal cancer screening with the most pronounced drop in the incidence rates.

At the end of his presentation, Dr Albreht spoke of the future development of the Health Educating Centres in primary care through their transformation into Health Promoting Centres with broader objectives and links to the local community, also through the implementation of a life-course approach.

Figure 1. Trends in colorectal cancer incidence and mortality, Slovenia, 1961-2014. Source: Cancer Registry of Slovenia.



**Table Exercise 3** - delegates discussed and contextualized the learning for their country.

What lessons may be transferable? Who are the key actors for a greater focus on prevention?

#### 4.4. Session 3: Walking the Talk 2: From tobacco reform to earmarking excise taxes

The introductory presentation to this session was delivered by Dr Vesna-Kerstin Petrič from the Public Health Directorate, at the MoH of Slovenia. She presented a case study on the implementation of a range of interventions in tobacco control, leading to a reform where earmarking of excise taxes was one of the important outcomes.

Initially, she presented the burden of disease caused by tobacco in Slovenia and the resulting costs to society because of smoking-related diseases, which reach 5% of GDP or 1.8 billion EUR

per year. The new National Health Plan, which is the main long-term planning and strategic document for health in Slovenia, included the goal of reducing the prevalence of smoking down to 15% in 2025. In order to reach that goal, the approach taken through the existing measures would not be sufficient. Consequently, the MoH decided to transpose the Directive 2014/40/EU and to adopt the following additional measures:

- introduction of earmarked tax on the sales of cigarettes and roll-your-own tobacco and the creation of a tobacco fund
- plain packaging for cigarettes and roll-your-own tobacco
- total advertising ban including point of sale displays
- licensing system for retailers
- ban on cross-border distance sales
- ban on the depiction of smoking or tobacco products on TV, with the exception of films
- ban on smoking in cars in the presence of minors
- the same scheme applies to electronic cigarettes (except for the earmarked tax and plain packaging)

Dr Petrič outlined the process of preparing the new law and the associated public consultation, where a total of 96 different proposals were received. They ranged from those supporting the proposed measures and even asking for their strengthening through to proposals to drop several of the key new measures or to significantly soften their impact. All major tobacco companies and chambers of commerce – domestic and mixed, including the American Chamber of Commerce and the Slovenian-German Chamber of Commerce - were against the key measures proposed. The biggest challenges therefore remained:

- opposition regarding plain packaging: the importance of a whole government approach
- establishing the licensing system including the IT support
- tobacco fund or adjusting the excise duty on tobacco products

It became clear that the MoH, in order to be successful, would need to address the inter-sectoral collaboration. The main challenges were in:

- Ministry of Finance opposing the earmarking, tobacco fund and plain packaging
- Ministry of Economy opposing earmarking, tobacco fund, plain packaging and the licensing system
- Ministry of Public Administration hesitant to cooperate regarding licensing
- Inter-sectoral lobbying by the tobacco industry

The MoH also notified the European Commission of the intention to introduce plain packaging and received comments both from the EC and some member states. This process led to a 3-month delay.

The ambitious plan to introduce a tobacco fund was eventually rejected by the MoF, but they consented to the allocation of 4 million EUR to public health NGOs in order to ensure their capacity building, financing of programmes and assuring employments. NGOs were essential in building up public pressure in favour of the new law as they spoke with one voice and managed to publicly disclose conflicts of interest of one of the key opponents of the proposed measures. The coalition of partners (NGOs, MoH, NIPH and WHO CO) with the help of the media and creative individuals managed to secure broad public support averaging two thirds of the population in favour of the proposed law.

One of the cornerstones of the future activities is on the further development of Health Promoting Centres in primary care, as presented by Dr Albrecht, where all smokers, regardless of their risk for developing NCDs and determined to go for smoking cessation will be referred counselling and workshops.

The second presentation in this session was by Dr Jean Tesche, WHO Advisor, who introduced the principles of tobacco tax earmarking and shared some country examples. This topic was covered more fully in the next session.

#### **4.5. Session 4: Influencing Policy; Building Your Case for Change; Shifting Investment**

In this session, Dr Jean Tesche outlined how to build the case for tobacco tax earmarking and support proposals for investing revenues from tobacco taxes in health. In the long-term, the reduction in the number of smokers leads to reduced public expenditures in health care from tackling the consequences of smoking. She stressed that that the earmarked tobacco taxes can take the form of an earmarked fraction of the overall tax on tobacco, or there can be a special additional tobacco tax, which is then earmarked for a specific purpose. Obviously, in the short-term tobacco tax earmarking and specific allocation of resources needs to compete with other governmental priorities and preferences.

Dr Tesche outlined the arguments in favour of earmarking as follows:

- People are more supportive of tax increases, which are used for targeted social programmes
- Earmarking helps guarantee funding for under-resourced programmes, such as health
- It can lead to better health outcomes
- Accountability can also be increased through a closer connection between tax and expenditure
- For the same reason efficiency of public expenditure may also be increased
- It can help raise awareness about the costs of a particular programme or service

Dr. Tesche then outlined the arguments most frequently raised against earmarking, including:

- Earmarking introduces more rigidity in the budgetary process – the earmarked funds become unavailable for use on more urgent priorities, should any arise. This is

especially the case if the main budget of the MoH is reduced to offset the additional allocation of funds through earmarking

- There may be waste of resources if the recipient institution and/or programme does not carefully plan
- It is pro-cyclical, which means that in the times of prosperity there will be booms, but, similarly, there may be sharp declines in the times of crises
- It may lead to fragmentation of programmes and lack of integration of health policy in other sectors
- Eventually, it will shrink as consumption of the product in question goes down

The arguments for and against earmarking are expanded on in the WHO 2016 report (*Earmarked tobacco taxes: lessons learnt from nine countries. World Health Organization 2016, Geneva, Switzerland*).

She continued by proposing three approaches to taxing tobacco:

- Levying a fixed sum per quantity of tobacco product (e.g. €10 per 1000 cigarettes in Romania)
- Levying a per cent of the price (retail, ex-factory or import prices)
- Taxing a base other than the price, such as the production costs of tobacco products (Botswana)

Beyond taxation, an additional mechanism that can be used to raise revenue that could be earmarked for health purposes was to introduce new fees or increase existing fees. In practice, this means that introduction or an increase in tobacco taxes are meant to raise revenues available for tobacco control. Such an additional revenue can include all or a part of incremental revenues. An extra levy or charge can be added as a lump sum, per weight unit or number of cigarettes. Another option is to introduce license fees, which can be paid at any or all levels of the supply chain. It is important to stress that the process of licensing is consistent with the WHO FCTC Illicit Trade Protocol and will assist in limiting illicit trade.

There are two types of earmarks, where the hard earmarks, where they have a legal setting provided and are often the main source of funding for an entire service or provision or, alternatively, a soft earmark, where earmarks do not have a legal backing and are recommended and as a consequence, this source is then used to fund educational or health promoting programmes or is even dedicated to non-health purposes.

Earmark taxes have been used for a number of different purposes, such as:

- Tobacco control
- Universal Health Coverage (UHC)
- Health insurance of certain vulnerable categories
- NCD control
- Health system infrastructure

- Other public health programmes

There have been other uses beyond health, such as providing alternative livelihoods for persons whose income depended on growing tobacco.

Earmarked taxes must be properly managed. The agencies that manage these funds vary in the level of independence from the government - from strongly integrated into the MoH structure to quite independent and self-managed. The specific solutions depend on the traditions and on the feasibility of the specific solution in the context of a given country.

Dr Tesche then presented a few cases from different countries. She started with Australia, where as early as in 1987 the government of Victoria established a Victoria Health Promotion Foundation for the management of these specially collected taxes. Later, the responsibility for such a solution moved from the state to the national level.

In Thailand, ThaiHealth, a national health promoting agency was established for the management of around 2% surcharge on tobacco products collected at the national level. Nowadays, they spend around 100 million USD annually for different health promoting activities.

In California, tax increases generated around 2.4 billion USD between 1989 and 2008 in additional funding for health promoting activities and led to a decline in lung cancer incidence that was four times that of the US average and in a reduction in health care spending by a cumulative 134 billion USD in the same period. They. Finally, Costa Rica directed in 2012 all of the tax increase into health promoting activities, which amounted to around 140 million USD annually. These funds went to: treatment and prevention of smoking-related diseases, health promotion, research on the prevention and cessation of alcohol and drug dependence and promotion of physical activity.

The final message is that additional money for health collected through earmarking of taxes is extremely important and valuable. It is best done if it is a part of an increase in or introduction of an excise or other tax. The process may be hard, but it is clear that upon the successful introduction, benefits for the system may be multiple. It is important that there is:

1. Careful planning of the process and strong leadership and dedication from those who champion the issue.
2. The proposal must be evidence-based and thorough.
3. Policy opportunities should be used to gain political support and develop strong partnerships
4. However, it is equally important that the funds are used efficiently and with strong sense of accountability.

**Table Exercise 4** - Delegates designed their theory of change or logic model to illustrate the required actors, stakeholders, inputs, outputs and outcomes, and shared these to identify common themes and any evidence, research or support gaps

Example of a proposed logic model from Bosnia and Herzegovina

Inputs		Outputs		Outcomes – for people, populations, services, and system		
People & Resources	Activities	Reach	Short Term	Medium Term	Long Term	
<i>Who and what we need and will invest</i>	<i>What we will do</i>	<i>Who we will reach in the process</i>	<i>Initial Changes</i>	<i>Mid-term Changes</i>	<i>Outcomes achieved</i>	
PRO Stakeholders: <ul style="list-style-type: none"> <li>MoHSD, FMOH, FMOF</li> <li>Health insurance Funds</li> <li>Government</li> <li>Parliament</li> <li>Public Health Institutes</li> <li>Academic institutions</li> <li>Patient associations</li> <li>Health Institutions</li> <li>“Role models”</li> <li>Media</li> <li>NGOs</li> <li>WHO, WB; European Union</li> </ul>	<ol style="list-style-type: none"> <li>Involvement of decisionmakers</li> <li>Scientific support</li> <li>Evidence for prevention programmes</li> <li>Good practice</li> <li>Transfer of experience</li> <li>Breaking of myths related to the CONTRA groups:               <ol style="list-style-type: none"> <li>Reduction in contributions to the budget</li> <li>Pricing policies</li> <li>Increased smuggling</li> </ol> </li> </ol>	<ul style="list-style-type: none"> <li>Decisions to be taken on:               <ul style="list-style-type: none"> <li>Hard approach: legislation</li> <li>Soft approach: strategy</li> </ul> </li> <li>Proposal for priorities:               <ul style="list-style-type: none"> <li>Health promotion</li> <li>Preventative programmes</li> </ul> </li> <li>Reporting</li> <li>Monitoring</li> </ul>	<ol style="list-style-type: none"> <li>Raising awareness of the population</li> <li>Distribution/allocation in line with priorities</li> <li>Completed programmes</li> <li>Definition of indicators evaluation               <ul style="list-style-type: none"> <li>Reporting</li> <li>Monitoring</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>Changes in health behaviour</li> <li>Use of health services</li> <li>Evaluation of indicators (e.g. morbidity and mortality)</li> <li>Reduced tobacco consumption having an impact on NCD incidence and prevalence               <ul style="list-style-type: none"> <li>Reporting</li> <li>Monitoring</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>Stable mechanisms of financing for health promotion</li> <li>Maintaining of trends of NCDs -&gt; decrease in incidence and mortality</li> <li>Monitoring of indicators               <ul style="list-style-type: none"> <li>Reporting</li> <li>Monitoring</li> </ul> </li> </ol>	
CONTRA Stakeholders: <ul style="list-style-type: none"> <li>Tobacco industry</li> <li>Front groups:</li> <li>Hospitality sector</li> <li>Employment Associations</li> <li>Media</li> </ul>						

International collaboration and networking established alongside the entire process

#### **4.6. Impressions from ‘keynote listeners’ and important points from table discussions**

In the fore last session, Nicolae Jelamschi, Chair of the SEEHN Executive Committee, and Ruxanda Glavan, WHO Expert Observer, were asked to share their reflections on the proceedings of the day. The following themes merged.

We should always ask ‘Why does change face resistance?’ The answer(s) to this question will help us in designing our actions and next steps. Kotter’s eight steps, which we discussed in the workshop exercises is an important tool, which can guide us through the process of designing, planning and implementing a change.

Some of the themes that were reflected in the table discussions include:

##### **Communication**

Communicating the need and the objectives of change is essential and a pre-condition for the successful initiation of the process. It is important to listen to the concerns expressed but also to present the improvements that might lead to positive changes, especially in areas where those affected might not immediately see it. Communication also needs to be continuous and not limited only to the initial phase. Enhancing the messages of the positive changes helps in motivating hesitant colleagues.

##### **Multi-sectoral coalition and political support**

As most issues in public health affect and involve different sectors of the society, it is extremely important to have them in the process from the beginning. As multi-sectoral approaches and agreement across the entire government may be crucial to success, support from the MoH as well as from the broader political spectrum is extremely important. The organisation of cross-sectoral coalitions needs to be carefully planned and adequately steered.

When proposing to earmark tobacco taxes, it is important to actively involve all the respective ministries, especially the Ministry of Finance, the Ministry of Economy, the Ministry of Commerce and the Ministry of Agriculture (the latter if there is domestic production of tobacco in the country).

There is an absolute need to diversify the sources of financing for different interventions. While public health is a state function and the core financing needs to stem from the main budget line, it is important to involve other sources of funding, raised from other contributions, such as earmark taxes on harmful products. It is also important to keep in mind that a broad spectrum of actors and stakeholders enable health, and that tax revenues can be used to channel funding towards actors that are typically underfunded such as NGOs.

##### **Implementation Framework**

There is a need to have a clear strategy and implementation framework for the change to allow appropriate action and to mobilise all those who need to be involved. This should include a risk assessment and actions to mitigate risks. There is a need for good connections between

public health and primary/hospital care as only harmonised and concerted action will result in positive outcomes, where all partners and stakeholders feel included in the process. One of the essential elements is definition of the desired outcomes to be achieved. Planning for outcomes should include a clear timeline, sufficient resources and outcome indicators that are both measurable and able to be evaluated from the qualitative aspects.

### **Investing in the Workforce**

Many countries in the region have been faced with emigration of their public health staff. Thus, it is important to make best use of this scarce resource and to streamline public health activities and priorities in such a way that they add value and lead to optimal outcomes. There is also the need to recognise and remunerate adequately the contribution of all who have been involved in facilitating change.

Without additional funding to secure additional capacity and possibly also additional staff, an ambitious plan for change might be at risk.

### **Learning together**

This policy dialogue and conference underline the need to analyse successes of other countries in different domains and transfer knowledge to own country or to other countries in the same region. We usually follow and build on strategies that have proven to be successful in other cases and in other countries but it is equally important to take into account strategies that do not work in order to avoid making the same mistakes.

A very common mistake that needs to be avoided is also the lack of assessment on implementation. It is the implementation, which will be perceived by the general public as the critical measure of success, not the preparatory work in the setup of the intervention or of the public health programme. Hence, we need to have a clear plan on how to assess and with which indicators the implementation phase of the intervention or of a programme.

SEEHN could contribute examples. Since countries in the region share a lot of the historical, organisational, cultural and conceptual background, the examples could be much more instrumental for future activities on health promotion, disease burden reduction and addressing health determinants through a multi-sectoral or whole-of-government approach.

## **5. Closing Remarks**

In closing the conference, Dr Kluge stressed the importance of such dialogue events. He said that previous experience shows that we often chain ourselves to the floor by lack of ambition and vision, believing that things are not possible or feasible. Therefore, it is very important to connect the why, the how and the who. There is no need for superhumans or exceptional strengths or talents but it is important to accumulate energy and to build internal resilience against emerging risks or challenges.

Since the last economic and financial crisis, it has become essential to forecast and adapt to these challenges that may not be so unpredictable as we had thought decades ago. Instead, it



has become more and more evident that they are cyclical and, especially those related to the demographic and epidemiologic transitions, also highly predictable challenges.

It is essential to keep the door open to new ideas, solutions, experiences and approaches. Such an open mental space can provide a better starting point for innovation and inclusion in addressing domestic challenges using international experience and good practices.

The last economic crisis has shown that in crisis people turn to public services because these are the only stable element, and one that does not randomly follow income and profit logic. Our public health services must provide stability, predictability and equity for the forthcoming and foreseeable future. We need to develop the mentality of 'freedom fighters', of those who fight for a world free of disease and free of suffering.

At the end of the policy dialogue, Dr Victor Olszavsky once again thanked the hosts, the Minister and the Ministry of Health and Social Development of the Republic of Srpska, all the delegates and the Swiss Agency for Development and Cooperation for the support and participation in the carrying out of the event.

# Annex 1 – WORKSHOP PROGRAMME

## Day 1 – Tuesday, 14 November 2017

09.30 – 09.00 Registration

09.00 – 09.30 **Welcome and Opening Remarks**

- Health authorities in Bosnia and Herzegovina
- Swiss Embassy in Bosnia and Herzegovina
- SEEHN
- WHO Europe

Objectives and Outline for the Policy Dialogue and introduction of participants

09.30 – 10.45 **Health System Transformation in Europe – from why to how**

Dr Hans Kluge, Director, Health Systems and Public Health, WHO Europe

Anne Hendry, International Centre for Integrated Care, Scotland, UK

- *Overview of the international evidence*
- *Exploring the expectations, experience and expertise in SEEHN countries*

10.45 – 11.15

*Refreshment break*

11.15 – 12.30

**Walking the Talk 1: Towards comprehensive screening and prevention**

Tit Albreht, Institute of Public Health, Slovenia

- *Facilitated group discussions to contextualize the learning for countries*
- *Report back on readiness, priorities, ideas for action and areas for support*

12.30 – 13.30

*Lunch*

13.30 – 14.45

**Walking the Talk 2: From tobacco reform to earmarking excise taxes**

Vesna Kerstin Petric, Ministry of Health, Slovenia and Jean Tesche, WHO

- *Facilitated group discussions to contextualise the learning*
- *Report back on readiness, priorities, ideas for action and areas for support*

14.45 – 15.15

*Refreshment break*

15.15 – 16.30

**Influencing Policy; Building Your Case for Change; Shifting Investment**

Anne Hendry and Jean Tesche

- *Action planning at tables*

16.30 –17.00 **Transforming Together: next steps to further transformational change in the region**

Nicolae Jelamschi, Chair of the SEEHN Executive Committee

Ruxanda Glavan, WHO Expert Observer

- Plenary discussion

17.00 –17.30 **Closing remarks**

## Annex 2 – LIST OF PARTICIPANTS

	<b>Name</b>	<b>Position / Institution</b>
1.	Goran Cerkez	Assistant Minister, Ministry of Health of the Federation of Bosnia and Herzegovina
2.	Ljiljana Pavlovic	Assistant Minister, Ministry of Health of the Federation of Bosnia and Herzegovina
3.	Dragan Bogdanic	Minister, Ministry of Health and Social Welfare of the Republika Srpska
4.	Amela Lolic	Assistant to the Minister, Ministry of Health and Social Welfare of the Republika Srpska (Project Coordinator)
5.	Miodrag Marjanovic	Director, Public Health Institute of the Republika Srpska
6.	Sabrija Candic	Head of Department of Health and Other Services of the Brcko District BIH
7.	Maja Zaric	Programme Coordinator for Health, Embassy of Switzerland in Bosnia and Herzegovina
8.	Arta Kuli	South-eastern Europe Health Network Technical Consultant
9.	Hans Kluge	Director, Health Systems and Public Health, WHO Regional Office for Europe
10.	Renata Balestero Brunner	WHO Regional Office for Europe
11.	Jean Tesche	WHO HQ Geneva
12.	Anne Hendry	WHO Consultant
13.	Daniel Verman	Ministry of Health, Senior counsellor
14.	Einav Shimron	Deputy Director General for Information and International Relations, Ministry of Health, Israel

15.	Ioana Filip	National Institute of Public Health. Regional Centre of Public Health in Sibiu, Romania
16.	Iurie Pinzaru	National centre of Public Health, Director
17.	Krayer von Krauss Martin Paul	WHO Regional Office for Europe
18.	Marija Palibrk	Public Health Institute, Montenegro
19.	Mira Dašić	Head of South-eastern Europe Health Network
20.	Nicolae Jelamschi	Chair of South-eastern Europe Health Network
21.	Ruxanda Glavan	South-eastern Europe Health Network Observer
22.	Verica Jovanovic	Institute of Public Health of Serbia "Dr Milan Jovanovic Batut", Director
23.	Tit Albreht	National Institute of Public Health of the Republic of Slovenia - NIJZ
24.	Vesna Kerstin Petric	European Observatory on Health Systems and Policies
25.	Natalia Caterinciuc	National centre of Public Health, Republic of Moldova
26.	Victor Olsavszky	Head of WHO Country Office for Bosnia and Herzegovina
27.	Boris Rebac	Project Manager, WHO Country Office for Bosnia and Herzegovina
28.	Mirza Palo	Project Officer, WHO Country Office for Bosnia and Herzegovina
29.	Vlajcic Sanid	Project Assistant, WHO Country Office for Bosnia and Herzegovina
30.	Dubravka Trivic	Administrative Assistant, WHO Country Office for Bosnia and Herzegovina

31.	Damir Lazic	Logistician Assistant, WHO Country Office for Bosnia and Herzegovina
32.	Dalibor Kesic	Interpreter, <i>Oxford prevodi</i>
33.	Gordana Ivancevic	Interpreter, <i>Oxford prevodi</i>

## **Annex 3 – LIST OF DOCUMENTS DISTRIBUTED ON USB STICK**

### **Folders**

#### **- Materials**

1. *Background Reading Transform;*
2. *Evaluation Form Transform;*
3. *Programme Transform;*
4. *Scope & Purpose Transform;*
5. *Session Briefs Speakers and Facilitators Transform.*

#### **- Presentations**

1. *Hans Kluge, Transformation;*
2. *Anne Hendry, Enabling System Transformation;*
3. *Tit Albrecht, Cancer Prevention;*
4. *Vesna-Kerstin Petrič, Tobacco Reform;*
5. *Jean Tesche, Tobacco Earmarking;*
6. *Jean Tesche, Tobacco Earmarking Case Studies.*

## **Annex 4 - Summary of the group exercises**

### Bosnia and Herzegovina

- Broad involvement of people and resources in a number of governmental agencies, state agency for taxation, Ministry of Finance and Parliaments.
- The tobacco industry saw the case of Bosnia and Herzegovina as a potential example for neighbouring countries.
- Especially in the Federation BIH there was a lot of pressure on the authorities to give up on the proposed measures (even if BIH is lagging behind the neighbouring countries in the implementation of measures to limit tobacco use).
- Involvement of governmental institutions was important as means of setting the ground for the forthcoming measures, especially in ensuring the support of the decision makers as well as the modalities of decisions and acts to be adopted.
- In health promotion programmes, it was important to identify target groups and define the most important implementation issues.
- The monitoring and evaluation process is based on the established set of predefined indicators.

### Israel

- Example of a successfully implemented intervention is in the introduction of green and red labels on food indicating healthy (green) or unhealthy (red) choices for consumers. Green labels indicate low content of sugar, transfats and salt, while red labels indicate high content of these. The intervention started about two years ago with initial strong opposition by the food industry.
- Decided and concerted activity in Israel resulted in higher coverage with seasonal flu vaccination.
- A negative example is in delays in diagnostic workup as contributing factor to lower survival. What is of particular importance is that most delays occur in women, which is a different pattern than in many high-income countries where men are those who are delaying the time until diagnosis.

### Montenegro

- Successfully implemented colo-rectal cancer screening programme. A special department for screening programmes was established at the NIPH within the Centre for Non-Communicable Diseases (NCDs). Mobile phone providers supported the campaign by offering free of charge SMSs to the target population directly on their phone.
- As a negative example, there are problems with the mortality statistics, related to the cause of death. Too large a percentage of causes of death still pertains to the group R of ICD-10, which should in principle not be used to select a cause of death at all. Action is needed to educate those doctors who fill in death certificates to improve this.



### Moldova and Serbia

- Their most important proposal was in the development of a tool, which would serve for evaluation and implementation of tobacco control policies.
- Both countries have achieved a substantial improvement of the situation through the adoption of tobacco control policies related to smoking in public places and earmarking excise tax.

### Romania

- The main focus in tobacco control was addressing smoking in youth. The MoH involved the Ministry of Education and Youth in order to enhance other activities and opportunities for a healthy lifestyle in a broader context, not focusing only on smoking.
- The Institute of Pulmonology participated with the development of cessation programmes, which should enhance the objective of reducing the number of smokers, where also the first results of these activities were very promising.
- When designing the proposal of the earmarked tax, which is defined as a levy per quantity of tobacco and not per package, the main objective was to stick to the transparency principles and allow all actors to be fully informed about the objectives of the use of the money collected through this additional tax.
- There was a gap in the continuity of monitoring of the situation but there are plans to address this gap. One of the main obstacles was in the fact that there was no dedicated money for broader public campaigns.

## Annex 5 – PHOTOGRAPHS FROM THE WORKSHOP









## The WHO Regional Office for Europe

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

### Member States

Albania  
Andorra  
Armenia  
Austria  
Azerbaijan  
Belarus  
Belgium  
Bosnia and Herzegovina  
Bulgaria  
Croatia  
Cyprus  
Czechia  
Denmark  
Estonia  
Finland  
France  
Georgia  
Germany  
Greece  
Hungary  
Iceland  
Ireland  
Israel  
Italy  
Kazakhstan  
Kyrgyzstan  
Latvia  
Lithuania  
Luxembourg  
Malta  
Monaco  
Montenegro  
Netherlands  
Norway  
Poland  
Portugal  
Republic of Moldova  
Romania  
Russian Federation  
San Marino  
Serbia  
Slovakia  
Slovenia  
Spain  
Sweden  
Switzerland  
Tajikistan  
The former Yugoslav  
Republic of Macedonia  
Turkey  
Turkmenistan  
Ukraine  
United Kingdom  
Uzbekistan

### World Health Organization Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark

Tel: +45 45 33 70 00 Fax: +45 45 33 70 01

Email: [eucontact@who.int](mailto:eucontact@who.int)

Website: [www.euro.who.int](http://www.euro.who.int)