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Summary interim report on implementation of the Tallinn Charter

This document is a summary of the interim report on implementation of the Tallinn Charter: Health Systems for Health and Wealth. The report was compiled by a team of WHO and external experts, aided by an external working group, on the basis of written responses to a questionnaire sent to Member States and contributions by heads of WHO country offices and other WHO staff. At its third session, the Eighteenth Standing Committee of the Regional Committee also received feedback from the discussions at the European Health Policy Forum for High-level Government Officials (Andorra, 9–11 March 2011). The full version of the report is available as document EUR/RC61/Inf.Doc./2.

As called for by the Regional Committee in its 2008 resolution on stewardship/governance of health systems in the WHO European Region (EUR/RC58/R4), the aim of the Interim Report is to illustrate some of the ways in which the various commitments and messages from the Tallinn Charter have been made operational by Member States, and to highlight the related support provided by the WHO Secretariat. It is expected that the final report in 2015 will assess the extent to which the Tallinn Charter commitments have been implemented by Member States and will derive lessons learned from this experience. In accordance with the request outlined in the Regional Committee's resolution on health in times of global economic crisis (EUR/RC59/R3), the report also presents some preliminary lessons learned at the regional level in the handling of the economic crisis.

The Interim Report and this summary have six chapters including the introduction. Chapter II illustrates initiatives that are consistent with the various "Commitments to Act" specified in the Charter. Following Chapter II, the rest of the report focuses in greater depth on three key dimensions of the Charter: assessing health system performance as a means of improving governance and accountability (Chapter III); ensuring solidarity and health gain in times of financial crisis (Chapter IV); and strengthening health systems' impact through leadership of intersectoral action to improve health (Chapter V). Chapter VI concludes the report, describes future directions for the WHO Regional Office for Europe in the light of lessons learned so far and highlights the synergies between the Tallinn Charter and Health 2020.

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I. Introduction and overview

1. The WHO European Ministerial Conference on Health Systems, held in Tallinn from 25 to 27 June 2008, was a milestone on the path towards a stronger political commitment to strengthening health systems. It was marked by the signing of the Tallinn Charter: Health Systems for Health and Wealth, and its later endorsement in a Regional Committee resolution on Stewardship/governance of health systems in the WHO European Region (EUR/RC58/R4).

2. The global financial and economic crisis that started in 2008 put to the test the commitments made in Tallinn. In 2009, the Regional Committee adopted a resolution based on the outcomes of a conference held in Oslo on the subject of "Health in times of global economic crisis: implications for the WHO European Region". Both resolutions requested the Regional Director to report back to the Regional Committee in 2011 and, because of the close links between the Tallinn Charter commitments and the Oslo recommendations, the Eighteenth Standing Committee of the Regional Committee (SCRC) decided at its second session (Andorra, 18–19 November 2010) that both reports should be combined in a single "envelope".

3. The year 2010 marked the launch of the WHO Regional Director for Europe's "Vision for better health in Europe", which was endorsed by the Regional Committee in its resolution EUR/RC60/R2. A central pillar of this vision is the new European health policy, Health 2020. Health 2020 aims to provide a coherent, evidence-based health policy framework for the European Region of WHO. Health 2020 will unequivocally reaffirm the central tenets of the Tallinn Charter and will integrate the implications of global trends in health policies across the European Region.

4. This document is a summary of the Interim report on implementation of the Tallinn Charter, an initial draft of which was presented and discussed at the SCRC session in Andorra; a consultation was held at the first meeting of the European Health Policy Forum for High-level Government Officials (Andorra, 9–11 March 2011). The report was compiled by a team of WHO and external experts, aided by an external working group, on the basis of written responses to a questionnaire sent to Member States and contributions by heads of WHO country offices and other WHO staff.

5. The aim of the Interim Report is to illustrate some of the ways in which the various commitments and messages from the Charter have been made operational by Member States and to highlight the related support provided by the WHO Secretariat.[1] It is expected that the final report in 2015 will assess the extent to which the Tallinn Charter commitments have been implemented by Member States and will derive lessons learned from this experience.

6. The Interim Report and this summary have six chapters including this introduction. Chapter II illustrates actions taken by Member States and WHO that are consistent with the various "Commitments to Act" specified in the Charter. Following Chapter II, the rest of the report focuses in greater depth on three key dimensions on the Charter: assessing health system performance as a way of improving governance and accountability (Chapter III); ensuring solidarity and health gain in times of financial crisis (Chapter IV); and strengthening health systems' impact through leadership of intersectoral action to improve health (Chapter V). Chapter VI concludes the report, describes future directions for the WHO Regional Office for

[1] In the interests of concision, the WHO secretariat is referred to below as "WHO".

Europe in the light of lessons learned so far and highlights the synergies between the Tallinn Charter and Health 2020.

II. Implementation of the Charter commitments: illustrations and highlights

7. This section illustrates the progress made by Member States in implementing the Charter commitments and the related support provided by WHO. It highlights innovative approaches to promoting solidarity and equity, the shared value of participation, cross-country learning and cooperation, and preparedness.

Promoting solidarity and equity

8. Solidarity and equity are the two most pronounced values identified as underpinning most of the actions taken by the health authorities of Member States and guiding the work of WHO. Promoting progress towards or sustaining universal coverage were often cited as the motivation for reforming health financing. In some cases, WHO's technical advice played a key role in the formulation of policy recommendations aimed at removing administrative barriers to the realization of entitlements to health benefits for certain vulnerable groups, such as the Roma population. Apart from financing, countries also introduced changes to make services more inclusive and friendly towards marginalized groups (such as ethnic minorities, migrants, drugs users and commercial sex workers), through a combination of outreach programmes and health promotion services targeted at these specific populations.

Fostering pro-health and pro-poor investment across sectors

9. Effective health system stewardship involves understanding and trying to influence factors outside the system that impact upon health, incorporating evidence on social determinants. In several countries, governments introduced a comprehensive set of measures aimed at influencing the social determinants of health and health inequalities. These included taxation (e.g. on alcohol, tobacco and sugar in beverages), interventions in housing, employment, schools and drug addiction, and social support. In such cases, a large number of ministries and local government bodies are involved, with the ministry of health playing a catalytic role.

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

10. "Participation" is one of the shared values to which Member States committed themselves in the Charter, as well as in the Health for All policy framework. This was to be done by making health systems more responsive and by engaging stakeholders in both the development and the implementation of policies. Several Member States have demonstrated their intention to have more citizen-centred systems within comprehensive national health strategies, for example by making recommendations on how to preserve and improve citizens' health, promoting patients' rights and awareness of these rights, and setting up hotlines or web-based channels in order to provide feedback on people's health or health system-related questions and to offer a means for citizens to register their complaints.

Cross-country learning and cooperation

11. Member States have frequently expressed interest in and taken the initiative of bringing experiences from other countries into their national health policy dialogue, and WHO has played a key role in facilitating such cross-country learning on a range of health issues, including the implementation of national and subnational health reforms. Several types of approaches have been used, often in collaboration with partner agencies, including producing and disseminating technical/policy analyses and syntheses, fostering networking, engaging directly with policymakers, and organizing national and multicountry meetings, workshops and training courses. Specific examples include the South-Eastern Europe Health Network (SEEHN), a political and institutional forum set up by nine countries to promote peace, reconciliation and health in south-eastern Europe. Also noteworthy are the policy analyses and syntheses produced by the European Observatory on Health Systems and Policies and the Regional Office's Health Evidence Network, such as the background papers produced for the conference on financial sustainability of health systems organized by the Czech Republic during its presidency of the European Union (EU). The Pharmaceutical Pricing and Reimbursement Information network has provided a powerful means for cross-country exchange by bringing together pharmaceutical policy-makers from EU countries twice a year. The Knowledge, Experience and Expertise Bank (KEE-Bank) enables health system decision-makers to rely on the experience of their peers across the Region for assessing different policy choices. Similarly, and in close collaboration with the European Observatory, WHO has convened numerous policy dialogue meetings, often in a format that brings together current or former decision-makers from several countries to help another country as it wrestles with challenging policy issues. Finally, numerous training programmes have been provided, for example the regional, subregional and national flagship courses on health system reform, health financing, and poverty/equity issues, and the European Observatory's Venice Summer School, which has addressed a wide variety of topics, such as EU integration and health systems, ageing, hospital re-engineering, and health technology assessment.

Health system preparedness and the International Health Regulations

12. The seventh commitment in the Tallinn Charter is that Member States will ensure that health systems are prepared and able to respond to crises, and that they collaborate with each other and enforce the International Health Regulations (IHR). Countries honouring this commitment have, for example, established a health sector-wide programme to build the capacity to anticipate, prevent, prepare for, respond to, mitigate the effects of and recover from health crises. WHO has provided input and guidance to Member States on how to assess national capacities and to develop and strengthen IHR core capacities, including the timely response to outbreaks and other public health events of international concern.

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

Country progress and lessons learned

13. Member States are increasingly engaging in health system performance assessment (HSPA). Recent experiences indicate that this generates added value for governance, by engaging stakeholders (e.g. government, health care providers, health authorities and citizens), fostering intersectoral dialogue, mainstreaming evidence on gaps in equity, promoting a common vision across programmes or levels, or establishing mechanisms for solidarity across regions. Despite diverse approaches to HSPA, key success factors can be identified, such as

stakeholder participation and balancing the use of qualitative and quantitative information. In addition, there is a clear trend towards using comprehensive, system-wide approaches, including the broad determinants of health.

14. The experience to date highlights the different ways in which performance assessment can contribute the attainment of health system goals. One has been the role of performance assessment as a means to promote public accountability and evidence-informed policy-making through regular, open publication of performance results at all levels. Another has been the value of performance assessment for informing intersectoral dialogue and promoting health as a "whole-of-government" responsibility, using comprehensive frameworks that make explicit the role of socioeconomic determinants of health, lifestyles and environment in health outcomes (including experiences with the Organisation for Economic Co-operation and Development – OECD – and the European Community Health Indicators Monitoring – ECHIM – project). Another has been the link between performance assessment and the development and monitoring of national and subnational health policies and strategies. Finally and perhaps most directly, performance assessment has been used to support performance management, by carefully selecting indicators (e.g. process vs. outcomes) or by introducing incentive schemes (e.g. reward vs. sanction, internal vs. public reporting).

Progress in fostering and using international comparisons and outstanding methodological issues

15. There is evidence of national initiatives embedding international comparisons in a national process of performance assessment. In addition to analysing national trends over time, comparator countries provide insights into the level of performance and potential targets. This is assisted through internationally standardized health system indicators (Health for All – HFA, ECHI) and survey instruments (European Community Household Panel – ECHP, the EU Statistics on Income and Living Conditions – EU-SILC, the Survey of Health, Ageing and Retirement in Europe – SHARE and the European Core Health Interview Survey – ECHIS). International comparisons have heightened awareness of issues regarding the availability, quality and reliability of data, as well as methodological questions regarding indicator development. Peer learning networks offer additional opportunities to understand variations in results and provide insight into how policies affect health system performance. WHO has a role to play in creating opportunities and providing tools for benchmarking within/between countries.

WHO support for evidence-informed policy-making

16. WHO has supported Member States with capacity-building and institutional development, in addition to providing support on technical aspects of HSPA, policy analysis and regular sectoral monitoring. This work rests on three pillars. The first pillar is **demand generation** or changing the policy-making culture, whereby evidence is sought prior to decision-making on a regular basis, and major policies are evaluated. The second pillar is **building capacity** to produce high-quality performance assessment, policy analysis and sector monitoring, using either/both explicit training mechanisms (e.g. international and country-level courses in health systems strengthening, health sector monitoring, and various topics in policy analysis) or/and engaging in joint analytical work with national counterparts. The third pillar involves **institutional development**, i.e. putting in place sustainable arrangements where demand for health evidence is both articulated and satisfied with a high-quality supply of health evidence, and where there are knowledge translation platforms that create a real bridge between evidence and policy.

17. In addition to providing technical support to individual Member States, the Regional Office aims to make the wealth of experience in the Region widely available. WHO has been engaged in developing a comprehensive package of tools to support countries in implementing HSPA, including guidelines and case studies on HSPA, a compendium of indicators proposed by various national and international organizations, and "indicator passports" that describe the definition, functions and key issues for selected indicators. Also available are background papers on health system and HSPA frameworks, international comparisons, and benchmarking.

18. In addition, the European Observatory has been asked by its partners to initiate a programme of work on comparison of health system performance. The objectives are "to help governments, regulators, citizens and other commentators gain a better understanding of the comparative performance of their health systems, to improve approaches to measurement and analysis, and to demonstrate how comparative metrics can help in the design and evaluation of initiatives intended to strengthen health systems." The initiative is being undertaken in close collaboration with the Regional Office and will involve liaison with other key collaborators, including the European Commission and OECD. The first substantive product of the initiative is a book on performance information for health system comparison. In parallel, the programme is developing a series of reports on metrics, methodology and performance comparison. In addition, the programme will produce a biennial comparative report for the European Region.

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

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

19. The Tallinn Charter has at its core the principles of equity, solidarity, financial protection and maximizing health gain through leadership and performance improvement in health systems. The Charter was signed in mid-2008, at a time when the magnitude and implications of the emerging financial and economic crisis were not yet clear. When it hit, the commitments of Member States to the above principles were put to the test. Commitment to equity, solidarity and financial protection has to be reinforced during an economic downturn, so that the health and social sectors are protected from across-the-board budget cuts or, if cuts in health budgets are unavoidable, they are implemented in a manner that minimizes their adverse effects on these objectives. From a purely fiscal perspective, the question of sustainability is limited to maintaining a balance between a government's income and expenditure. But from a health/welfare perspective, sustainability is meaningless if it is not linked to objectives. Performance orientation gives a more nuanced approach to the concept of sustainability and shifts the focus of attention to the question of what level of achievement of the different public policy objectives we can or are we willing to sustain.

From values to action: The Oslo recommendations

20. In April 2009 a high-level meeting was convened jointly by the Regional Office and the Government of Norway in Oslo. A set of recommendations were proposed for guiding pro-health and pro-poor policy responses, and these were in line with and driven by the Tallinn Charter commitments. The Oslo recommendations included prioritizing cost-effective public health and primary health care services. They also recognized the importance of ensuring the efficient use of public funds ("more health for the money"), which is a prerequisite to effective advocacy for "more money for health". The Oslo recommendations argue for the introduction of new taxation on sugar and salt consumption, as well as increases in levies on alcohol and tobacco, fiscal measures that are concurrently effective public health interventions.

Protecting health budgets and maintaining provision of essential services

21. Member States have employed a range of actions in their efforts to protect health budgets. Counter-cyclical spending measures (either depleting reserves that have been built up in (the) insurance fund(s) or deficit spending on health from the government budget) are an obvious first response when this option exists (i.e. if the country entered the crisis with substantial reserves in its insurance fund(s) or with an accumulated public sector deficit that was not so large as to preclude deficit spending). At times, however, this was done at the expense of the budget for public health programmes. Another option used in some countries was to delay investments, which allowed the health sector to maintain the level and volume of health services (including public health services) in the short term. For any of these options to be viable, a political commitment must be made to protect the health budget.

Sustaining health gain through social spending

22. Research[2] suggests there is association between all-cause mortality rates and economic crises, using unemployment as a measure of the economic stress and accompanying uncertainty faced by the population. Governments can protect their populations during economic crises with additional social welfare spending. With spending above US$ 190 per capita, there was no impact on suicide rates with rising unemployment rates. Similarly, a comparison of Spain and Sweden during the severe economic problems that each faced in the late 1980s and early 1990s shows that while suicides increased in parallel with unemployment in Spain, the two measures diverged in Sweden, where the long-term decline in suicides continued despite increasing unemployment.

Sustainability, rationing and trade-offs

23. While there is a strong case for protecting health and social budgets during an economic downturn, if the options for governments to do so are simply not there and cuts are inevitable, then health policy-makers face the challenge of minimizing the adverse effects on population health and poverty. All countries must address trade-offs between competing priorities and objectives in the face of limited resources. Shifting the burden of financing health care from pooled public sources to the patient via increased direct payments (user fees, co-payments, etc.) reduces the utilization of health services, and sometimes of clinically justified needed services, resulting eventually in higher costs to the health system and worse health outcomes for the individual. In the Tallinn Charter, Member States declared that “today, it is unacceptable that people become poor as a result of ill health”, but this can be undermined as governments look to shift the burden of financing to households as a policy response to fiscal pressures. Where the cost of seeking care is lower, the reduction of utilization during a crisis is also lower.

24. In addition to explicit efforts to shift costs to patients, many countries engage in implicit rationing mechanisms. These are less tangible to both patients and policy-makers, and they are also difficult to detect through systematic research. When the level of funding going to providers is reduced but there are no explicit compensating financial measures introduced, demands for informal payments from patients may grow. In addition, providers may themselves engage in rationing, for example by delaying, denying and diluting clinical services. Such “quality skimping” can have significant implications for health gain and efficiency in the use of limited resources. Where monitoring of provider compliance with clinical standards is weak and

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

professional organizations are less rigorous in enforcing good clinical practice, implicit rationing mechanisms may hide some of the adverse effects of the financial crisis.

Spending more efficiently

25. Spending more efficiently helps reduce the severity of the impact of budget cuts. Policy instruments in the area of medicines illustrate the range of options available to policy-makers. Spending on medicines ranges between 10% and 25% of total health expenditures in EU countries, and between 20% and 40% in countries in economic transition. Given that this is a large single item, cuts in public expenditure on pharmaceuticals are always high on policymakers' list of options for dealing with a deficit. Several countries achieved efficiency gains, for example, through more cost-effective use of medicines and by applying health technology assessment (HTA) to inform reimbursement decisions. Some also introduced cost-containment measures by announcing overall price cuts for manufacturers and negotiating lower prices, more efficient purchasing of medicines through tendering, enhancing policies on prescribing and use of generic medicines, reducing distribution margins for wholesalers and pharmacies, and taking measures to increase the rational prescribing of medicines.

How to prepare better for economic downturns?

26. Countries that accumulate reserves during periods of economic growth or at a minimum reduce budget deficits and external debts can opt for deficit financing through borrowing or depleting reserves when the crisis hits. Whether these counter-cyclical strategies are guaranteed through institutional arrangements or are simply the result of a political commitment to health varies across countries. Attention to efficiency and responsible management of public resources in the health sector, combined with prudent fiscal policy in the public sector as a whole, is essential during the years of economic growth, because in times of economic crisis, the population may be more likely to need social and health services, for which sufficient public financing is needed to ensure equity and efficiency in providing universal coverage. Those countries that entered the crisis with the ability to use reserves or sustain deficit spending have been much better able to protect their populations from the consequences of the crisis.

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

27. Increasingly, governance for health is being recognized as an area of critical importance in the pursuit of health gains. A major study on the whole-of-government approach and on governance tools and frameworks for Health in All policies (HiAP) is currently being conducted to inform the development of Health 2020. The theme of "governance for health" is expected to feature prominently in Health 2020, and the points set out below should be seen in this context.

Health in All Policies (HiAP)

28. The Tallinn Charter states that health systems "encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health". In this context, the Charter states that health systems "are more than health care and include disease prevention, health promotion and efforts to influence other sectors to address health concerns in their policies". "Ministries of health should promote inclusion of health considerations in all policies and advocate their effective implementation across sectors to maximize health gains." This thinking has come to be

called HiAP. Policies on agriculture, education, housing, labour, transport, taxation and welfare, for example, shape and affect the social determinants of health and patterns of health inequities in society. Experience to date suggests that we need acceleration of know-how, tools and instruments to strengthen and support health ministries to lead/influence practices to promote health and health equity in all policies. More learning from evaluation of results and impact is also essential.

Governance tools that support HiAP

29. A variety of approaches have been used to further intersectorality and HiAP. These can be categorized as "whole-of-government" approaches, implementing intersectoral actions based on health targets and on assessment of impact on health and health equity. Variations in approaches reflect different specific objectives, differences in know-how and human resource capacity across countries, and differences in the way that institutional arrangements are fragmented.

30. WHO has played various roles in providing support for ministries of health to lead and influence multisectoral actions to incorporate health concerns in all policies and address health determinants in Member States. One role has been acting as a "broker" or "knowledge translator" of innovation, evidence and know-how, as well as developing tools and methods to support HiAP, such as analysis of the social determinants of health and health inequalities. Another has been using WHO's convening power to bring different stakeholders together. WHO has also introduced health concerns into EU "platforms", building alliances and partnerships through specialized centres for HiAP.

Lessons learned in the process

31. Experience and the existing literature point to several essential elements for the successful implementation of HiAP which will be taken into account for the development of Health 2020. Key among these is strong leadership, both within the health system and at the highest level of government. Leaders must be able to articulate a clear vision of ways to improve health and health equity, combined with specific policies (including objectives and targets). Because administrative fragmentation is an obstacle to good intentions for multisectoral action, establishing a supra-departmental authority or organization in charge of HiAP, setting up other new organizational structures supportive of HiAP that are multisectoral in nature (e.g. a dedicated health impact assessment unit with its own budget), or effecting a substantial assignment of new responsibilities (with shared budgets) to existing structures can be critical steps towards real implementation of simultaneous actions by different organizational units. Finally, legal support also appears to be essential, both for endorsing specific activities and more generally to provide support for HiAP through revision of public health law.

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

From values to actions: a summary

32. The Tallinn Charter: Health Systems for Health and Wealth was a significant landmark for health policy in the European Region of WHO. Member States affirmed the fundamental importance of health for society and their collective responsibility to foster health and health equity. They declared their conviction that the services provided by health systems also include

public health services such as those for disease prevention and health promotion, as well as efforts to influence other sectors to address health concerns in their policies.

33. This summary report has highlighted many of the policies and innovations consistent with the commitments made in Tallinn Charter that have been implemented in recent years throughout the Region, often supported by WHO, and has synthesized lessons learned. As noted, these commitments were put to the test when the financial crisis hit. Equity, solidarity and financial protection could easily have been compromised in the face of fiscal pressures created by the deterioration in public finances during the years of economic downturn, and indeed in some countries, budget cuts for health and social sectors have had harmful consequences. However, several countries were able to use the crisis as a political opportunity to make long-needed shifts in priorities and to achieve efficiency gains that reduced the adverse effects on the poor and vulnerable. And the efforts to sustain performance have been closely linked to the use of evidence to assess performance and maintain accountability at a time when public spending has come under increased scrutiny. In short, countries that have been implementing the commitments embedded in the Charter have demonstrated that moving from values to action within a short period of time is possible with leadership, innovation, and openness.

34. Successes notwithstanding, there are also a number of challenges and barriers that have prevented Member States from translating the values of the Tallinn Charter into action. While health sector policymakers are enthusiastic about the commitments in the Tallinn Charter, getting the broader spectrum of government and politicians “on board”, particularly to engage them in activities for long-term health gain and more comprehensive approaches to governance, can prove to be challenging.

From the Tallinn Charter to Health 2020

35. The lessons emerging from the implementation of the Tallinn Charter will serve to inform the development of the new European health policy, Health 2020. That policy will reaffirm the central tenets of the Tallinn Charter, such as the urgent need to redress health inequalities, the need to engage stakeholders in decision-making related to health and its determinants, and the necessity of tackling modern health challenges through partnerships for learning and cooperation. In four areas, the synergies between the Tallinn Charter and Health 2020 will be particularly meaningful: rejuvenating public health services and action, national health plans and strategies, implementing health in all policies, and improving governance through performance assessment.

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

37. In the Tallinn Charter, Member States acknowledged that the decisive influence of social, environmental and economic determinants on health outcomes requires an effective stewardship function to address these. However, health ministers often do not possess sufficient authority within the government to initiate and sustain change outside of their own portfolios, and governance mechanisms (formal and informal) must be put in place to support ministries of health in leading intersectoral policy responses to health challenges. In the light of the above, Health 2020 will advocate a “whole-of-government” approach, entailing strong leadership to engage other sectors and enact change, horizontal governance processes to promote better health

as one of the shared societal goals pursued by all parts of government, and establishment of the governance mechanisms to support the approach.

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

39. The development of national health plans and strategies, a project led by the WHO's Global Policy Group, will benefit greatly from strong sector monitoring, good HSPA reports, and analytical work. The Tallinn Charter recognizes that working towards the broad goals of health systems in each country requires the identification of objectives that are linked to the goals and actionable by policy. Because of this, national health plans targeting ultimate population goals and intermediate outcomes can be important instruments with which to drive reform.

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

40. The Regional Office will continue to support Member States in implementing the commitments made in the Tallinn Charter by strengthening their health systems. WHO will do so by using the tools at its disposal (technical work, policy dialogue, convening power, capacity strengthening, facilitating cross-country learning, etc.) to improve health system performance in Member States through actions in a wide range of areas such as improving health financing arrangements, strengthening public health services, improving the quality of medical services, generating the appropriate level and quantity of resources (human resources and medicines) and strengthening governance arrangements. In addition to one-on-one engagement with Member States, the Regional Office has a number of intercountry products to offer such as guidance on HSPA and health financing policy, case studies that share know-how in a number of fields of health system strengthening, analytical work, courses, and other cross-country knowledge sharing events. Finally, the new WHO initiative on national health plans will provide a particular opportunity for engagement and support, under the umbrella of Health 2020, for those Member States that are starting new planning cycles.

41. The experience summarized in this report suggests that the principles and commitments affirmed in the Tallinn Charter are being implemented in policy environments characterized by complexity, uncertainty, high stakes and sometimes conflicting values. As a Region-wide set of commitments focused on accountability for the performance of health systems, the Tallinn Charter gives fresh momentum to health system strengthening, and valuable lessons can be learned from its implementation process. The planning for an evaluation that would aim to assess both lessons from country experience with reforms and the role played by this international political agreement should be initiated in the near future. The approach adopted in the present mid-term review could be bolstered to include individual interviews, focus groups and case studies, and selected Member States or an independent body could be invited to facilitate preparation of the final report. This would ensure that the wealth of experience gained in the process could be collected, appropriately analysed and synthesized in time for the sixty-fifth session of the Regional Committee in 2015.