WORLD HEALTH ORGANIZATION
EUROPE

WHO European Ministerial Conference on Health Systems:

"Health systems, health and wealth"

Tallinn, Estonia, 25–27 June 2008

REPORT

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Introduction

In response to a resolution of the WHO Regional Committee for Europe in 2005 *(1)*, the WHO Regional Office for Europe held the WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth" at the Estonia Concert Hall and National Opera and Ballet Theatre in Tallinn, Estonia, from 25 to 27 June 2008, hosted by the Government of Estonia. Focusing on the dynamic relationship between health systems, health and wealth, the Conference:

1. explored how well-functioning health systems contribute not only to health but also to wealth and economic development (through, for example, workforce development, increased productivity, alleviating the cost of illness and lowering the number of those seeking early retirement);
2. considered the conditions in which good governance ensures that wealth (economic development) leads to improvements in health, and vice versa; and
3. investigated how productive investment in health systems can contribute to both economic development and social welfare.

The Conference venue

Specifically, the objectives of the Conference were:

- to lead to a better understanding of the impact of health systems on people's health and therefore on economic growth in the WHO European Region;
- to take stock of recent evidence on effective strategies to improve the performance of health systems, given the increasing pressures on them to ensure sustainability and solidarity; and
- to culminate in the adoption of a charter on health systems that would provide a strategic framework for strengthening health systems throughout the Region and foster political commitment and action, while recognizing the diversity of the Region's health systems and policy contexts.

Over two-and-a-half days, the participants:

1. explored the philosophy behind the concept of a health system and its dynamic relationship to health and wealth;
2. discussed technical subjects relating to the four functions of health systems *(2)*: service delivery, financing, creation of the health workforce and other inputs, and stewardship/governance; and
3. held political discussions on health systems and then made political commitments to following up the Conference by adopting the Tallinn Charter (Annex 1).

In addition, the Conference programme (Annex 2) included a workshop on using performance assessment to improve health systems and six satellite events, and the Regional Office's Health Evidence Network and the European Observatory on Health Systems and Policies supplied participants with policy briefs and background documents exploring the Conference topics (Annex 3).

Over 500 participants (Annex 4) attended the Conference, including: ministers responsible for health, civil affairs, and finance and economic affairs from 52 of the 53 Member States in the Region, internationally recognized experts on health systems, observers and representatives of international and civil-society organizations and the mass media. The participants elected Ms Maret Maripuu, Minister of Social Affairs of Estonia, as President of the Conference and Professor Tomica Milosavljević, Minister of Health of Serbia, as Vice-President. Video coverage of the whole Conference – along with bulletins, photographs and interviews – is available through the Regional Office web site *(3)*.

Ms Maripuu opened the Conference by welcoming the participants and commending the thorough preparation for the event, which would discuss what sustainable elements were required for the four functions of health systems. The Conference brought together evidence, knowledge and political commitment in an appropriate setting: Estonia, which had seen health reforms lead to a healthier population and then to a better economy.

Dr Marc Danzon, WHO Regional Director for Europe, welcomed the participants, observers and WHO staff from the European Region and beyond, and thanked the Government of Estonia for hosting the Conference. He was certain that it would be a historic event and that the proposed charter would prove to be as influential as policy statements from previous conferences, such as the Declaration of Alma-Ata *(4)* and the Ottawa Charter for Health Promotion *(5)*. The evidence pointed to the Conference's potential to be both a technical and a political watershed in public health. There was a recent but profound understanding that a high-quality health system was essential to sustainable improvements in public health, and recent health crises had showed the need for sustainable, solid health systems to underpin response from countries and at the international level.

Health systems, health and wealth: revisiting conventional thinking

Keynote speeches

Three keynote speakers examined the links between health systems, health and wealth from the international and European viewpoints and in the framework of health as a human right. The fourth examined the need for performance assessment for health systems.

International perspective: health systems based on social goals

Professor Uwe Reinhardt used research evidence to describe how countries all over the world structured their health systems according to different social goals, and how health systems could contribute to well-being. First, most countries built their health systems on a set of social goals, including a distributive ethic, which determined the systems' structure. For example, many European countries and Canada saw health as a pure social good for all and developed rather equitable systems, respectively; the United States saw health as a private good and had a multi-tiered system. Depending on their culture, history and current income distribution, different countries therefore imposed different social ethics on their health systems. Most developed countries expressed these ethics through strict regulation of the financing and health-insurance facet of their systems. Systems based on the ethic of social solidarity intended most or all citizens to get health care on equal terms, and many used social health insurance to finance care and pool risks.

Second, health systems around the world varied in their ownership and financing arrangements (Table 1). Systems using any form of social health insurance, including most of those in the WHO European Region, had two major features.

1. Usually under government auspices, they created large risk pools to which individuals or families could shift their financial risk of illness.
2. The individual or family's contribution (premiums or taxes) to that risk pool was based mainly on ability to pay, not on health status (actuarial risk).

Table 1. A taxonomy of health system components

Ownership of providers	Financing and health insurance				
	Social insurance (ability-to-pay financing)		Private insurance (actuarially set financing)		No health insurance
	Single payer	Multiple carriers	Non-profit-making	Profit-making	Out of pocket
Government	A	D	G	J	M
Private, but non-profit-making	B	E	H	K	N
Private, and commercial	C	F	I	L	O

If the government regulated the finance and insurance functions of the health system to achieve the desired distributive ethic, the health service delivery and purchasing functions could be private and entrepreneurial. In contrast, systems using private health insurance, such as that in the United States, based their premiums on the health status of the insured and made health financing entrepreneurial, which violated social solidarity and carried huge administrative costs.

Finally, health systems could move from providing health care to promoting well-being by widening their scope to address the wide range of interrelated social, environmental and personal factors that, along with care, produced well-being. Research in 22 countries *(6)* had shown variation across Europe in the magnitude of inequalities in health associated with socioeconomic status. These inequalities might be reduced by improving educational opportunities, income distribution, health-related behaviour or access

to health care. For example, a good health system would reach into the education system to promote healthy lifestyles. Performance measurement was essential to a good health system; a new profession – health care accountants – and adequate resources were needed to ensure accountability.

European perspective: synergy between health, wealth and health systems

Professor Martin McKee described the reciprocal relationships between health systems, health and wealth. Since the WHO Conference on European Health Care Reforms in 1996 *(7)*, consensus had been reached in the WHO European Region on the need to base reforms on evidence, and the focus on cost-containment and financing had given way to a new paradigm in which countries pursued both health and wealth in synergy, through such means as careful investment in health systems. As symbolized in the logo of the WHO European Ministerial Conference on Health Systems, health, wealth and health systems had mutually reinforcing relationships that pointed the way forward for Europe. The challenge for all was to create the conditions in which policies would bring the three together to create a virtuous cycle.

Wealth was well known to contribute to health: richer people and countries had longer life expectancy. On the other hand, health contributed to wealth in several ways. For example, the European Observatory on Health Systems and Policies *(8)* had shown that, in western countries, people in good health were more productive. Better health was associated with investment in education or savings in high-, middle- and low-income countries. Further, projections showed that failure to reduce adult mortality acted as a brake to economic growth, and failure to tackle health inequalities in western countries exacted substantial economic costs.

Health and health systems also had a reciprocal relationship. Research showed that modern health systems had contributed to important reductions in avoidable mortality. The eastern part of the Region had real problems here, although Estonia's success in reducing deaths and disability from stroke through modern primary care both showed what could be done and indicated the impact of better health on health systems. As to the latter, the Wanless report *(9)* from the United Kingdom had shown that a fully engaged scenario – in which prevention and effective early treatment received priority – would substantially reduce future costs to the health system. Contrary to some arguments, extending life would not on its own increase future costs; the driving factor was not age but proximity to death.

As to health systems and wealth, richer countries could afford better health care systems. On the other hand, some countries recognized that health systems could contribute to wealth: for example, by attracting investment to regional development programmes.

Human rights approach as both goal and means of strengthening health systems

Ms Mary Robinson argued that work for human rights and work to strengthen health systems were mutually supportive. The human rights to health and equity in health were both the basis for and the goal of strengthening health systems, and a human rights approach supplied both the principles and tools for this task. The proposed Tallinn Charter was grounded in Member States' commitment to the human right to health, as expressed in both the WHO Constitution *(10)* and its Eleventh General Programme of Work *(11)*.

A robust health system was essential to realizing all people's right to health. It would help to improve health outcomes and to reduce the massive inequities between and within countries, including the growing east–west health gradient in the European Region.

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Keynote speakers

In addition, a human rights approach could bolster efforts to strengthen health systems by empowering individuals and communities, promoting equitable solutions and providing a framework for monitoring and accountability. It required not only that high-quality health services be available to and accessible by all but that action be taken to address the economic, social and political inequality behind ill health. Further, this approach provided a system for monitoring the reduction of health-related inequities through mechanisms that included international human rights treaty bodies and national human rights institutions, and required the development of indicators to measure progress.

The evidence showed examples from around the world of how a human rights approach contributed to an effective, integrated and accessible health system. The GAVI Alliance had worked towards improving vaccination coverage in Georgia by strengthening its health system. Working for transparency and access to information had improved the allocation of national and district budgets in Indonesia. The participation and engagement of a network on nongovernmental organizations had enabled the network to contribute evidence to improve the allocation of resources for the socially excluded in Tanzania's health sector. While these successes had the potential to strengthen health systems and make them more responsive, they could be further supported by reflecting a gender perspective and ensuring participation and access to information for all individuals and communities.

Health systems performance assessment

Professor Peter Smith explained that the rationale for assessing health system performance was to inform the policy debate by identifying what differences in disease, treatment and outcome an otherwise identical citizen would experience in different health systems. The domains of performance measurement therefore included individual health outcomes, clinical quality and appropriateness, population health, responsiveness, financial protection, equity and productivity.

The comprehensive approach to measurement of health system performance, as exemplified in *The world health report 2000 (12)*, entailed adopting a whole system perspective and summarizing a huge volume

of information. It posed many methodological challenges, but captured the attention of policy-makers. A fragmentary approach – such as the information on quality indicators collected by the Organisation for Economic Co-operation and Development (OECD) or the European Commission's Health Benefits and Service Costs in Europe (HealthBASKET) project – undoubtedly offered useful information, too, but gave rise to problems with securing accurate and uniform measurements.

Performance assessment could result in policy interventions in a number of fields. One country had recently taken steps to include patient-reported outcome measures in its official information system; another was conducting a trial to compare the effects of public reporting of hospital performance against private reporting, with a control group of hospitals providing no reports. A contract between the national government and general practitioners offered an example of an intervention designed to offer incentives for good-quality performance: some 20% of practitioners' income was determined by their performance, with considerable reliance on self-reporting (verified by external audit). Another type of intervention aimed to promote improvements in professional practice through the use of quality registers: a comparison and evaluation of outcome and quality information over time and between providers.

Governments had a number of stewardship responsibilities in the area of performance measurement. For example, they would need to develop a clear conceptual framework, mandate data collection mechanisms, carry out quality assurance procedures, design incentives for acting on performance measures and, not least, evaluate performance measurement instruments, notably in terms of cost–effectiveness. Without performance assessment, it was impossible to identify good and bad practitioners and delivery practice, to offer protection to patients and payers, or ultimately to make the case for investing in health care.

Perspectives from Member States: ministerial panel 1

The ministerial panel brought together ministers responsible for health and for finance from Albania, Belgium, Estonia, Iceland, Israel, Moldova and Slovakia.[1] The finance ministers were convinced by the keynote speakers that countries should invest more in health systems. Although ageing populations would not necessarily lead to rising costs, it would be important to cut superfluous expenditure and channel resources in a purposeful way towards where they could be used most efficiently. Depending on their circumstances, countries might focus on improving their health system infrastructure, preventing disease, promoting healthy lifestyles or adopting a mix of approaches.

To initiate and foster intersectoral cooperation, health ministries would need to demonstrate the economic benefits of policies on health and health systems. Measures to reduce the number of road traffic accidents involving children, for instance, would prevent a significant waste of economic potential. Conversely, social interventions such as incentives for people to prolong their working lives could have favourable health effects in terms of increased life expectancy. The scope of public health was so extensive that it had to be approached in a systematic, integrated manner, through partnerships with sectors such as agriculture and education and with the full involvement of citizens in setting priorities.

As to resource allocation, governments should consciously decide where in the value chain it would be best to invest, to maximize returns. There were good reasons, however, to adopt a balanced and empirical approach to expenditure. In countries with poor education facilities, for instance, it might be appropriate to give priority to channelling resources towards education.

[1] Annex 2 lists the names of all the ministers participating in and chairing the six panels.

Solidarity was recognized as a value espoused by most European health systems and given effect, in many cases, by schemes for universal coverage. People's realization that the government actively supported vulnerable and weak groups strengthened their confidence in health policy. Expecting patients to be the countervailing force to provider-induced demand for health care was unrealistic; that was part of the government's stewardship function, as was responsibility for assessing the progress being made by the health system.

The Tallinn Charter: Health Systems for Health and Wealth

The leaders of the Charter Drafting Group described the aims, content and development of the proposed Tallinn Charter: Health Systems for Health and Wealth.

Dr Fiona Adshead, Chair of the Drafting Group, said that Member States and partners had developed the Charter:

- to place health systems high on the political agenda and contribute to policy dialogue in the WHO European Region;
- to provide guidance on prioritizing actions; and
- to give a focus for strengthening WHO's support to countries.

More specifically, it was expected to be a statement of the values and principles underlying health system development and the contribution of health to social well-being; to convey a common understanding of health systems and what they sought to achieve; to embody explicit commitments by countries to improve the performance of their health systems; and to offer the public and the media a tangible product conveying the core messages of the Conference.

The Charter accordingly explored the relationship between health systems, health and wealth, set out the values and principles of health systems, and expressed the key commitment to move from values to action. It also defined the boundaries of health systems and described their various inputs and functions in service delivery, financing, resource generation and stewardship. The key messages of the Charter were that:

- health systems involved more than health care, as effective health systems promoted both health and wealth;
- investment in health was an investment in future human development; and
- well-functioning health systems were essential for any society to improve health and attain health equity.

Dr Ainura Ibraimova, co-Chair of the Drafting Group, described the structure of the Charter. It began with a preamble explaining the need for such a statement, defining a health system and setting out the values and principles espoused by the signatories. The next section expressed the commitments being made by Member States, WHO and partner organizations. The remainder set out ways of strengthening health systems in their four functional areas.

Dr Leen Meulenbergs, co-Chair of the Drafting Group, noted that representatives of 26 Member States and a number of partner organizations had taken part in drawing up the Charter. The Drafting Group had met in Gastein, Austria (October 2007), Valencia, Spain (February 2008) and Moscow, Russian Federation (May

2008), and successive drafts had been considered at subsequent pre-Conference meetings of Member States and partners in Bled, Slovenia (November 2007), Rome, Italy (April 2008) and Brussels, Belgium (June 2008). There was broad agreement that the final draft offered a good overview and a strong vision for the future.

Perspectives from Member States: ministerial panel 2

Ministers responsible for health and civil affairs in Armenia, Bosnia and Herzegovina, Bulgaria, Serbia and the former Yugoslav Republic of Macedonia warmly endorsed the Tallinn Charter, as did a participant speaking on behalf of the South-eastern Europe (SEE) Health Network *(13)*, which covered nine countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Moldova, Montenegro, Romania, Serbia and the former Yugoslav Republic of Macedonia.

Participation in the drafting of the Charter had led to positive change in Serbia and the former Yugoslav Republic of Macedonia, and both the process and the Charter's principles had supported countries' efforts to strengthen their health systems. This included, for example, improvements in monitoring in Armenia, legislation in Bosnia and Herzegovina, the effectiveness, accessibility and efficiency of care in Bulgaria, cardiology care in Serbia and investment in the health sector and intersectoral cooperation in the former Yugoslav Republic of Macedonia. In addition, the SEE Health Network, which worked for strong health systems to promote political stability, was replacing vertical programmes with a whole-system approach.

Further, once adopted, the Charter would assist countries' current and future work. By showing that investment in health was an investment in economic development, it would:

- draw all ministers together in a team working with the health minister, and promote intersectoral work for health;
- identify stronger health systems as the key to better health, and help to focus government attention on non-health-care determinants of health;
- promote the monitoring and performance measurement needed to ensure accountability; and
- help to secure political support for strong health systems in countries and the European Region as a whole.

At the Conference and in the Charter itself, a range of partners – WHO, the World Bank, the European Investment Bank, the United Nations Children's Fund, the International Organization for Migration, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Council of Europe and the European Commission – committed themselves to implementing the Charter.

Health systems: technical aspects

Keynote speech

Professor Sir Michael Marmot, Chair of the WHO Commission on Social Determinants of Health *(14)*, analysed the interplay between these determinants and health systems. The significant health inequalities between and within countries were well known: life expectancy for men in some eastern countries in the WHO European Region was 20 years less than in some western countries, while infant

mortality rates showed even larger differences. Survival and disability rates for people between the ages of 45–49 and 70–74 years also revealed marked geographical variations, resulting in cohorts of missing men (those who had died prematurely) in eastern countries. The evident differences in health status (for example, life expectancy and mortality ratios) within countries were attributable to a number of social determinants, including levels in the occupational hierarchy (as shown by the Whitehall study in England *(15)*, for instance) and educational levels. Despite improvements in many absolute rates, inequalities were increasing, and the social gradient in health was seen across the whole of society. Targeting only the poorest 10% of the population would not be a solution, since it would mean missing most of the health problems.

The conceptual framework adopted by the Commission on Social Determinants of Health therefore started by looking at the distribution of health and well-being within a society and considering how they were affected by biological factors, people's material circumstances and behaviour, psychosocial factors, social cohesion and, of course, the health system. Those elements were themselves linked to an individual's social position, education, occupation, income, gender and ethnicity/race, which in turn were set in a socioeconomic and political context made up of cultural and societal norms and values, macroeonomic, social and health policy, and the overall framework of governance.

There were no good biological reasons for health inequalities: they depended on how people organized their affairs in society. Inequalities in health that were avoidable were inequitable. Tackling health inequities was primarily a matter of social justice, although there were also sound economic arguments for doing so; when health was regarded as both a capital good and a consumption good, the combined costs of health inequalities in European countries amounted to some 11% of gross domestic product (GDP). A fairer distribution of health would lead to increased societal well-being; indeed, population health and health equity were good measures of a country's performance in economic and social development.

The Commission advocated action on:

- the conditions in which people were born, grew, lived, worked and aged;
- the structural drivers of those conditions at the global, national and local levels; and
- monitoring, training and research.

Such action needed to be taken in not only all sectors (health in all policies) but also all countries. The effects of structural drivers and living conditions were in turn mediated by the degree of people's empowerment and participation or voice, both of which affected the attainment of health equity as a development outcome.

Examples of intersectoral linkages for health and health equity included measures to promote early child development and education, healthy environments, fair employment, social protection and universal health care. More broadly, the notion of health equity would need to be incorporated in all policies, to ensure gender equity, market responsibility and fair financing, and to secure political empowerment and good global governance.

Given the implications of trade and trade agreements for global health and health equity, high-income countries in the WHO European Region clearly had an important role to play in debt relief and overseas development assistance. The overall aim of the Commission on Social Determinants of Health was to achieve a world that took social justice seriously.

Perspectives from Member States: ministerial panel 3

Ministers and other officials concerned with health from France, Finland, Kazakhstan, Latvia, the Netherlands and Portugal strongly endorsed the speech and welcomed the forthcoming report of the Commission on Social Determinants of Health. They acknowledged the growing health inequities in the European Region, and described particular problems in their countries and the action taken to respond. Although their circumstances and resources differed, they used similar methods to pursue the same goal: equity in health.

Differences in life expectancy between socioeconomic groups were important indicators of inequity in Finland and the Netherlands. Concern focused on lifestyle factors (smoking, alcohol and nutrition-related issues) in Finland and Latvia and on ensuring access to services by vulnerable groups: the poor in Finland and Latvia, isolated rural populations in Kazakhstan, neighbourhoods pooling a range of adverse factors in the Netherlands and immigrants in Portugal.

Finland and Portugal had pursued the issue at the international level, through their European Union (EU) presidencies, focusing on health in all policies and determinants of health, respectively. At home, these countries also had intersectoral structures: a government programme for health promotion in Finland and a survey committee in Portugal in which ministers exchanged information and searched for solutions.

All countries had taken a range of action against inequities in health. Finland had an action plan, focusing on poverty, young people's health, tobacco, alcohol and access to services. With help from WHO and the World Bank, Kazakhstan's health budget for 2009–2010 would pursue increased efficiency in the health system and equal access to services; a government plan focused on tackling social determinants of health and reducing mortality and diseases such as cancer and AIDS, and legislation had been passed on nutrition, the environment and lifestyles. Similarly, Latvia had banned smoking in public places and the sale of sugary drinks and salty snacks in schools, and started a needle exchange programme for intravenous drug users. In addition to passing a law to ensure equal access to services, Portugal had created mobile units to take services to immigrants, and targeted inequities affecting this group in its 2009–2010 health plan.

In response, Professor Sir Michael Marmot noted that countries were already taking the next step: starting to find solutions. The Commission's report should assist by making recommendations that stakeholders would interpret and apply as they could. In this work, the health sector should convince the finance ministry to take and play a role in ethical decision-making.

The four functions of health systems: parallel sessions

Dr Josep Figueras, Coordinator, European Observatory on Health Systems and Policies – WHO European Centre on Health Policy, WHO Regional Office for Europe, reported on the four sets of parallel sessions held on the functions of health systems *(2)*: service delivery, resource creation, financing and stewardship (see Annex 2). All shared a number of common themes:

- the need to adopt a whole system approach and align incentives and strategies;
- the importance of involving stakeholders, consumers and patients;
- leadership factors and the political dimension;
- adaptation to diversity of contexts; and
- the requirement to build in performance assessment and continuous adjustment and regulation of any measures taken.

Summary of discussions in parallel sessions

In the parallel sessions considering service delivery, participants agreed that its main thrust was the need to improve performance by strengthening primary care. Thirty years after the Declaration of Alma-Ata *(4)*, the Health for All values and principles behind primary health care were still valid, but strategies might need to be rethought or updated. A range of organizational models could be used (family medicine, privatization, etc.), but maintaining the mutual strengthening of regulation, financing and delivery was important. In that context, vertical programmes (such as those for control of HIV/AIDS or tuberculosis) would need to be integrated into primary care services. While integration was agreed to increase cost–effectiveness, due consideration would need to be paid to the features of the underlying disease or risk factor, the characteristics of the health system (such as organizational capacity and sustainability) and the political economy (donor pressure). In view of the increased burden of chronic diseases, avoiding health service fragmentation and episodic care was essential. A continuum of effective and high-quality coordinated or integrated care would need to be ensured. While a wide range of service delivery models could be used, they would most likely entail a change of culture among both providers and patients, with increasing adoption of patient self-management, and realignment of training to meet new workforce requirements.

Second, a set of parallel sessions looked in more detail at resource creation, whose aims included improving health systems' performance through optimizing skill mix. This was a highly context-specific area, where long-term planning and commitment were needed. The strategies available included substitution, delegation and task transfer, where e-health technologies could offer support. Close links would need to be maintained with the education sector, and making sure that the health professions were on board would be important. Another aspect of resource creation was the role of innovation and health technology assessment, which needed to be transparent and embedded in, yet distinct from, decision- and policy-making, and where stakeholder involvement and international cooperation were

essential. One session had been devoted to exploring ways of improving access to pharmaceuticals, and their effectiveness and value for money. Measures proposed included strengthening regulatory efforts to ensure quality, promoting appropriate prescription and use of medicines, and encouraging the right type and level of investment in research and development.

The third group of parallel sessions addressed health financing, where the aim was to enhance solidarity through reforms of financing arrangements. Competing insurance schemes and decentralized budgets frequently led to reduced financial protection and limited the scope for redistribution. Similarly, moves from a single-payer scheme to insurance competition were frequently resource intensive, given regulatory requirements. Pro-equity reforms would therefore centralize pooling, as far as possible, introduce risk adjustment mechanisms and emphasize competitive purchasing, rather than risk selection. There were promising signs that financing instruments could be used to improve the quality and efficiency of health care providers' performance, but they would need to be coordinated with delivery strategies.

The parallel sessions on stewardship focused on the health ministry's role, health in all policies and citizens' empowerment. As the steward of stewards, the health ministry should have a clear policy for tackling health inequities, as well as the capacity, skills and organizational architecture to implement it. Building on the progress made since the adoption of the Ljubljana Charter on Reforming Health Care in 1996 *(8)*, its mandate and responsibility would be to row less and steer more. The incorporation of health in all policies, across sectors and health determinants, was an example of the health ministry's broader role of stewardship. Intersectoral tools such as health impact assessment and target setting would be valuable in that connection, as would arguments based on the economics of prevention, and political commitment and leadership. A wide range of strategies was available to empower citizens; they included mechanisms for consultation and representation, choice of insurer and provider, and patient participation in clinical decision-making.

Health systems, health and wealth: a political viewpoint

Keynote speeches

Mr Andrus Ansip, Prime Minister of Estonia, said it was a great honour for his country to host the Conference. The impact of better health on economic performance was one of the key issues being addressed by governments throughout the world.

Demographic changes and an ageing society put enormous pressure on health systems in all European countries: an OECD analysis had shown that financing requirements were expected to rise by an additional 6% of GDP by 2050. European countries' health systems faced greater challenges than in many previous decades. Pressures on public finances called for policy action to strengthen the health system, promote healthy lifestyles and further increase productivity. The Charter that was due to be adopted at the end of the Conference was a high-quality policy document focusing on those challenges. In view of that forecast, governments sought ways to improve health systems' performance and effectiveness and to motivate people to care more about their health.

Estonia offered a good example of a country that had implemented major health care reforms in the previous decade, readjusting most components, from financing to patients' rights and service delivery. Recent surveys had shown that 69% of patients were satisfied with the quality of health services in the country. A stable but balanced financial system, clear and transparent rules, strong participation of the

private sector and activity-based contractual agreements had all led to a high-performing, self-sustaining health system, with effective use of finances and a very low level of corruption.

Nonetheless, there were four main priorities for health policy in the future, in both Estonia and Europe. First, promoting healthy lifestyles and reducing people's risk behaviour were essential. Health status and healthy life expectancy depended greatly on the values prevalent in society, and people had still not become accustomed to thinking about and caring for their health while leading their daily lives. Prompt policy action was therefore needed to improve people's quality of life, prolong their healthy life-span and contribute to higher productivity.

The second priority was to encourage effective and transparent governance, which should lead to sustainable financing without harming the quality and accessibility of health services. That in turn entailed transparency of expenditures and cooperation between the public and private sectors. The redesign of health governance mechanisms in Estonia had started in 1992, to move towards an independent, performance-based system. The principles of broad-based and stable financing had been applied with the introduction of social health insurance, leading to the creation of a single, independent public body – the Health Insurance Fund – in the late 1990s. Those reforms had strengthened the public sector, increased organizational efficiency and, most important, enhanced public accountability.

High-quality primary care and disease prevention were the third priority. Without quality services, it was impossible to find and respond to cases of diseases such as cancer or cardiovascular diseases in their early stages of development. Estonia had introduced a family-medicine-centred primary health care system that performed a gatekeeping function to secondary and tertiary care. Performance-based pay was designed to provide family doctors with the incentives to take more responsibility for diagnostic services and treatment, to ensure continuity of care and to compensate for the financial risks of caring for older people and working in remote areas.

Innovation and active use of computerized health information systems were the fourth priority. Estonia had launched a comprehensive e-health programme in 2005, based on the principle that all information about patients' health should be managed centrally and be available to patients and health professionals on request. That was complemented by technology development and innovation, especially with regard to new pharmaceuticals.

Dr Margaret Chan, WHO Director-General, noted that unprecedented interest was currently being expressed in health systems. Progress towards the health-related Millennium Development Goals *(16)* had stalled in many parts of the world. Despite the availability of powerful interventions, proven strategies for implementation and strong political commitment, little could be achieved without health systems that reached those in greatest need. Progress towards those goals was measured by changes in the health status of poor and marginalized populations, and the ultimate objective of health system reform was to reduce the gaps in health outcomes and raise the overall level of health within populations.

The world had other major concerns: disease trends, especially for chronic conditions, were alarming. Chronic noncommunicable disease frequently required long-term management, and countries were facing a burden from growing numbers of frail elderly people. The complexity of patient care and demands on the health system were growing. The health effects of increases in international travel, trade agreements, urbanization and population ageing were all global in nature. All countries therefore sought ways to manage the added strain on health services, contain costs and secure staff with the appropriate level of skills.

While medicine and science continued to make impressive advances, new vaccines and drugs were nearly always more expensive and ill health was becoming increasingly costly for both economies and individuals. If health systems did not address those problems, the gaps in health outcomes would grow even wider. Health systems would not automatically gravitate towards greater efficiency or greater equity in access; deliberate steps had to be taken.

Health systems had strong political dimensions and faced strong political pressures. Those pressures often led to the construction of expensive, show-case hospitals, while poor communities struggled with rudimentary or non-existent care. Health leaders in all countries wanted to know how to make health systems perform better; they were looking for greater efficiency and seeking fair financing and the right incentives; and they wanted to ensure that medicines were rationally procured, prescribed and used. The frank assessment of successes and failures at the Conference had significance for countries well beyond Europe. The Conference would send a powerful message to the rest of the world: improving health systems' performance was an urgent, high-level priority, even in wealthy countries with excellent levels of health.

It was gratifying to see the value system underpinning the draft Tallinn Charter, as well as the strong commitments it expressed to health promotion, disease prevention, programmes for the integrated management of disease and collaboration with the many other sectors that influenced health. In that connection, Dr Chan commended the European Commission on adopting the health-in-all-policies approach. The Charter was clearly connected and referring to the Declaration of Alma-Ata *(4)*, adopted 30 years before.

The policy briefs and reports that had been compiled to provide evidence about the dynamic links between health systems, health and wealth, enabled WHO to make the case at the Conference for paying serious political attention to the performance of health systems. The evidence also showed how performance assessment could be a tool to improve health systems in targeted ways, and how investment in health systems brought results that could be measured in terms of better health and greater wealth.

In 1994 a WHO evaluation of progress in reorienting health systems had concluded that the exchange of practical experience in overcoming problems was the most important tool for ensuring success. That conclusion remained valid. By stressing the dynamic relationship between health and wealth, the Conference was telling a watching world that work to improve health systems was worthy of high-level political attention.

Mrs Androulla Vassiliou, European Commissioner for Health, agreed that the Tallinn Charter would help raise people's awareness of the importance of health systems. The Commission had recently issued a white paper setting out the European Community's health strategy for 2008–2013 *(17)*, one principle of which was to strengthen integration of health concerns into all policies (health in all policies). That was a good example of the stewardship function advocated in the Tallinn Charter.

In addition, the strategy was based on the shared values of universality, access to good-quality care, equity and solidarity. European health systems faced common challenges, in the forms of demographic changes (population ageing) and the resulting shift in disease patterns (more morbidity from chronic diseases). One of the strategy's objectives was therefore to foster good health in an ageing Europe by promoting health and preventing disease throughout the life-span. Another objective was to support dynamic health systems and new approaches such as e-health, genomics and biotechnologies, while

strengthening patient safety and guarding against the adverse effects of health care. In that context, the Commission intended to propose legislation to facilitate the application of patients' rights in relation to cross-border health care.

The Commission was also concerned about health inequalities and the health workforce. The geographical and social gradient of mortality and morbidity was unacceptable, because it led to a loss of health and undermined social cohesion. The Commission recognized that a broad response was required from many policy sectors; it would launch an initiative to tackle health inequalities in 2009. The aim for the health workforce was to meet the demand for personnel without depriving poor countries of their professionals. The Commission would issue a discussion document or green paper on that subject later in 2008.

Like the Director-General, Mrs Vassiliou emphasized that much could be gained by sharing experience. The Conference and the Tallinn Charter represented significant steps in strengthening cooperation between the two organizations and their respective Member States.

Dr Nata Menabde, Deputy Regional Director, WHO Regional Office for Europe, emphasized that health indicators for the WHO European Region were good overall, but efforts should focus on social groups and countries with particular problems. Child mortality varied enormously between the countries with the lowest and highest rates, while the average for countries in the Commonwealth of Independent States (CIS) was three times that for the EU. Cardiovascular diseases caused more than 50% of all deaths in Europe and, together with deaths from external causes, were the main contributor to the twenty-year difference in life expectancy across the Region. As noted, insufficient health system capacity was a considerable barrier to achieving the health-related Millennium Development Goals *(16)*, in the WHO European Region as elsewhere. The health system's role was evident, for instance, in the finding that, if coverage with key interventions in obstetrics and gynaecology rose to 99%, the number of maternal deaths would fall by 73%.

The Commission on Macroeconomics and Health had elucidated the many links between health and economic development, mediated through elements such as economic policies and institutions, governance, provision of public goods, human capital and technology *(18)*. The positive correlation between wealth and life expectancy had been found to work mainly through the impact of gross national product per head on people's income (especially that of the poor) and on public spending (particularly on health care). The triangular framework of the Conference logo depicted the relationship between health systems, health and wealth, as well as their combined impact on people's well-being. Health systems improved health by reducing the occurrence and duration of illness and complications. Equitable health systems improved the level and distribution of health outcomes. At the same time, health systems contributed to wealth both directly (production of goods and services, capital investment, etc.) and indirectly (higher productivity, lower health care costs); increased wealth resulted in better health systems.

For health systems, the way forward was to revitalize primary health care in the new context, reaffirming principles such as equitable access, community involvement and intersectoral participation. Their remit should be updated to include areas such as (re)emerging diseases, the epidemiological transition, urbanization and demographic changes. They would need to pay attention to the public–private mix in financing and delivery, to take account of population and provider mobility and of patients' expectations and preferences, and to apply advances in medical and information technology.

Countries and WHO should maintain the specific responses produced in the area of non-personal services, including the adoption of public health bills and reports, the implementation of target-setting programmes, the introduction of smoking bans and, notably, the application of health impact assessment. This was expressed in the Framework Convention on Tobacco Control *(19)*, the European Charter on Counteracting Obesity *(20)*, etc.

Health system functions were interconnected, so improving their performance demanded coordinated action on multiple functions. One important stewardship task for governments was to ensure better measurement of health systems' performance and its assessment in terms of attainment, performance and potential. Here, too, a number of initiatives had already been taken in countries, including benchmarking, inspection and audit, quality assurance, setting of national standards and public release of comparative information. The ultimate aim of all these efforts was to ensure that people were happier, produced more and lived longer, and that societies developed in a better way.

Perspectives from Member States

Ministerial panel 4

Ministers and officials from health ministries in Croatia, the Czech Republic, Germany, Ireland, Luxembourg, Malta, Monaco and Turkey used examples from their experience to address questions arising from the Conference discussions, and considered how to implement the Tallinn Charter, once it was adopted.

In making health policy and reforming their health systems, countries found that basing action on evidence and ensuring or negotiating stakeholders' commitment to proposed changes were particularly effective. Both instruments were critical to Ireland's success in extending life expectancy and improving cancer care. Partnership with stakeholders was crucial to Croatia's health and other reforms, the plans for reform being made in the Czech Republic (along with legislation) and the negotiation of reforms such as hospital rationalization in Turkey. Key partners included not only non-health sectors (particularly finance and labour) but also service providers and patients. Along with evidence from WHO, that gained from the use of key performance targets and indicators was key to reforming hospital management and clinical performance in Malta, making money follow performance, and could be used Region-wide.

As solidarity was a basic value, countries worked to ensure equitable access to care, which was essential to achieving the human right to health. Monaco pursued universal access by ensuring financing to provide essential hospital services and technology; it provided protection for vulnerable groups and was examining the role of the private sector, trying to link costs to patients' ability to pay. Luxembourg ensured health insurance coverage for 98% of the population, cooperation between levels and providers of care, and, like Germany, linked health insurance with other support for elderly people. Like other small countries, Luxembourg pursued access to and high-quality and efficient care by sending patients abroad for specialized services and concentrating some services within the country. Intelligent investment to ensure equitable service distribution was part of Germany's efforts to ensure the sustainability of its health system, along with robust financing and an emphasis on prevention.

Using the example of tobacco control, countries such as Germany, Ireland and Malta had found that a preventive approach offered a range of benefits. Stakeholders bought into measures such as bans on smoking in public places when they were promoted as preventing illness. Education programmes

reinforced laws or bans. In addition, stressing the long-term economic benefits of preventing tobacco-related harm had ensured stakeholder buy-in to measures with immediate economic costs, such as tobacco price increases. Croatia had annual comprehensive preventive programmes to raise awareness, particularly in the public and schoolchildren, of lifestyle factors such as obesity and alcohol, as well as smoking.

In response, the European Commissioner for Health noted that the combination of prohibition and education would form part of the EU strategy on young people. The WHO Director-General commended the use of strong economic arguments and evidence in the struggle for tobacco control and noted ministers' understanding of health as a political issue and their recognition of patients, parliamentarians and the public as important partners. Politicians were needed to champion health; the way to bring them on board was to provide persuasive evidence of the economic benefits of health, including that gleaned from evaluating health systems' performance. WHO helped countries develop health information systems that could accomplish this task.

WHO organizers and heads of delegations from Member States

Finally, the whole panel called for the implementation of the Tallinn Charter. The preparation process had clarified thinking on health systems in the European Region, and action based on the Charter's principles – transparency, accountability, solidarity, efficiency and support of the whole system to meet people's needs – could serve a range of purposes, including:

- integrating health into all policy-making;
- mobilizing the health sector to take its leadership role in intersectoral work for health; and
- ensuring sustainability and increasing efficiency in health systems.

The Charter would be a common instrument that countries could use for action at the national level and for mutual learning and support, with such partners as WHO and the EU, at the international level. Adopting the Charter would be a real commitment; afterwards, countries would face the challenge of implementation.

Ministerial panel 5

Ministers and officials from health ministries in Austria, Denmark, Greece, Hungary, Kyrgyzstan, Lithuania, Romania, the Russian Federation and Uzbekistan explored the concepts of intersectorality, transparency and accountability, and the value of the Tallinn Charter as a political instrument at the national and international levels.

Introducing the discussion, the Chair of the panel noted that health policy often occupied an ambiguous position: sometimes it formed one of the building blocks of overall government policy, but sometimes (notably in countries of the former Soviet Union) it was subordinate to state policy imposed from above. Nonetheless, panellists agreed that involving other sectors (such as transport and the environment) in planning measures to promote health and prevent disease was essential.

The concept of transparency was readily understood in the context of pharmaceuticals, for instance, where safety, efficacy and cost–benefit analyses were commonly made and published before products were licensed for sale. Reaching agreement on the criteria to be used for measuring health system performance and hence for ensuring transparency, however, was more difficult. The increased use of information technology and modern management practices, when coupled with reforms to hospitals and other components of the health system, would undoubtedly lead to greater transparency for both service providers and users. Patient satisfaction was one important criterion of outcome quality, in which both parties had an interest; better informed and empowered patients, in turn, would lead to more accountability within the system.

One country's recent public sector reform included entrusting municipalities with more comprehensive responsibility for disease prevention, health promotion and public health, and for integrating those areas in education, transport, planning, etc.; consolidating and reducing the number of hospitals at regional level; and strengthening the stewardship and governance roles of the national health administration. Another country had introduced a national health operations centre, to ensure proper coordination and interoperability of medical facilities in remote areas. All those measures would increase transparency and accountability. Transparency had been crystallized in the Tallinn Charter, owing to the involvement of Member States throughout the drafting process. The Charter also embodied other principles that underlay reform efforts in many countries, such as better access to health care, sustainable financing and greater accountability. Furthermore, it was in line with the Paris Declaration on Aid Effectiveness *(21)*, and some countries were seeing increased funding of the health sector as a result. Implementation of the Charter was nonetheless foreseen to be a long and heterogeneous process, with a continuing need for international cooperation.

Ministerial panel 6

Ministers and officials from health ministries in Albania, Azerbaijan, Cyprus, Switzerland and the United Kingdom considered the impact that the Tallinn Charter might have on future work in their countries. For many, the Charter was being adopted at just the right time: they were either starting to discuss health system reforms in their national parliaments, in the process of acceding to membership of the European Union and would incorporate its principles into their revised national legislation, or expanding the health ministry's stewardship role. Others would build on the joint participation in the Conference of representatives of ministries of health and of finance to forge closer day-to-day working links. More generally, the panellists appreciated the evidence that had been compiled for the Conference (policy briefs, background documents, etc.), the political commitment expressed in the Charter and participants' opportunity to learn from each others' experience.

One panellist pointed out that economic development formed the foundation of better health, since it allowed for the necessary investment in infrastructure and services, and that the health sector could not develop at a much faster pace than the other factors on which it depended. Increased financing, for instance, would be of little use if it exceeded the health system's absorption capacity. Others reiterated, however, that while financial viability was important, social solidarity and equity were values that had imbued health system development in the WHO European Region since the Declaration of Alma-Ata *(4)*.

Adopting the Charter also challenged countries' health ministries to develop common indicators to measure the impact of health system reforms, especially health outcomes in the poorest sections of the population. When combined with advocacy for health in other areas, this would ensure that health ministries really played their role as stewards of health, not just personal health services.

Contributions from partners

Representatives of six partner organizations expressed the partners' commitment to the Tallinn Charter, which they had helped to develop, and described how their activities, including work with WHO and one another, supported the Charter's principles and objectives. The representatives were: Dr Armin H. Fidler (World Bank), Mr Philippe Maystadt (European Investment Bank), Professor Michel Kazatchkine (Global Fund to Fight AIDS, Tuberculosis and Malaria), Mr Aart De Geus (OECD), Dr Piotr Mierzewski (Council of Europe) and Ms Shahnaz Kianian-Firouzgar (United Nations Children's Fund (UNICEF) Regional Office for Central and Eastern Europe and the Commonwealth of Independent States).

To move towards healthier societies, the World Bank would work with all stakeholders in the economy to strengthen health systems and achieve measurable positive health outcomes. Countries' investment in health, if focused on the right priorities, always paid off. Healthy populations were more productive, and the health sector and related industries contributed to employment, economic growth and prosperity in many countries. Stronger health systems were therefore essential to achieving better health. To pursue this result, the World Bank had launched a new global health strategy, whose objectives were reflected in the Charter, and recognized, as did the Charter, the need for: health in all policies (led by the health sector), evidence as the root of policy and rigorous monitoring and evaluation. The World Bank was committed to partnerships with member countries, WHO and the other international organizations represented at the Conference. All these needed to work together for stronger health systems as the key to achieving health and wealth.

Similarly, the European Investment Bank (EIB) tried to contribute significantly to generating health and wealth by supporting the development and maintenance of effective, efficient and sustainable health systems. EIB invested in human capital; the Conference had shown economic evidence that better health led to greater productivity in countries at all stages of development. Since 1997, EIB had invested in strengthening health systems in most EU Member States and some of their neighbours, including Serbia. Through funding facilities addressing different geographical areas, it offered technical assistance to support investment projects in, for example, Mediterranean countries such as Morocco, new EU Member States such as Estonia and western Balkan countries such as the former Yugoslav Republic of Macedonia. EIB would use lessons learned at the Conference in updating its lending strategy for health; to follow up, perhaps the European Commission (EC) and EIB, with WHO, could develop a funding facility to support health projects. The Conference and the Tallinn Charter would raise the profile of health as an essential and productive investment.

Participants

The Global Fund to Fight AIDS, Tuberculosis and Malaria supported the Charter as part of its commitment to building sustainable health systems and more equitable access to care. This complemented its commitment to tackling the three communicable diseases. About 35% of the Global Fund's resources was spent on strengthening health systems: on human resources for health, infrastructure and monitoring and evaluation. The efforts of partners such as WHO, the World Bank, UNICEF, the EC and countries (including Germany, Norway and the United Kingdom) were essential to this task and to ensuring equitable access to care. Towards the latter end, the Global Fund was starting to invest in strengthening community systems, health insurance and social protection schemes. The Global Fund welcomed the Charter, which would provide a framework that countries throughout the European Region would use to strengthen their health systems; this would help them meet the health-related Millennium Development Goals *(16)*.

In the face of inequities in health, the uneven quality of care and increasing cost pressures on health systems, OECD collected and analysed data on health and health systems, to help countries ensure the provision of high-quality health care to all and the efficiency and financial sustainability of their health systems. OECD would work to develop comparable indicators of socioeconomic inequalities in health and health care for tracking and international benchmarking, and it provided a forum in which policy-makers could discuss the impact of policies to reduce inequalities. This could help countries improve health systems' performance. OECD welcomed partnerships with, for example, WHO to make the economic case for preventing overweight and obesity, the World Bank to assess Turkey's health system and the EC and WHO to achieve global standards for health and accounting and reduce the reporting burden on countries. Through close cooperation with international partners, OECD was ready to help countries address health policy challenges and work for better health and wealth on the basis of two key values: solidarity and excellence.

The Council of Europe believed that health and wealth and human rights constituted a joint agenda, and that the Tallinn Charter provided the best way for the Council and WHO to pursue it. The economic imperative of value for money should be supplemented by an ethical imperative of money for values such as solidarity and equity. The Council of Europe and WHO had a long tradition of fruitful cooperation for these values, including the successful SEE Health Network *(13)*. The Council of Europe was already working to implement the Charter; it shared the Charter's focus on the social determinants of health and health system governance. The Charter was a mechanism to direct health spending wisely; the triangle of medicine, money and morality should contain good governance.

The UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States believed that the Tallinn Charter and other recommendations from the Conference would help Member States to improve their citizens' health and strengthen their health systems to deliver high-quality health services, particularly to the most vulnerable members of society, including children. It supported the Charter's stress on disease prevention and health promotion. UNICEF was already working on a number of related issues in central and eastern Europe and the CIS; this included advocating:

- health systems and budgets that took special account of children and adolescents;
- during health system reforms, the protection of a package of essential services for children and women and the maintenance of well-functioning primary health care interventions such as immunization;
- greater responsiveness of health and social systems to children disadvantaged by the rapid demographic, environmental and epidemiological changes in the region; and
- strong health promotion and public health communication to ensure that individuals, families and communities were correctly informed about the risks and value of interventions such as immunization and HIV/AIDS prevention.

The UNICEF Regional Office had identified the strengthening of health systems as a priority and would work closely with Member States, WHO and all other partners in this important area. The Charter was a strategic framework and guide that needed to be translated into policies, legislation, standards, programmes and interventions that would help realize every child's right to survival, growth, and development.

In response, Dr Nata Menabde, Deputy Regional Director, WHO Regional Office for Europe thanked WHO's partners for their contributions to the preparation of the Charter and welcomed their commitment to the final product. For example, she invited the representative of EIB to the Regional Office to discuss new steps to help countries in the WHO European Region.

Dr Mohamed Abdi Jama, Deputy Regional Director, WHO Regional Office for the Eastern Mediterranean noted the common challenges facing the European and Eastern Mediterranean regions and the well-established cooperation between the regional offices. Other WHO regions could learn much from the Conference and European experience. The concept of and European action to strengthen health systems were innovative and could benefit the whole world. The Conference had presented compelling evidence on the link between health systems, health and wealth, and the health-in-all-policies approach, along with the stewardship role of health ministries, was the most useful contribution to the debate on health systems and work in communities. The WHO Regional Office for the Eastern Mediterranean would take part, with the Regional Office for Europe and other partners, in the next steps in the process.

Signing of the Tallinn Charter

Signing of the Tallinn Charter and closure of the Conference

The Tallinn Charter (Annex 1) was signed by Dr Marc Danzon, WHO Regional Director for Europe and Ms Maret Maripuu, Minister of Social Affairs of Estonia.

In closing the Conference, Ms Maripuu emphasized that the Charter, which she had just signed on behalf of the 53 Member States in WHO's European Region, embodied their shared values of solidarity, equity and participation. Countries now faced the task of implementing it, and she pledged that the government of her country would do all in its power to improve the health of its people.

Dr Marc Danzon, WHO Regional Director for Europe, emphasized once more that people's health had to improve, and that health systems needed to take serious and radical steps. Change was perhaps more difficult to effect in the health sector than in other areas, however, owing to the high proportion of a highly educated human element. The health system had to have the courage to measure its results, to prove to funding bodies that their investment was worth while. In the same way, he intended to measure the impact of the Conference on European countries' health systems, and to publish the results in the interests of transparency.

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Annex 1. The Tallinn Charter: Health Systems for Health and Wealth

Preamble

1. The purpose of this Charter is to commit Member States of the World Health Organization (WHO) in the European Region to improving people's health by strengthening health systems, while acknowledging social, cultural and economic diversity across the Region. The Tallinn Charter reaffirms and adopts the values embodied in earlier charters, conventions and declarations.[1]
2. Within the political and institutional framework of each country, a health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health.
3. All countries in the WHO European Region have to address major health challenges in a context of demographic and epidemiological change, widening socioeconomic disparities, limited resources, technological development and rising expectations.
4. Beyond its intrinsic value, improved health contributes to social well-being through its impact on economic development, competitiveness and productivity. High-performing health systems contribute to economic development and wealth.
5. Therefore we, the Member States and partners, believe[2] that:

- investing in health is investing in human development, social well-being and wealth;
- today, it is unacceptable that people become poor as a result of ill-health;
- health systems are more than health care and include disease prevention, health promotion and efforts to influence other sectors to address health concerns in their policies;
- well-functioning health systems are essential to improving health: strengthened health systems save lives; therefore,
- health systems need to demonstrate good performance.

Commitment to act

6. We, the Member States, commit ourselves to:

- **promote shared values of solidarity, equity and participation** through health policies, resource allocation and other actions, ensuring due attention is paid to the needs of the poor and other vulnerable groups;
- **invest in health systems and foster investment across sectors that influence health**, using evidence on the links between socioeconomic development and health;

[1] The WHO European Ministerial Conference on Health Systems is taking place as we mark the thirtieth anniversary of the Declaration of Alma-Ata on primary health care, whose recommendation that health systems should be centred around citizens, communities and primary health care is as relevant today as it was 30 years ago. The Charter also acknowledges the importance of other charters and declarations on health promotion (1986 Ottawa, 1997 Jakarta, 2005 Bangkok), the 1996 Ljubljana Conference on Reforming Health Care, the 2004 Mexico Statement on Health Research, and the 2005 update of the Health for All policy framework for the WHO European Region. The right to enjoyment of the highest attainable standard of health is also expressly included in the WHO Constitution, the Universal Declaration of Human Rights, the Convention on the Rights of the Child, and the United-Nations-sponsored Millennium Development Goals.

[2] This belief is based on evidence, particularly the background material produced by WHO for the European Ministerial Conference on Health Systems.

- **promote transparency and be accountable** for health system performance to achieve measurable results;
- **make health systems more responsive** to people's needs, preferences and expectations, while recognizing their rights and responsibilities with regard to their own health;
- **engage stakeholders** in policy development and implementation;
- **foster cross-country learning and cooperation** on the design and implementation of health system reforms at national and subnational levels; and
- **ensure that health systems are prepared and able to respond to crises**, and that we collaborate with each other and enforce the International Health Regulations.

7. WHO will support its European Member States in the development of their health systems and will provide cross-country coordination in implementation of the Charter, including the measurement of performance and the exchange of experiences on the above commitments.
8. We, WHO, the World Bank, the United Nations Children's Fund, the International Organization for Migration and the Global Fund to Fight AIDS, Tuberculosis and Malaria, commit ourselves to working with Member States on the implementation of this Charter, in accordance with the provisions of our statutes and mandates, to help improve the performance of health systems. We invite the Council of Europe and the European Commission and related institutions to take the objectives of this Charter into account in developing their activities on health systems. The European Investment Bank will seek to work with Member States and to cooperate with involved institutions, in accordance with and within the limits established by its mandates and statutory provisions, to support the implementation of this Charter. We, the Member States, invite other willing partners to join.

Strengthening health systems: from values to action

9. All the Member States of WHO in the European Region share the common value of the highest attainable standard of health as a fundamental human right; as such, each country shall strive to enhance the performance of its health systems to achieve the goal of improved health on an equitable basis, addressing particular health needs related to gender, age, ethnicity, and income.
10. Each country shall also seek to contribute to social well-being and cohesiveness by ensuring that its health system:

- distributes the burden of funding fairly according to people's ability to pay, so that individuals and families do not become impoverished as a consequence of ill-health or use of health services; and
- is responsive to people's needs and preferences, treating them with dignity and respect when they come in contact with the system.

11. Countries shall pursue these broad performance goals to the greatest extent possible given their means. This requires efficiency: making the best use of available resources.
12. The practical application of these broad goals in each country requires the identification of objectives that are linked to the goals and "actionable" by policy, and that are relevant in the context of the country's sociopolitical priorities and economic and fiscal means. Improving access to high quality health care and enhancing people's knowledge of how to improve their own health are examples relevant to all countries. The objectives should be specified in a measurable way to enable explicit monitoring of progress. This approach orients the design, implementation and assessment of health system reforms.
13. Health systems are diverse, yet share a common set of functions under which can be identified the aims and actions laid out below.

- **Delivering health services** to individuals and to populations
  - Policy-makers throughout the Region value and strive to make possible the provision of

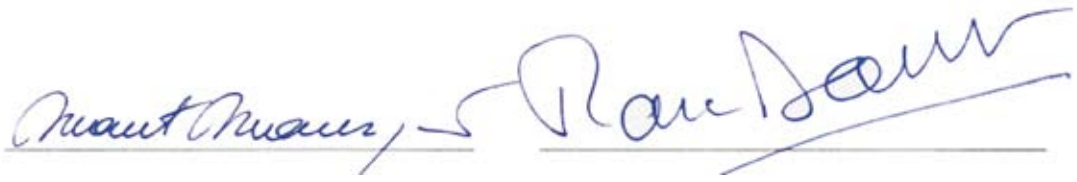
quality services for all, particularly for vulnerable groups, in response to their needs, and to enable people to make healthy lifestyle choices.
  - Patients want access to quality care, and to be assured that providers are relying on the best available evidence that medical science can offer and using the most appropriate technology to ensure improved effectiveness and patient safety.
  - Patients also want to have a relationship with their health care provider based on respect for privacy, dignity and confidentiality.
  - Effective primary health care is essential for promoting these aims, providing a platform for the interface of health services with communities and families, and for intersectoral and interprofessional cooperation and health promotion.
  - Health systems should integrate targeted disease-specific programmes into existing structures and services in order to achieve better and sustainable outcomes.
  - Health systems need to ensure a holistic approach to services, involving health promotion, disease prevention and integrated disease management programmes, as well as coordination among a variety of providers, institutions and settings, irrespective of whether these are in the public or the private sector, and including primary care, acute and extended care facilities and people's homes, among others.
- **Financing the system**
  - There is no single best approach to health financing; distinctions between "models" are blurring as countries develop new mixes of revenue collection, pooling and purchasing arrangements according to their needs, their historical, fiscal and demographic context, and their social priorities and preferences.
  - Financing arrangements should sustain the redistribution of resources to meet health needs, reduce financial barriers to the use of needed services, and protect against the financial risk of using care, in a manner that is fiscally responsible.
  - Financing arrangements should also provide incentives for the efficient organization and delivery of health services, link the allocation of resources to providers on the basis of their performance and the needs of the population, and promote accountability and transparency in the use of funds.
  - The overall allocation of resources should strike an appropriate balance between health care, disease prevention and health promotion to address current and future health needs.
- **Creation of resources**
  - In a rapidly globalizing world, generation of knowledge, infrastructure, technologies, and, above all, human resources with the appropriate skills and competence mix requires long-range planning and investment to respond to changing health care needs and service delivery models.
  - Investment in the health workforce is also critical, as it has implications not only for the investing country but for others due to the mobility of health professionals; the international recruitment of health workers should be guided by ethical considerations and cross-country solidarity, and ensured through a code of practice.[3]
  - Fostering health policy and systems research and making ethical and effective use of innovations in medical technology and pharmaceuticals are relevant for all countries; health technology assessment should be used to support more informed decision-making.

[3] In line with the World Health Assembly's resolution on international migration of health personnel: a challenge for health systems in developing countries (WHA57.19) and with the WHO Regional Committee for Europe's resolution on health workforce policies in the European Region (EUR/RC57/R1).

- **Stewardship**
  - While each Member State has its own way of governing its health system, ministries of health set the vision for health system development and have the mandate and responsibility for legislation, regulation and enforcement of health policies, as well as for gathering intelligence on health and its social, economic and environmental determinants.
  - Health ministries should promote inclusion of health considerations in all policies and advocate their effective implementation across sectors to maximize health gains.
  - Monitoring and evaluation of health system performance and balanced cooperation with stakeholders at all levels of governance are essential to promote transparency and accountability.

14. Health system functions are interconnected; therefore, improving performance demands a coherent approach involving coordinated action on multiple system functions. Experience suggests that action on one single function or programme is unlikely to lead to substantial progress or the desired results.
15. We, the Member States of WHO in the European Region, commit ourselves to using this Charter as a basis to transform our shared values into action and as a milestone to catalyse implementation of the above commitments on strengthening health systems.

Tallinn, Estonia, 27 June 2008



Ms Maret Maripuu
Minister of Social Affairs of Estonia

Dr Marc Danzon
WHO Regional Director for Europe

Annex 2. Programme

Opening of the Conference

Ms Maret Maripuu, Minister of Social Affairs, Estonia

Dr Marc Danzon, WHO Regional Director for Europe

Election of officers

Introduction to the programme

Adoption of the programme

Session 1 – Health systems, health and wealth: revisiting conventional thinking

Chair: Ms Maret Maripuu, Minister of Social Affairs, Estonia

Keynote speeches

Health systems, health and wealth and social well-being: an international perspective
Professor Uwe Reinhardt, James Madison Professor of Political Economy and Professor of Economics, Princeton University, Princeton, New Jersey, United States of America

Health systems, health and wealth: a human rights perspective
Ms Mary Robinson, President, Realizing Rights: the Ethical Globalization Initiative and Co-Chair, Health Worker Global Policy Advisory Council, New York, United States of America

Health systems, health and wealth: a perspective from within the WHO European Region
Professor Martin McKee, Professor of European Public Health, London School of Hygiene and Tropical Medicine, United Kingdom and Head of Research Policy, European Observatory on Health Systems and Policies

Health systems performance assessment
Professor Peter C. Smith, Director, Centre for Health Economics, University of York, United Kingdom

Ministerial Panel 1. Perspectives from Member States: health systems, health and wealth

Professor Avi Israeli, Director-General, Ministry of Health, Israel (Chair)

Mr Sherefedin Shehu, Deputy Minister of Finance, Ministry of Finance, Albania

Dr Dirk Cuypers, President of the Board of Directors, Federal Public Health Service of Food Chain Safety and Environment, Belgium

Mr Ivari Padar, Minister of Finance, Ministry of Finance, Estonia

Mrs Berglind Ásgeirsdóttir, Permanent Secretary, Ministry for Health, Iceland

Dr Larisa Catrinici, Minister of Health, Moldova

Dr Adam Hochel, Director-General, Health Section, Ministry of Health, Slovakia

The Tallinn Charter: Health Systems for Health and Wealth

Presentations

Dr Fiona Adshead, Deputy Chief Medical Officer, Chief Government Advisor on Inequalities, Department of Health, England, United Kingdom (Chair of the Charter Drafting Group)

Dr Ainura Ibraimova, Deputy Minister of Health, Ministry of Health of Kyrgyzstan (Co-Chair of the Charter Drafting Group)

Dr Leen Meulenbergs, Head, International Relations Department, Federal Public Service for Public Health, Food Chain Safety and the Environment, Belgium (Co-Chair of the Charter Drafting Group)

Ministerial Panel 2. Perspectives from Member States

Professor Tomica Milosavljević, Minister of Health, Ministry of Health of Serbia (Chair)

Professor Harutyun Kushkyan, Minister of Health, Armenia

Dr Drazenka Malicbegovic, Assistant Minister, Department for Health, Ministry of Civil Affairs of Bosnia and Herzegovina

Dr Valeri Tzekov, Deputy Minister of Health, Ministry of Health, Bulgaria

Dr Imer Selmani, Minister of Health, the former Yugoslav Republic of Macedonia

Session 2 – Health systems: technical aspects

Keynote speech

Social determinants of health and health systems
Professor Sir Michael Marmot, Director, International Institute for Society and Health and MRC Research Professor, Department of Epidemiology and Public Health, University College London, United Kingdom

Ministerial Panel 3. Perspectives from Member States

Professeur Didier Houssin, Directeur Général de la santé, Ministère de la Santé, de la Jeunesse, des Sports et la Vie associative, France (Chair)

Ms Paula Risikko, Minister of Social Affairs and Health, Ministry of Social Affairs and Health, Finland

Mr Rinalds Mucins, Under-secretary of State for Policy Plan, Ministry of Health, Latvia

Dr Anatoliy G. Dernovoy, Minister of Health, Kazakhstan

Dr Marc J.W. Sprenger, Director-General, National Institute for Public Health and the Environment (RIVM), Netherlands

Professor Maria do Céu Machado, High Commissioner of Health, Ministry of Health, Portugal

Parallel sessions

Stewardship/governance

Chair: Dr Antonio Duran, Adviser, WHO Regional Office for Europe

Exercising health systems stewardship through health in all policies

Empowering the citizen

Strengthening the stewardship role of the ministry of health

Health financing

Chair: Mr Joseph Kutzin, Unit Head, Country Policies, Systems and Services, WHO Regional Office for Europe

Balancing insurance competition with solidarity

Promoting solidarity through centralization of financing

Purchasing to improve performance

Resource creation

Chair: Dr Bernhard Gibis, Head a.i., Health Intelligence Services, WHO Regional Office for Europe

Enhancing performance through innovation: the role of health technology assessment

Ensuring effective and affordable quality pharmaceuticals

Health workforce: seeking the right skills mix for improved performance

Service delivery

Chair: Dr Enis Barış, Director, Division of Country Health Systems, WHO Regional Office for Europe

Enhancing coordination of care for improved quality, patient satisfaction and health outcomes

Integrating vertical programmes into primary care and health systems

Improving performance through primary care

Session 3 – Health systems, health and wealth: a political viewpoint

Chair: Dr Marc Danzon, WHO Regional Director for Europe

Keynote speeches

Mr Andrus Ansip, Prime Minister, Estonia

Dr Margaret Chan, WHO Director-General

Mrs Androulla Vassiliou, European Commissioner for Health

Dr Nata Menabde, Deputy Regional Director, WHO Regional Office for Europe

Ministerial Panel 4. Perspectives from Member States

Ms Mary Harney, Minister for Health and Children, Ireland (Chair)

Dr Ante-Zvonimir Golem, State Secretary, Ministry of Health and Social Welfare, Croatia

Dr Tomás Julínek, Minister of Health, Ministry of Health of the Czech Republic

Dr Klaus Theo Schröder, State Secretary, Federal Ministry of Health, Germany

M. Roger Consbruck, Licencie en sciences hospitalières, Ministère de la Santé, Luxembourg

Dr Joseph Cassar, Parliamentary Secretary for Health, Malta

M. Jean-Jacques Campana, Conseiller, Gouvernement pour les Affaires sociales et de la Santé, Ministère d'Etat, Monaco

Professor Sabahattin Aydın, Deputy Undersecretary, Ministry of Health, Turkey

Ministerial Panel 5. Perspectives from Member States

Professor Ruslan Khalfin, Deputy Minister, Ministry of Health and Social Development, Russian Federation (Chair)

Dr Clemens Martin Auer, Director-General, Federal Ministry of Health, Family and Youth, Austria

Mr Jesper Fisker, Director-General and Chief Medical Officer, National Board of Health, Denmark

Dr Panagiotis Efstathiou, Head, National Health Operation Centre, Ministry of Health and Social Solidarity, Greece

Dr Tamás Székely, Minister of Health, Hungary

Dr Nazgul Tashpaeva, Head, Department of Social Development, Central Administration of Kyrgyzstan

Dr Rimvydas Turcinskas, Minister of Health, Lithuania

Mr Mircea Manuc, Secretary of State, Ministry of Health of Romania

Dr Vasila S. Alimova, Head, Treatment and Prophylactics Department, Ministry of Health, Uzbekistan

Wrap-up and debriefing of parallel sessions: key messages

Dr Josep Figueras, Coordinator, European Observatory on Health Systems and Policies – WHO European Centre on Health Policy, Brussels, WHO Regional Office for Europe

Ministerial Panel 6. Perspectives from Member States

Dr Abbas Soltan Valibayov, Deputy Minister, Ministry of Health, Azerbaijan (Chair)

Ms Zamira Sinoimeri, Deputy Minister of Health, Ministry of Health, Albania

Dr Christos Patsalides, Minister of Health, Ministry of Health, Cyprus

Dr Marija Seljak, Director, Institute of Public Health of the Republic of Slovenia

Professor Thomas Zeltner, Secretary of State, Director, Federal Office of Public Health, Switzerland

Professor David R. Harper, Chief Scientist and Director-General, Health Improvement and Protection Directorate, Department of Health, United Kingdom

Contributions from the partners

Chair: Dr Nata Menabde, Deputy Regional Director, WHO Regional Office for Europe

World Bank – Dr Armin H. Fidler, Lead Health Policy Adviser

European Investment Bank – Mr Philippe Maystadt, President

Global Fund to Fight AIDS, Tuberculosis and Malaria – Professor Michel Kazatchkine, Executive Director

Organisation for Economic Co-operation and Development – Mr Aart De Geus, Deputy Secretary-General

Council of Europe – Dr Piotr Mierzewski, Head, Health Division

United Nations Children's Fund – Ms Shahnaz Kianian-Firouzgar, Deputy Regional Director

Signing of the WHO European Charter on Health Systems: "The Tallinn Charter: Health Systems for Health and Wealth"

Ms Maret Maripuu, Minister of Social Affairs, Estonia

Dr Marc Danzon, WHO Regional Director for Europe

Closure of the Conference

Ms Maret Maripuu, Minister of Social Affairs, Estonia

Dr Marc Danzon, WHO Regional Director for Europe

Pre-Conference event, WHO workshop on performance assessment for health systems improvement

Opening and welcome

Dr Nata Menabde, Deputy Regional Director, WHO Regional Office for Europe

Professor Peter C. Smith, Director, Centre for Health Economics, University of York, United Kingdom

Key international comparisons: how healthy are they?
Professor Niek Klazinga, Department of Social Medicine, Academic Medical Centre, University of Amsterdam, Netherlands

Session 1 – Evidence from recent policy developments

Chair: Dr Enis Barış, Director, Division of Country Health Systems, WHO Regional Office for Europe

Recent developments in performance measurement
Professor Peter C. Smith, Director, Centre for Health Economics, University of York, United Kingdom

Performance measurement and professional improvement
Dr Arnold Epstein, John H. Foster Professor of Health Policy, Chair, Department of Health Policy and Management, Harvard School of Public Health, Boston, United States

Performance incentives
Professor Douglas Conrad, Professor of Health Services and Co-Director, Center for Health Management Research, Department of Health Services, University of Washington, Seattle, United States

Session 2 – Case studies

Chair: Dr Antonio Duran, Adviser, WHO Regional Office for Europe

Sectoral case study: mental illness
Mr David McDaid, Coordinator, Mental Health Economics European Network, and Research Fellow, London School of Economics and Political Science, United Kingdom

Public performance reporting
Dr Paul G. Shekelle, Director, Southern California Evidence-Based Practice Center, Department of Health, RAND Corporation, Santa Monica, United States of America

Performance reporting: Dutch case study
Professor Gert P. Westert, Head, Health Care Performance Report, Centre for Prevention and Health Services Research, National Institute of Public Health and the Environment (RIVM), Bilthoven, Netherlands

Performance information: Italian case study
Dr Fabrizio Carinci, National Expert, National system for verification and control of health assistance (SIVEAS), Directorate-General for Health Planning, Ministry of Health, Pescara, Italy

Concluding remarks

Mr Nick Fahy, Deputy Head, Health Information Unit, Directorate-General for Health and Consumers, European Commission, Brussels, Belgium

Satellite events

Satellite session 1 – Migration of health personnel: ethical considerations

Welcome
Dr Marc Danzon, WHO Regional Director for Europe

Introduction
Dr Bjørn-Inge Larsen, Chief Medical Officer, Director-General, Directorate for Health, Norway (Chair)

Main findings of a recent OECD study
Dr Peter Scherer, Head, Family Medicine Department, Employment Labour and Social Affairs Directorate, OECD

Outlines and development process for a code of practice on the international recruitment
Dr Manuel Dayrit, Director, Department of Human Resources for Health, WHO headquarters

Main findings of an ongoing study on existing codes in Europe
Professor James Buchan, Health Sciences, Queen Margaret University, Edinburgh, United Kingdom

The perspective from countries with critical shortages of health workers
Dr Mubashar Sheikh, Executive Director, Global Health Workforce Alliance

The European Commission perspective
Dr Tapani Piha, Head, Health Law and International Unit, Directorate-General for Health and Consumers, European Commission

Discussion and conclusions
Mr Gérard Schmets, Coordinator, Health Systems Governance, Policy and Aid Effectiveness, WHO headquarters

Satellite session 2 – Public health information systems in Europe. A web-based experience of the EU Public Health Information and Knowledge System (EUPHIX)

Introduction
Professor Dr Hans van Oers, EUPHIX project leader, National Institute for Public Health, Netherlands

Panel Discussion
Ms Eveline van der Wilk, Researcher, National Institute for Public Health and the Environment (RIVN), Netherlands

Ms Monique Kuunders, Researcher, National Institute for Public Health and the Environment (RIVN), Netherlands

Dr Bernard Ledésert, Directeur, Observatoire régional de la santé du Languedoc-Roussillon, France

Satellite session 3 – The European Network for Health Technology Assessment (EUnetHTA). Results and perspectives

Welcome and introduction to EUnetHTA
Professor Finn Børlum Kristensen, Director, Danish Centre for Health Technology Assessment, National Board of Health, Denmark, Project Leader of EUnetHTA (Chair)

Core Health Technology Assessment Model
Dr Kristian Lampe, Senior Medical Officer, Finnish Office for Health Technology Assessment, Finland, Co-Leader of EUnetHTA work package on the core HTA model

Monitoring of new and emerging health technology
Dr François Meyer, Director, Department of Medical and Surgical Procedures Assessment, French National Authority for Health, France

Health technology assessment: Institution and capacity development
Dr Oriol Solà-Morales Serra, Director, Catalan Agency for Health Technology Assessment, Spain, Leader of EUnetHTA work package on institution and capacity development

Satellite session 4 – Presentation of the 2008 edition of the Health Systems in Transition (HiT) profile on Estonia and celebration of the tenth anniversary of the European Observatory on Health Systems and Policies

Welcome and introduction
Dr Nata Menabde, Deputy Regional Director, WHO Regional Office for Europe

Presenting the new HiT country profile on the Estonian health system
Ms Maret Maripuu, Minister of Social Affairs, Estonia

Main findings of the HiT profile for Estonia. An overview.
Dr Jarno Habicht, Head, WHO Country Office, Estonia, WHO Regional Office for Europe

The European Observatory on Health Systems and Policies: 10 years of putting evidence into practice
Dr Josep Figueras, Coordinator, European Observatory on Health Systems and Policies – WHO European Centre for Health Policy, Brussels, WHO Regional Office for Europe

Satellite session 5 – Building capacity in the European Union for a workforce for health

The workforce for health – A European issue
Mr Andrzej Jan Rys, Director, Public Health and Risk Assessment, Directorate-General for Health and Consumers, European Commission

Main findings of a recent OECD study
Dr Peter Scherer, Head, Family Medicine Department, Employment Labour and Social Affairs Directorate, OECD

Organization of working time in the health sector
Ms Madeleine Reid, Directorate-General for Employment and Social Affairs, European Commission

Shared solutions for common problems – European collaboration in health systems research
Dr Jan Paehler, Scientific/Technical Project Officer, Public Health, Directorate-General for Research, European Commission

European research in action: Mobility of health professionals
Dr Caren Weilandt, Deputy Managing Director, Scientific Institute of the German Medical Association (WIAD), Bonn, Germany

Satellite session 6 – Health systems decentralization in the WHO European Region. Regional perspectives

Introduction: the Regions for Health Network
Dr Marianna Pénzes, Chair, Secretariat of the WHO Regions for Health Network, Health Faculty, University of Debrecen, Nyíregyháza, Hungary

Ten theses on regional health and wealth
Professor Rainer Fehr, State Institute of Health and Work North Rhine-Westphalia (LIGA.NRW), Bielefeld, Germany

Annex 3. Core publications

The background documents and policy briefs are available in hard copy from and in electronic form on the web site of the WHO Regional Office for Europe.[4]

Background documents

The economic costs of ill health in the European Region

Performance measurement for health system improvement: experiences, challenges and prospects (summary)

Health systems, health and wealth – Assessing the case for investing in health systems (summary)

Performance measurement for health system improvement: experiences, challenges and prospects (full study – draft for consultation)

Health systems, health and wealth – Assessing the case for investing in health systems (full study – draft for consultation)

Policy briefs

How can European health systems support investment in and the implementation of population health strategies?

How can the impact of health technology assessments be enhanced?

Where are the patients in decision-making about their own care?

How can the settings used to provide care to older people be balanced?

When do vertical (stand-alone) programmes have a place in health systems?

How can chronic disease management programmes operate across care settings and providers?

How can the migration of health service professionals be managed so as to reduce any negative effects on supply?

How can optimal skill mix be effectively implemented and why?

Do lifelong learning and revalidation ensure that physicians are fit to practise?

[4] Conference core publications [web site]. Copenhagen, WHO Regional Office for Europe, 2008 (http://www.euro.who.int/healthsystems/Conference/Documents/20080620_34, accessed 30 June 2008).

Annex 4. Participants

Albania

Mr Saimir Kadiu
Director, Financial Planning, Ministry of Health

Dr Ehad Mersini
Head of Sector, Policy and Health Planning Department, Ministry of Health

Mr Sherefedin Shehu
Deputy Minister of Finance, Ministry of Finance

Ms Zamira Sinoimeri
Deputy Minister of Health, Ministry of Health

Dr Alban Ylli
Director, Institute of Public Health

Andorra

Dr Josep M. Casals Alis
Gouvernement de l'Andorre

Armenia

Professor Ara Babloyan
Chairman, Standing Committee on Social Affairs, Health Care and Environmental Protection, National Assembly

Professor Vladimir Davidyants
Director, National Institute of Health

Dr Naira Davtyan
Chief Specialist, Department of Financial Programming of Expenditures in Social Sphere, Ministry of Finance and Economy

Mr Tigran Kostanyan
Deputy Head, Department of Macro-Economic Policy, Ministry of Finance and Economy

Professor Harutyun Kushkyan
Minister of Health, Ministry of Health

Ms Roza Melkonyan
Assistant to the Minister of Health, Ministry of Health

Dr Gagik Sayadyan
Head of Staff, Ministry of Health

Austria

Dr Clemens Martin Auer
Director-General, Federal Ministry of Health, Family and Youth

Ms Mag. Birgit Bürger
Deputy Head, Cabinet of the Minister, Federal Ministry of Health, Family and Youth

Ms Daniela Klinser
Spokeswoman of the Minister, Federal Ministry of Health, Family and Youth

Ms Alexandra Punzet
Deputy Head of Department, International Health Relations, Federal Ministry of Health, Family and Youth

Azerbaijan

Dr Samir A. Abdullayev
Head, International Relations Department, Ministry of Health

Dr Rauf M. Aghayev
Deputy Head, Personnel, Science and Education, Ministry of Health

Mr Javid Mammadov
Deputy Head, Social Fields Financing Department, Ministry of Finance

Professor Oktay Shiraliyev
Minister of Health, Ministry of Health

Dr Abbas Soltan Valibayov
Deputy Minister, Ministry of Health

Belarus

Dr Igor Vladimirov Brovko
Director, Medical Assistance Organization Department, Ministry of Health

Mr Aleksandr Ostrovsky
Consul General, Consulate General of Belarus in Tallinn

Dr Vasilii Ivanovich Zharko
Minister of Health, Ministry of Health

Belgium

M. Benoît Collin
Administrateur général adjoint, Institut national d'assurance maladie-invalidité (INAMI)

M. Johan De Cock
Administrateur général, Institut national d'assurance maladie-invalidité (INAMI)

Dr Dirk Cuypers
President of the Board of Directors, Federal Public Service of Health, Food Chain Safety and Environment

Mr Pierre C. Dubuisson
Ambassador to Estonia

Dr Pascal Meeus
Service des soins de santé, Direction Recherches, Développement et Promotion de la Qualité, Institut national d'assurance maladie-invalidité (INAMI)

Dr Leen Meulenbergs
Head, International Relations Department, Federal Public Service of Health, Food Chain Safety and Environment

Dr Ri De Ridder
Directeur General, Service des soins de santé, Institut national d'assurance maladie-invalidité (INAMI)

Bosnia and Herzegovina

Dr Marina Bera
Assistant to Minister of Health, Ministry of Health Federation of Bosnia and Herzegovina

Dr Drazenka Malicbegovic
Assistant Minister, Department for Health, Ministry of Civil Affairs of Bosnia and Herzegovina

Bulgaria

Dr Svetlana Spassova
Director, National Health Policy Directorate, Ministry of Health

Dr Valeri Tzekov
Deputy Minister of Health, Ministry of Health

Ms Elena Ugrinova
Senior Expert, European Affairs and International Cooperation Directorate, Ministry of Health

Croatia

Dr Ante-Zvonimir Golem
State Secretary, Ministry of Health and Social Welfare

Mr Kresimir Kopcic
First Secretary, Embassy of the Republic of Croatia

Ms Sibila Zabica
Adviser, Minister's Cabinet, Ministry of Health and Social Welfare

Cyprus

Dr Elisavet Constantinou
Chief Medical Officer, Ministry of Health

Mr Christos Patsalides
Minister of Health, Ministry of Health

Dr Andreas Polynikis
Chief Medical Officer, Ministry of Health

Czech Republic

Dr Lucie Bryndová
Adviser to the Minister, Ministry of Health of the Czech Republic

Dr Pavel Hroboň
Deputy Minister, Ministry of Health of the Czech Republic

Dr Tomás Julínek
Minister of Health, Ministry of Health of the Czech Republic

Ms Lucie Rounova
Translator, Ministry of Health of the Czech Republic

Ms Martina Tothova
Director, Department of International Affairs and the European Union, Ministry of Health of the Czech Republic

Denmark

Mr Jesper Fisker
Director-General and Chief Medical Officer, National Board of Health

Dr Svend Juul Jorgensen
Senior Adviser, National Board of Health

Professor Finn Børlum Kristensen
Director, Danish Centre for Health Technology Assessment (DACEHTA), National Board of Health

Ms Marianne Kristensen
Senior Adviser, National Board of Health

Dr Lone de Neergaard
Head of Department, Division for Health Care Planning, National Board of Health

Estonia

Mr Tõnu Lillelaid
Chief specialist, Ministry of Finance

Ms Maret Maripuu
Minister of Social Affairs, Ministry of Social Affairs (*Conference President*)

Dr Ivi Normet
Deputy Secretary-General on Health, Health Policy, Ministry of Social Affairs

Dr Ülla-Karin Nurm
Head, Public Health Department, Ministry of Social Affairs

Mr Ivari Padar
Minister of Finance, Ministry of Finance

Dr Liis Rooväli
Head of Department, Health Information and Analysis Department, Ministry of Social Affairs

Mr Riho Tapfer
Secretary-General, Ministry of Social Affairs

Finland

Dr Taru Koivisto
Ministerial Adviser, Ministry of Social Affairs and Health

Ms Marja-Liisa Partanen
Deputy Director-General, Ministry of Social Affairs and Health

Ms Paula Risikko
Minister of Social Affairs and Health, Ministry of Social Affairs and Health

Dr Marjukka Vallimies-Patomäki
Ministerial Adviser, Health Department, Ministry of Social Affairs and Health

Ms Maria Waltari
Senior Officer, International Affairs Unit, Ministry of Social Affairs and Health

France

Mme Géraldine Bonnin
Délégation aux affaires européennes et internationales, Ministère de la Santé, de la Jeunesse, des Sports et de la Vie associative

Dr Charles Bruneau
Direction de l'Accréditation et de l'Evaluation des Pratiques Professionnelles, Haute Autorité de santé

Dr Alain Fontaine
Charge de mission, MASPRAS / Direction générale de la santé, Ministère de la Santé, de la Jeunesse, des Sports et de la Vie associative

Professeur Didier Houssin
Directeur Général de la santé, Ministère de la Santé, de la Jeunesse, des Sports et de la Vie associative

Dr Louis Lebrun
Conseiller medical, Direction de l'Hospitalisation et de l'organisation des Soins, Ministère de la Santé, de la Jeunesse, des Sports et de la Vie associative

Georgia

Dr Sofia Lebanidze
Head, Health Department, Ministry of Labour, Health and Social Affairs

Professor Nikoloz Pruidze
Deputy Minister, Ministry of Labour, Health and Social Affairs

Germany

Dr Birgit Cobbers
Strategic Planning of Health Policy, Federal Ministry of Health

Mrs Britta Groeger
Interpreter, Federal Ministry of Health

Ms Dagmar Reitenbach
Head of Division, Multilateral Cooperation in the Field of Health, Federal Ministry of Health

Mr Udo Scholten
Leiter, Unterabteilung Z 3, Europäische und internationale Gesundheitspolitik, Bundesministerium für Gesundheit

Dr Klaus Theo Schröder
State Secretary, Federal Ministry of Health

Dr Josephine Tautz
Desk Officer, Division Medical Issues of Statutory Health Insurance, Disease Management Programmes, Federal Ministry of Health

Greece

Dr Panagiotis Efstathiou
Head, National Health Operation Centre, Ministry of Health and Social Solidarity

Dr Efstratios Geragotis
Special Adviser on European Affairs, General Secretariat, Ministry of Health and Social Solidarity

Ms Marousa Liapi-Manola
General Director for Welfare, Ministry of Health and Social Solidarity

Dr Kalliopi Mantzavinou
Adviser on Mental Health Issues to Secretary-General, Ministry of Health and Social Solidarity

Ms Alexandra Papadia
General Director for Administrative Support, Ministry of Health and Social Solidarity

Ms Filomila Raidou
Director, International Relations Division, Ministry of Health and Social Solidarity

Hungary

Dr Mihály Kökény
Chairman, Health Committee, Hungarian Parliament

Ms Noémi Kondorosi
Counsellor, Department of European and International Affairs, Ministry of Health

Mr B. Alex Lawani
Interpreter, Ministry of Health

Dr Katalin Rapi
Deputy Director-General, National Health Fund Administration

Dr Tamás Székely
Minister of Health, Ministry of Health

Iceland

Mrs Berglind Ásgeirsdóttir
Permanent Secretary, Ministry for Health

Ireland

Ms Catherine Dardis
Personal Assistant to the Minister, Department of Health and Children, Ministry of Health and Children

Dr John Devlin
Deputy Chief Medical Officer, Department of Health and Children, Ministry of Health and Children

Ms Frances Fletcher
Assistant Principal Officer, Research, EU and International, Department of Health and Children, Ministry of Health and Children

Ms Mary Harney
Minister for Health and Children, Ministry of Health and Children

Mr Peter Hogan
Second Secretary, Embassy of Ireland in Estonia

Mr Noel Kilkenny
Ambassador of Ireland to Estonia

Mr Oliver O'Connor
Special Adviser to the Minister, Department of Health and Children, Ministry of Health and Children

Ms Patricia Ryan
Special Adviser to the Minister for Health and Children, Ministry of Health and Children

Mr Darragh Scully
Private Secretary, Office of the Minister, Department of Health and Children, Ministry of Health and Children

Israel

Professor Avi Israeli
Director-General, Ministry of Health

Italy

Dr Laura Arcangeli
National Expert, National system for verification and control of health assistance (SIVEAS), Directorate-General for Health Planning, Ministry of Labour, Health and Social Policy

Dr Fabrizio Carinci
National Expert, National system for verification and control of health assistance (SIVEAS), Directorate-General for Health Planning, Ministry of Labour, Health and Social Policy

Dr Francesco Cicogna
Senior Medical Officer, Directorate-General for EU and International Relations, Ministry of Labour, Health and Social Policy

Dr Gaetano Guglielmi
Senior Medical Officer, Directorate-General for EU and International Relations, Ministry of Labour, Health and Social Policy

Dr Maria Paola Di Martino
Director-General, Directorate-General for EU and International Relations, Ministry of Labour, Health and Social Policy

Kazakhstan

Dr Aykan Akanov
Rector, Kazakh National Medical Academy

Mr Serik Ayaganov
Deputy, Member of the of the Social-Cultural Development Committee, the Senate of Parliament of Republic of Kazakhstan

Dr Anatoliy G. Dernovoy
Minister of Health, Ministry of Health

Ms Salidat Kairbekova
Head of Sector, Department of Social Economic Monitoring, Cabinet of the President of the Republic of Kazakhstan

Professor Alexander Nersessov
Director, Department for Strategic Development and International Cooperation, Ministry of Health

Mr Marat Shoranov
Deputy Director, Organizational and Economic Issues, Scientific Centre of Urology

Kyrgyzstan

Dr Ainura Ibraimova
Deputy Minister of Health, Ministry of Health of Kyrgyzstan

Dr Mederbek Ismailov
Head, Human Resources Policy Unit, Ministry of Health of Kyrgyzstan

Mr Arzybek Kojoshev
Deputy Minister, Ministry of Finance of Kyrgyzstan

Dr Alimjan Koshmuratov
Head, Department of Strategic Planning and Reform, Ministry of Health of Kyrgyzstan

Mr Kiyal B. Mukashev
Head, Social Expenditure Policy Department, Ministry of Finance of Kyrgyzstan

Dr Dinara Saginbaeva
Head, Department for Organization of Medical Care and Licensing, Ministry of Health of Kyrgyzstan

Dr Nazgul Tashpaeva
Head, Department of Social Development, Central Administration of Kyrgyzstan

Latvia

Ms Lūcija Akermane
Director, Health Compulsory Insurance State Agency

Dr Ainārs Čivčs
Director, Department of Public Health, Ministry of Health of Latvia

Dr Viktors Jaksons
Adviser to the State Secretary for International Affairs, Ministry of Health of Latvia

Mr Rinalds Mucins
Under-secretary of State for Policy Plan, Ministry of Health of Latvia

Ms Liga Serna
Deputy Director, Department of European Affairs and International Cooperation, Ministry of Health of Latvia

Lithuania

Ms Rasa Eilunavičienė
Press Attaché, Ministry of Health

Ms Jolanta Iždonienė
Deputy Director, Health Policy and Economy, Ministry of Health

Dr Janina Kumpiene
State Secretary, Ministry of Health

Mr Martynas Pukas
Chief Specialist, Foreign Affairs Division, Ministry of Health

Dr Rimvydas Turcinskas
Minister of Health, Ministry of Health

Luxembourg

M. Roger Consbruck
Licencie en sciences hospitalières, Ministère de la Santé

Malta

Mr Antony Cassar
Director, Programme Implementation Monitoring, Ministry for Social Policy

Dr Joseph Cassar
Parliamentary Secretary for Health

Mr M. Vella Haber
Personal Assistant to Parliamentary Secretary

Dr Ray G. Xerri
Director Special Initiatives, Department for Special Initiatives, Ministry for Social Policy

Moldova

Dr Eugenia Berzan
Head, Foreign Relations, Ministry of Health

Dr Larisa Catrinici
Minister of Health, Ministry of Health

Dr Aurel Grosu
Chair, Expert Advisory Group, Ministry of Health

Dr Cristina Mahu
Head of Department, Regional Collaboration with South-east Europe, Ministry of Foreign Affairs and European Integration

Ms Larisa Rotaru
Department of Human Resources Development and Wage Policies, Ministry of Economy and Trade

Ms Larisa Stucalov
Deputy Director, Department of Human Resources Development, Labour and Wage Policies, Ministry of Economy and Trade

Dr Ghenadie Turcanu
Director, Policies Analysis, Monitoring and Evaluation, Ministry of Health

Monaco

M. Jean-Jacques Campana
Conseiller, Gouvernement pour les Affaires sociales et de la Santé, Ministère d'Etat

Dr Thierry Picco
Directeur General, Département des Affaires sociales et de la Santé, Ministère d'Etat

Montenegro

Mr Ramo Bralic
Director, Health Insurance Fund of Montenegro

Ms Valentina Dragojevic
Interpreter, Ministry of Health, Labour and Social Welfare

Ms Mirjana Kojicic
Assistant Director, Health Insurance Fund of Montenegro

Mrs Smiljka Kotlica
Secretary of the Ministry, Ministry of Health, Labour and Social Welfare

Ms Nina Milovic
Adviser, Ministry of Health, Labour and Social Welfare

Ms Lorena Vlahovic
Public Relations Assistant, Ministry of Health, Labour and Social Welfare

Netherlands

Ms Annemiek van Bolhuis
Director, Nutrition, Health Protection and Prevention, Ministry of Health, Welfare and Sport

Mr Lejo van der Heiden
Project Leader, Prevention, Ministry of Health, Welfare and Sport

Mr Serge Heijnen
Representative, Health System Research Platform, Ministry of Health, Welfare and Sport

Mrs Lenie Kootstra
Director, Department of International Affairs, Ministry of Health, Welfare and Sport

Mr Fred Lafeber
Head, Global Affairs Unit, Department of International Affairs, Ministry of Health, Welfare and Sport

Ms Diana M.J.J. Monissen
Director-General for Curative Care, Ministry of Health, Welfare and Sport

Ms Frieda M. Nicolai
Senior Adviser, Department of International Affairs, Ministry of Health, Welfare and Sport

Dr Marc J.W. Sprenger
Director-General, National Institute for Public Health and the Environment (RIVM)

Professor Gert P. Westert
Head, Health Care Performance Report, National Institute for Public Health and the Environment (RIVM)

Norway

Dr Andreas Disen
Director-General, Department of Primary Health and Care Services, Ministry of Health and Care Services

Dr Bjørn-Inge Larsen
Chief Medical Officer, Director-General, Directorate for Health

Mrs Toril Roscher-Nielsen
Director-General, Division for International Cooperation and Preparedness, Ministry of Health and Care Services

Mr Arne-Petter Sanne
Director, Multilateral Affairs, Secretariat for International Cooperation

Ms Tone Wroldsen
Adviser, Ministry of Health and Care Services

Poland

Dr Adam Fronczak
Undersecretary of State, Ministry of Health

Ms Sylwia Lis
Director, Department of Health Insurance, Ministry of Health

Dr Michal Marek
Counsellor to the Minister, Department of Health Insurance, Ministry of Health

Portugal

Professor José Maria Albuquerque
Deputy High Commissioner of Health, Ministry of Health

Professor Maria do Céu Machado
High Commissioner of Health, Ministry of Health

Dr Paulo Jorge de Morais Zamith Nicola
Medical Advisor, High Commissioner of Health, Ministry of Health

Dr Manuel Teixeira
Ministry of Health

Romania

Mr Mircea Manuc
Secretary of State, Ministry of Health of Romania

Mrs Silvia Olteanu
Health Attaché, Public Health Policies, Romanian Permanent Representation to the EU

Russian Federation

Dr Oleg Chestnov
Deputy Director, Department for International Cooperation and Public Relations, Ministry of Health and Social Development

Professor Ruslan Khalfin
Deputy Minister, Ministry of Health and Social Development

Ms Nadejda Kuleshova
Chief Specialist, Department for International Cooperation and Public Relations, Ministry of Health and Social Development

San Marino

Mr Mauro Chiaruzzi
Minister of Health, Ministry of Health and Social Security, National Insurance and Gender Equality

Dr Fabio Della Balda
Particular Secretary, Ministry of Health and Social Security, National Insurance and Gender Equality

Mr Paolo Pasini
Director-General, Institute for Health Services, Licensing, Accreditation and Health Services Quality Authority

Serbia

Professor Tomica Milosavljević
Minister of Health, Ministry of Health of Serbia (*Conference Vice-President*)

Dr Ivana Misic
Assistant Minister, Sector for Health Care Organization and Health Inspection, Ministry of Health of Serbia

Dr Elizabet Paunovic
Assistant Minister of Health, Sector for EU Integration and International Cooperation, Ministry of Health of Serbia

Slovakia

Dr Klára Frecerová
Director-General, Department of International Relations, Ministry of Health

Dr Adam Hochel
Director-General, Health Section, Ministry of Health

Slovenia

Dr Tit Albreht
Adviser to the Director, Institute of Public Health of the Republic of Slovenia

Dr Vesna-Kerstin Petric
Head, Sector for Health Promotion and Healthy Lifestyles, Ministry of Health of the Republic of Slovenia

Dr Marija Seljak
Director, Institute of Public Health of the Republic of Slovenia

Spain

Dr Alberto Infante Campos
Director-General, National Health System Cohesion, Ministry of Health and Consumer Affairs

Dr Concepcion Colomer-Revuelta
Director, National Health System and Women Observatory, Ministry of Health and Consumer Affairs

Mr José Perez Lazaro
Deputy Director-General, International Relations, Ministry of Health and Consumer Affairs

Dr José Martínez Olmos
General Secretary for Health, Ministry of Health and Consumer Affairs

Sweden

Ms Ingvor Bjugård
Health and Social Care Division, Swedish Association of Local Authorities and Regions

Ms Anna Halén
Deputy Director, Division for EU and International Affairs, Ministry of Health and Social Affairs

Mr Lars-Erik Holm
Director-General, National Board of Health and Welfare

Mr Bosse Pettersson
Senior Advisor and Independent Consultant, Public Health Policy, Swedish National Institute of Public Health

Ms Olivia Wigzell
Deputy Director General, Ministry of Health and Social Affairs

Switzerland

Mrs Delphine Sordat Fornerod
Scientific Collaborator, Division of International Affairs, Federal Office of Public Health

Mr Alexandre von Kessel
Scientific Collaborator, Deputy Head, Division of International Affairs, Federal Office of Public Health

Dr. Gaudenz Silberschmidt
Vice-Director, Head of Division of International Affairs, Federal Office of Public Health

Professor Thomas Zeltner
Secretary of State, Director, Federal Office of Public Health

Tajikistan

Mr Ilhom S. Bandaev
Head of Unit, Department of Reform Management and International Relations, Ministry of Health of Tajikistan

Dr Salomudin Isupov
Head, Department of Human Resources Management, Ministry of Health of Tajikistan

Dr Shamsidin M. Kurbonov
Head, Department of Maternal and Child Health, Ministry of Health of Tajikistan

Dr Dilorom Sadikova
Head, Department of Reform Management and International Relations, Ministry of Health of Tajikistan

Mr Nousratullo F. Salimov
Minister of Health, Ministry of Health of Tajikistan

The former Yugoslav Republic of Macedonia

Ms Angelina Bacanovik
Head, Department of Legal Affairs, Ministry of Health

Mr Nenad Kolev
Head of Mission in Estonia, Ministry of Foreign Affairs

Dr Vladimir Lazarevik
Deputy Minister of Health, Ministry of Health

Ms Fljora Ljatifi-Maljoku
Adviser for Health for the President, Cabinet of the President

Dr Edis Ramo
Ministry of Health

Dr Imer Selmani
Minister of Health, Ministry of Health

Mr Bajram Skenderi
Cabinet of the Minister, Ministry of Health

Turkey

Professor Sabahattin Aydın
Deputy Undersecretary, Ministry of Health

Ms Sevim Tezel Aydın
Deputy Head, Department of Foreign Affairs, Ministry of Health

Dr Fehmi Aydınlı
Deputy General Director, Directorate of Primary Health Care, Ministry of Health

Mr Kamuran Özden
Head, Department of Foreign Affairs, Ministry of Health

Mr Murat Ugurlu
Head of Department, Ministry of Finance

Ukraine

Professor Tetiana Gruzeva
Head, Information and Analysis, National Medical University

Dr Oleksandr Tolstanov
Head, Department of Public Health, Zhytomyr Region State Administration

Ms Zhanna Tsenilova
Head, Department of International Relations, Ministry of Health of Ukraine

United Kingdom of Great Britain and Northern Ireland

Dr Fiona Adshead
Deputy Chief Medical Officer, Chief Government Advisor on Inequalities, Department of Health

Mr Chris Brookes
Programme Manager, International Health Inequalities, Department of Health

Ms Maggie Davies
Principal Adviser, International Health Improvement, Department of Health

Professor David R. Harper
Chief Scientist and Director-General, Health Improvement and Protection Directorate, Department of Health

Uzbekistan

Dr Abduvali Agzamov
Director, Centre for Privatization and Paid Services, Ministry of Health

Dr Vasila S. Alimova
Head, Treatment and Prophylactics Department, Ministry of Health

Observers from Member States of the United Nations Economic Commission for Europe

Canada

Mr Gavin Brown
Director, Health Care System Division, Health Canada

United States of America

Ms Jessica Adkins
Chief, Political/Economic Section, United States Embassy in Estonia

Ms Taimi Alas
Specialist, Political/Economic Section, United States Embassy in Estonia

Representatives of the United Nations and related organizations

United Nations Children's Fund (UNICEF)

Dr Shahnaz Kianian-Firouzgar
Deputy Regional Director, UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States

Mr Toomas Palu
Estonian National Committee, UNICEF

Dr Dragoslav Popovic
Immunization Specialist, UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States

World Bank

Dr Armin H. Fidler
Lead Health Policy Adviser, Human Development Network, Health, Nutrition and Population, World Bank Regional Office for Central Europe and the Baltic States

Mr Patricio V. Marquez
Lead Health Specialist, Human Development Department, World Bank Regional Office for Central Europe and the Baltic States

Representatives of other intergovernmental organizations

Council of Europe

Dr Piotr Mierzewski
Head, Health Division

European Centre for Disease Prevention and Control (ECDC)

Mr John O'Toole
Head, External Relations and Partnerships

European Commission

Mrs Nathalie Chaze
Policy Officer, Health Strategy and Health Systems Unit, Directorate-General for Health and Consumers

Mr Erdem Erginel
Member of Cabinet, European Commissioner for Health

Mr Nick Fahy
Head, Health Information Unit, Directorate-General for Health and Consumers

Ms Elisabeth Kidd
Policy Officer, Health Strategy and Health Systems Unit, Directorate-General for Health and Consumers

Mr Toivo Klaar
Head of Representation, Estonia

Dr Bernard Merkel
Head, Health Strategy and Health Systems Unit, Directorate-General for Health and Consumers

Mr Jan Paehler
Scientific/Technical Project Officer, Public Health, Directorate-General for Research

Dr Tapani Piha
Head, Health Law and International Unit, Directorate-General for Health and Consumers

Dr Matti Rajala
Minister Counsellor, Permanent Delegation to the International Organizations in Geneva

Ms Madeleine Reid
Legal Officer, EU Labour Law, Directorate-General for Employment and Social Affairs

Dr Andrzej Jan Rys
Director, Public Health and Risk Assessment, Directorate-General for Health and Consumers

Mrs Androula Vassiliou
European Commissioner for Health

European Investment Bank

Ms Chris Blades
Senior Economist, Projects Directorate

Mr Philippe Maystadt
President

International Organization for Migration

Ms Roumyana Petrova-Benedict
Senior Regional Migration Health Manager for Europe, Liaison to the EU/EC

Organisation for Economic Co-operation and Development

Mr Aart de Geus
Deputy Secretary-General

Mr Peter Scherer
Head, Health Division, Family Medicine Department

Representatives of nongovernmental organizations in official relations with WHO

International Council of Nurses

Mr David C. Benton
Consultant, nursing and health policy

World Organization of Family Doctors (WONCA)

Dr Egle Zebiene
Department of Family Medicine

Special guests and observers from the host country

Mr Arto Aas
Adviser to Prime Minister and Head of Office, State Chancellery of the Republic of Estonia

Mr Jaak Aab
Member of Parliament, Estonian Parliament

Dr Ain Aaviksoo
Director of Health Policy Program, PRAXIS Centre for Policy Studies

Mr Tõnis Allik
Head, Management Board, North Estonian Medical Centre

Dr Ralf Allikvee
Head, Management Board, East Tallinn Central Hospital

Dr Tiiu Aro
General Director, Health Protection Inspectorate

Dr Toomas Asser
Dean, Medical Faculty, University of Tartu

Mr Hannes Danilov
Chairman of Management Board, Estonian Health Insurance Fund

Ms Triin Habicht
Head of Health Economics Department, Estonian Health Insurance Fund

Dr Maris Jesse
Director, National Institute for Health Development

Dr Tiina Juhansoo
Vice-rector of Development, Tallinn Health College

Dr Katrin Kaarma
Director, Labour Inspectorate

Dr Kristiina Kahur
Senior Health Economist, Estonian Health Insurance Fund

Dr Üllar Kaljumäe
Director, Estonian Health Care Board

Ms Anneli Kannus
Rector, Tartu School of Health Care

Mr Keit Kasemets
Head, Strategy Department, State Chancellery of the Republic of Estonia

Ms Piret Kruuser
Head of Board, Estonian Health Care Workers Association

Mr Tõnis Kõiv
Member of Parliament

Dr Ago Kõrgvee
Chairman of the Executive Board, Estonian Ambulance Service Federation

Ms Heli Laarmann
Head, Chemical Unit, Department of Public Health, Ministry of Social Affairs

Dr Peeter Laasik
Chairman of the Council, Elva Hospital

Dr Aili Laasner
Chair of the Board, Health Promotion Union of Estonia

Ms Helve Luik
Chairman, Estonian Chamber of Disabled People

Dr Merike Martinson
Deputy-Mayor, Health and Social Care, Tallinn City Government

Dr Andrus Mäesalu
Manager of the Surgery Clinic, East-Tallinn Central Hospital

Mr Peep Mühls
Chairman of the Board, Foundation for Public Understanding

Ms Ülle-Marika Põldma
Head, Protocol Department, State Chancellery of the Republic of Estonia

Ms Siiri Põllumaa
President, Association of Midwives

Ms Inna Rahendi
President, Trade Union Association of the Health Workers of Estonia

Dr Kristin Raudsepp
Director General, State Agency of Medicines

Mr Johannes Rebane
Press Officer, Ministry of Foreign Affairs

Ms Marge Reinap
Head of Health Policy, Department of Public Health, Ministry of Social Affairs

Ms Pille Saar
Chief Specialist, System Resource Unit, Department of Health Care, System Resource Unit, Ministry of Social Affairs

Mrs Kaidi Sarv
Head Pharmacist, Estonian Pharmacists' Association

Mrs Katrin Sibul
Acting Head of Mission, Permanent Mission of Estonia to the United Nations Office and Other International Organizations in Geneva

Dr Urmas Siigur
Chairman, Executive Board, Tartu University Hospital

Ms Kyllike Sillaste-Elling
Adviser to Prime Minister, State Chancellery of the Republic of Estonia

Ms Eve Sirp
Counsellor, Ministry of Foreign Affairs

Dr Urmas Sule
Chairman of the Executive Board, Pärnu Hospital

Mr Harri Taliga
Chair, Confederation of Estonian Trade Unions

Mr Paul Teesalu
Director, International Organizations Division, First Political Department, Ministry of Foreign Affairs

Dr Jelena Tomasova
Director, Tallinn Health Protection Service

Mr Andres Tsahkna
Minister's Adviser, Ministry of Social Affairs

Dr Anneli Uuskula
Chair, Department of Public Health, University of Tartu

Dr Piret Väli
President, Tallinn Section, Estonia Dentistry Society

Guests and invited speakers

Mr Andrus Ansip
Prime Minister, Estonia

Professor Sir Michael Marmot
Director, International Institute for Society and Health and MRC Research Professor, Department of Epidemiology and Public Health, University College London, United Kingdom

Professor Martin McKee
Professor of European Public Health, London School of Hygiene and Tropical Medicine, United Kingdom and Head of Research Policy, European Observatory on Health Systems and Policies

Professor Uwe Reinhardt
James Madison Professor of Political Economy and Professor of Economics, Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University, United States of America

Ms Mary Robinson
President, Realizing Rights: the Ethical Globalization Initiative and Co-Chair, Health Worker Global Policy Advisory Council, New York, United States of America

Professor Peter C. Smith
Director, Centre for Health Economics, University of York, United Kingdom

European Network for Health Technology Assessment (EUnetHTA)

Dr Kristian Lampe
Senior Medical Officer, Finnish Office for Health Technology Assessment (FinOHTA), Finland

Dr François Meyer
Directeur, Evaluation Medicale, Economique et de Santé Publique, Haute Autorité de Santé, France

EU Public Health Information and Knowledge System (EUPHIX)

Ms Monique Kuunders
Scientist, National Institute for Public Health and the Environment (RIVM), Netherlands

Professeur Bernard Ledésert
Directeur, Observatoire régional de la santé du Languedoc-Roussillon, France

Professor Johannes van Oers
Project leader, National Institute for Public Health, Netherlands

Ms Eveline van der Wilk
Researcher, National Institute for Public Health and the Environment (RIVM), Netherlands

Global Fund to Fight AIDS, Tuberculosis and Malaria

Professor Michel Kazatchkine
Executive Director

Ms Madeleine Leloup
Senior Adviser to the Executive Director

Global Health Workforce Alliance

Ms Beth Magne-Watts
Advocacy and Communications Officer

Dr Mubashar R. Sheikh
Executive Director

Regions for Health Network (RHN)

Professor Rainer Fehr
State Institute of Health and Work North Rhine-Westphalia (LIGA.NRW), Bielefeld, Germany

Dr Marianna Pénzes
Health Faculty, Debrecen University, Nyíregyháza, Hungary

Dr Manfred H.J. Schmitz
Head, Division of International Affairs, Ministry of Employment, Health and Social Affairs, North Rhine-Westphalia, Germany

Temporary advisers

Professor Rifat A. Atun
Professor of International Health Management, Director, Centre for Health Management, Tanaka Business School, Imperial College London, United Kingdom

Professor James Buchan
Health Sciences, Queen Margaret University, Edinburgh, United Kingdom

Professor Reinhard Busse
Department of Health Care Management, Berlin University of Technology, Germany and Associate Head of Research Policy, European Observatory on Health Systems and Policies

Ms Kate Charlesworth
Research Fellow, London School of Hygiene and Tropical Medicine, United Kingdom

Dr David Chinitz
Senior Lecturer, Health Policy and Management, School of Public Health, Hebrew University-Hadassah, Israel

Professor Douglas Conrad
Professor of Health Services and Co-Director, Center for Health Management Research, Department of Health Services, University of Washington, Seattle, United States of America

Dr Angela Coulter
Chief Executive, Picker Institute Europe, Oxford, United Kingdom

Dr Peter Coyte
Professor of Health Economics and Chair, Department of Health Policy, Management and Evaluation, University of Toronto, Canada

Dr Arnold Epstein
John H. Foster Professor of Health Policy, Chair, Department of Health Policy and Management, Harvard School of Public Health, Boston, United States of America

Mr Ewout van Ginneken
Department of Health Care Management, Berlin University of Technology, Germany

Professor Niek S. Klazinga
Professor of Social Medicine, Department of Social Medicine, Academic Medical Centre, University of Amsterdam, Netherlands

Dr John N. Lavis
Associate Professor and Canada Research Chair in Knowledge Transfer and Exchange, Health Sciences Centre, McMaster University, Hamilton, Canada

Professor Jon Magnussen
Faculty of Medicine, Department of Public Health, Norwegian University of Science and Technology, Trondheim, Norway

Professor José M. Martin-Moreno
Professor of Medicine and Public Health, Medical School, University of Valencia, Spain

Mr David McDaid
Coordinator, Mental Health Economics European Network, and Research Fellow, London School of Economics and Political Science, United Kingdom

Dr Ellen Nolte
Senior Lecturer, European Centre on Health of Societies in Transition, London School of Hygiene and Tropical Medicine, United Kingdom

Professor Charles Normand
Edward Kennedy Professor of Health Policy and Management, University of Dublin, Trinity College, Ireland

Ms Irene Papanicolas
Research Associate, LSE Health, London School of Economics and Political Science, United Kingdom

Professor Richard B. Saltman
Professor of Health Policy and Management, Department of Health Policy and Management, Rollins School of Public Health, Emory University, Atlanta, United States of America and Associate Head of Research Policy, European Observatory on Health Systems and Policies

Dr Paul G. Shekelle
Director, Southern California Evidence-Based Practice Center, Department of Health, RAND Corporation, Santa Monica, United States of America

Professor Igor Sheiman
Researcher, Economics of Public Sector, State University – Higher School of Economics, Moscow, Russian Federation

Ms Debbie Singh
London, United Kingdom

Ms Corinna Sorenson
LSE Health, London School of Economics and Political Science, United Kingdom

Dr Caren Weilandt
Deputy Managing Director, Scientific Institute of the German Medical Association (WIAD), Bonn, Germany

Mr Norbert Wilk
Deputy Director, Analytical Division, Agency for Health Technology Assessment, Warsaw, Poland

Observers

British Medical Journal

Dr Tessa Richards
Assistant Editor

European Federation of Nurses Association

Mr Paul De Raeve
General Secretary

European Forum of Medical Associations and WHO

Dr Ramin Walter Parsa-Parsi
Head of Department, German Medical Association

Dr René Salzberg
Adviser

European Forum of National Nursing and Midwifery Associations and WHO

Ms Mary Higgins
Assistant Director of Midwifery, Midwives Section, Irish Nurses Organisation

Ms Madeline Spiers
Chairperson

European Forum for Primary Care

Mr Diederik Aarendonk
Coordinator

EuroPharm Forum

Dr T.F.J. Tromp
Co-ordinator, Health Systems Programme

European Public Health Alliance

Mr Paul Belcher
Non-Executive Director

European Public Health Association

Dr Dineke Zeegers-Paget
Executive Director

European Society for Quality in Healthcare

Mr Laimutis Paskevicius
Executive Board Member

Global Alliance for Vaccines and Immunization (GAVI)

Ms Nilgun Aydogan
Programme Officer

International Federation of the Red Cross and Red Crescent Societies (IFRC)

Mr Georg Habsburg
President, Hungarian Red Cross

International Forum Gastein

Professor Gunther Leiner
President

Mr Matthias Schuppe
Secretary-General

International Planned Parenthood Federation (IPPF) European Network

Ms Irene Donadio
Advocacy Officer

The Lancet

Dr Astrid James
Deputy Editor

National Research and Development Centre for Welfare and Health (STAKES), Finland

Dr Ilmo Keskimäki
Director, Division of Health Services Research

Mr Marko Lähteenmäki
Development Manager

Ms Tiinaa Puhazza
Planning Officer

Professor Vappu Taipale
Director-General

Ms Anna Turunen
Planning Officer

Project Hope

Ms Judit Csiszar
Regional Director

World Health Organization

Regional Office for Europe

Ms Susan M.R. Ahrenst
Programme Assistant, Country Health Policies and Systems

Ms Marija Andjelkovic
Administrative Assistant, WHO Country Office, Slovenia

Dr Anshu Banerjee
Head, WHO Country Office, Albania

Dr Enis Bariş
Director, Division of Country Health Systems

Mr Karim Benthami
Administrative Services, Supply and Conference Officer

Ms Mary Stewart Burgher
Editor, Health Intelligence Services

Mr André Calmîs
Technical Assistant, IT Support to Country Offices, Customer Support Services

Mr Oluf Christoffersen
Supervisor, Printing and Conference Services

Dr Yelizabet Danielyan
Head, WHO Country Office, Armenia

Dr Marc Danzon
WHO Regional Director for Europe

Mr Joachim Robin Dartell
Technical Officer, Country Operations Management Support

Dr Antonio Duran
Adviser

Dr François Decaillet
Senior Policy Adviser and Representative of WHO/EURO to the European Union

Mr Sasa Delic
Assistant, Printing and Conference Services

Dr Lucica Ditiu
Medical Officer, Communicable Diseases

Dr Nedret Emiroglu
Director a.i., Division of Health Programmes

Ms Mirona Eriksen
Programme Assistant, Regional Director's Office

Dr Josep Figueras
Coordinator, European Observatory on Health Systems and Policies – WHO European Centre for Health Policy, Brussels

Ms Elena Galmond
Programme Assistant, Country Policies and Systems

Mr Kamran Garakhanov
Head, WHO Country Office, Azerbaijan

Dr Bernhard Rudolf Gibis
Unit Head, a.i., Health Information Services

Dr Jarno Habicht
Head, WHO Country Office, Estonia

Mr Clayton Hamilton
Database Coordinator, Solutions Development

Ms Tine Hansen
Intern

Ms Gitte Andersen Havn
General Services Assistant, Administration, Supplies and Conference

Ms Birgit Heesemann-Nielsen
Documentation and Translation Assistant, Health Intelligence Services

Mr Imre Hollo
Director, Division of Administration and Finance

Dr Gabit Ismailov
Head, WHO Country Office, Kazakhstan

Mr Marijan Ivanusa
Head, WHO Country Office, Slovenia

Ms Anne Elizabeth Jakobsen
Technical Assistant, Strategy Group

Mr Kees de Joncheere
Regional Adviser, Country Policies and Systems

Mr Bent Jørgensen
Office Equipment Operator, Printing and Conference Services

Dr Matthew Jowett
Senior Health Financing Specialist

Ms Kaja Kaasik-Aaslav
Intern

Ms Yulnara Kadirova
Programme Assistant, Noncommunicable Diseases and Environment

Dr Antoinette Kaic-Rak
Head, WHO Country Office, Croatia

Dr Bahtygul Karriyeva
Head, WHO Country Office, Turkmenistan

Dr Marija Kisman
Head, WHO Country Office, the former Yugoslav Republic of Macedonia

Dr Rusudan Klimiashvili
Head, WHO Country Office, Georgia

Mr Blerim Komoni
Logistics Assistant, WHO Office, Pristina

Mr Yavuz Mehmet Kontas
Liaison Officer, WHO Country Office, Turkey

Ms Kadri Kont-Kontson
Administrative Assistant, WHO Country Office, Estonia

Dr Agris Koppel
Technical Officer, WHO Country Office, Estonia

Dr Michal Krzyzanowski
Regional Adviser, Acting Head, Bonn Office

Mr Joseph Kutzin
Unit Head, Country Policies, Systems and Services

Ms Suszy Lessof
Project Manager, European Observatory on Health Systems and Policies – WHO European Centre for Health Policy, Brussels

Dr Lucianne Licari
Regional Adviser, Environment, Health Coordination and Partnerships

Ms Claudia Bettina Maier
Technical Officer, Research Fellow, European Observatory on Health Systems and Policies – WHO European Centre for Health Policy, Brussels

Ms Maria Teresa Marchetti
Administrative Officer, European Observatory on Health Systems and Policies – WHO European Centre for Health Policy, Brussels

Dr Srdan Matic
Acting Section Head, Communicable Diseases

Ms Geraldine McWeeney
Technical Officer, Environmental Health in SEE Region

Dr Nata Menabde
Deputy Regional Director

Ms Sherry Merkur
Research Fellow – Web Officer, European Observatory on Health Systems and Policies – WHO European Centre for Health Policy, Brussels

Ms Tanya Michaelsen
Acting Special Events Administrator, Partnership and Communications

Dr Luigi Migliorini
Head, WHO Country Office, Russian Federation

Dr Paulina Marianna Miskiewicz
Head, WHO Country Office, Poland

Dr Oskon Moldokulov
Head, WHO Country Office, Kyrgyzstan

Ms Natela Nadareishvili
Technical Officer, Country Operations Management Support

Ms Liuba Negru
External Relations Officer, Press and Media Relations, Partnership and Communications

Mr Jens Nielsen
Technical Assistant, Operations (Production and Support)

Dr Dorit Nitzan Kaluski
Manager, WHO Country Office, Serbia

Dr Arun Nanda
Adviser on Health Threats, Division of Health Programmes

Ms Elena Nivaro
Assistant to Director, Director's Office, Division of Administration and Finance

Mr Jonathan North
Publications Officer, European Observatory on Health Systems and Policies – WHO European Centre for Health Policy, Brussels, and LSE Health, London School of Economics and Political Science, United Kingdom

Dr Victor Olsavszky
Head, WHO Country Office, Romania

Mr Willy Palm
Dissemination Development Officer, European Observatory on Health Systems and Policies – WHO European Centre for Health Policy, Brussels

Dr Galina Perfilieva
Regional Adviser, Health Sector Human Resources, Country Policies and Systems

Dr Govin Permanand
Technical Officer, Health Intelligence Services

Dr Robertas Petkevicius
Head, WHO Country Office, Lithuania

Miss Teresa Pinto
Intern

Dr Igor Pokanevych
Head, WHO Country Office, Ukraine

Dr Maria Cristina Profili
Health Systems Conference Coordinator

Ms Francesca Racioppi
Head, Centre for Health Impact of Environmental and Development Policies

Ms Janna Riisager
Administrative Officer, Regional Director's Office

Mr Charles Robson
Head, Translation and Editorial, Health Intelligence Services

Ms Anna Roepstorff
Programme Assistant, Partnership and Communications

Dr Aiga Rurane
Head, WHO Country Office, Latvia

Ms Cristiana Salvi
Technical Officer, Partnership and Communications

Dr Darina Sedláková
Head, WHO Country Office, Slovakia

Dr Santino Severoni
Head, WHO Country Office, Tajikistan

Ms Tarang Sharma
Intern

Dr Elena Shevkun
Technical Officer, Country Operations Management Support

Ms Julia Solovieva
Administrative Officer, Director's Office, Division of Country Health Systems

Ms Margarita Spasenovska
National Professional Officer, WHO Country Office, the former Yugoslav Republic of Macedonia

Dr Alena Steflova
Head, WHO Country Office, Czech Republic

Dr Marc Suhrcke
Policy Development Officer, Venice Office

Dr Skender Syla
Head, WHO Office, Pristina

Dr Kinga Szepeshazi
Health Policy and System Officer, WHO Country Office, Hungary

Dr Michel Louis Marie Tailhades
Head, WHO Country Office, Uzbekistan

Ms Rouruina Teura
Technical Assistant, Customer Support Services

Ms Emilia Tontcheva
Head, WHO Country Office, Bulgaria

Dr Agis Tsouros
Unit Head a.i., Noncommunicable Diseases and Environment

Dr Pavel Ursu
Head, WHO Country Office, Moldova

Mr Jeremy Veillard
Acting Regional Adviser for Health Policy and Equity, Country Policy and Systems

Dr Isidora Sylvia Yvonne Vromans
Special Adviser, Director's Office, Division of Country Health Systems

Dr Melita Vujnovic
Liaison Officer, WHO Country Office, Serbia

Ms Helena Vuksanovic
Administrative Assistant, WHO Country Office, Serbia

Ms Caroline White
Research and Publications Secretary, European Observatory on Health Systems and Policies – WHO European Centre for Health Policy, Brussels

Dr Matthias Wismar
Senior Health Policy Analyst, European Observatory on Health Systems and Policies – WHO European Centre for Health Policy, Brussels

Dr Egor Zaitsev
Head, WHO Country Office, Belarus

Dr Erio Ziglio
Head, Venice office

Headquarters

Mr Toufic Abi-chaker
Chief Interpreter, Interpretation Service

Dr Margaret Chan
Director-General

Dr Manuel Dayrit
Director, Department of Human Resources for Health

Dr Carissa Etienne
Assistant Director-General, Health Systems and Services

Dr David Bruce Evans
Director, Health Systems Financing Department

Mr Cong Fu
Adviser to the Director-General, Director-General's Office

Dr Gaya Gamhewage
Team leader, Corporate Communications, Director-General's Office

Dr Adrian Ong
Executive Officer, Director-General's Office

Dr Pongsadhorn Pokpermdee
Executive Officer, Director-General's Office

Ms Veronica Riemer
Assistant, Department of Communications

Mr Gérard Schmets
Coordinator, Health Systems Governance, Policy and Aid Effectiveness

Dr Susanne Weber-Mosdorf
Assistant Director-General, WHO Office at the European Union

Dr Regina Winkelmann
Executive Officer, Director-General's Office

Other regional offices

Regional Office for the Americas/Pan American Health Organization

Dr Jacques Girard
Country Adviser, Health Systems and Services

Dr Hernan Montenegro
Regional Adviser, Health Systems and Services

Professor Eliot Sorel
Global Health, Health Services Management, and Leadership, School of Public Health, George Washington University

Regional Office for the Eastern Mediterranean

Dr Mohamed Abdi Jama
Deputy Regional Director

Regional Office for the Western Pacific

Dr Henk Bekedam
Director, Health Sector Development

Host country secretariat

Mrs Ivi Aalak

Ms Kristiina Alliksaar

Mrs Anneli Berends

Ms Liisi Bucht

Mr Tarmo Inno

Ms Ööle Janson

Mrs Edith Kallaste

Mr Ursel Kedars

Mr Kalle Kingsepp

Ms Eda Kondra

Ms Eli Lilles

Mrs Edda-Helen Link

Ms Mairi Laanetu

Ms Marle Malvet

Ms Merilin Mäesalu

Ms Kerstin Peterson

Mrs Ülle-Marika Põldma

Mr Johannes Rebane

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Ms Maris Salekešin

Mrs Kristel Sarapuu

Mr Marek Seer

Ms Kati Tamm

Ms Helvi Tarien

Mrs Ene Tomberg

Ms Tatjana Tšernjak

Ms Triinu Täht

Mrs Marika Vaher

Mr Jako Vernik

Mr Andris Viltsin

Ms Jana Zdanovitš

EUROPE

The WHO Regional Office for Europe

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

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The WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth" was organized in Tallinn, Estonia in June 2008 by the WHO Regional Office for Europe and hosted by the Government of Estonia. Over 500 participants attended, including ministers responsible for health, civil affairs, and finance and economic affairs from 52 of the 53 Member States in the WHO European Region, internationally recognized experts on health systems and representatives of international and civil-society organizations and the mass media. The Conference was a major turning point in the evolution of public health.

This report describes how the participants explored the dynamic relationships between health systems, health and wealth and discussed the four functions of health systems (service delivery, financing, creation of the health workforce and other inputs, and stewardship/governance). It concludes by detailing how WHO, Member States and a range of international partners made political commitments to strengthen health systems, ultimately adopting the Tallinn Charter: Health Systems for Health and Wealth.

While the Conference gave both visibility and credibility to the subject, the follow-up to the event will drive the improvement of health systems' performance. This includes the endorsement of the Charter by the WHO Regional Committee for Europe in September 2008, the development of tools to improve performance assessment and the publication of this report to spread the word. Readers will find this report a useful tool in the implementation phase, started by the Charter's adoption, whose aim is to increase health and wealth by strengthening health systems in Europe.

World Health Organization
Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen Ø
Denmark
Tel.: +45 39 17 17 17
Fax: +45 39 17 18 18
E-mail: postmaster@euro.who.int
Web site: www.euro.who.int

9 789289 014137