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Europe



IMPLEMENTATION OF THE

TALLINN CHARTER: FINAL REPORT



Cover photo:

The Old Raeapteek (Town Pharmacy) and traditional house on Raekoja Plats (Town Hall Square) in Tallinn.

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**IMPLEMENTATION OF THE
TALLINN CHARTER:
FINAL REPORT**

Keywords

DELIVERY OF HEALTHCARE
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ABBREVIATIONS

AAAO	availability, accessibility, acceptability and quality (framework)
CIHSD	coordinated/integrated health services delivery
CPD	continuing professional development
DSP	Division of Health Systems and Public Health
EC	European Commission
EMA	European Medicines Agency
EU	European Union
GP	general practitioner
GRADE	grading of recommendations assessment, development and evaluation (methodology)
HAS	Haute Autorité de Santé: National Authority for Health (of France)
HIA	health impact assessment
HSPA	health system performance assessment
HTA	health technology assessment
HTP	health technologies and pharmaceuticals
IHR	International Health Regulations
NCD	noncommunicable disease
NICE	National Institute for Health and Care Excellence (of the United Kingdom)
NHSP	national health strategies and plans
OECD	Organisation for Economic Co-operation and Development
SCRC	Standing Committee of the Regional Committee (for Europe)
SEE 2020	South East Europe 2020 (strategy)
SHA 2011	System of Health Accounts, 2011 edition
SMC	Scottish Medicines Consortium
TB	tuberculosis
WHO FCTC	WHO Framework Convention on Tobacco Control

KEY MESSAGES

- In the WHO European Region, the Tallinn Charter: Health Systems for Health and Wealth (1) has helped stewards of health systems – ministries of health – to put a commitment to solidarity, equity and participation at the heart of their decision-making. Important advances include a better understanding of the need to invest both in health systems for the benefit of society and in policies that respond to the needs of vulnerable groups, including measures to extend coverage and to create and sustain universality in entitlements. Health 2020 – the new European health policy framework – which promotes whole-of-government and whole-of-society approaches to ensure the contribution of health systems in improving health outcomes, supports this approach.
- The Tallinn Charter, which signalled a significant development after the adoption of the Ljubljana Charter on Reforming Health Care in 1996 (2), emphasizes the importance of transparent and accountable health system performance monitoring in the WHO European Region. This is relevant to high-, low- and middle-income countries alike, and is reflected in the various innovations and efforts to institutionalize measurement and evaluation seen across the 53 Member States in the Region. The WHO Secretariat continues to support this work under the Health 2020 agenda.
- A reorientation towards primary care and public health services has been observed in some parts of the Region, but it needs to be accelerated in tandem with the development of a better understanding of patient needs in order to achieve improved health outcomes. The Tallinn Charter raised the importance of patients as stakeholders; Health 2020 further puts them at the centre of health systems.
- The Charter emphasizes the importance of reference indicators for promoting health system accountability, particularly in the delivery of health services. These measures reflect a shift in values towards the patient as an important stakeholder and have helped to inform the people-centred health system approach under Health 2020.
- Since the Tallinn Charter was signed, greater focus has been placed on health financing, largely due to the economic crisis. Although some countries have taken important measures to ensure adequate health system funding and to promote financial protection for households, millions of people continue to experience financial hardship when accessing the health services they need. This requires action to reduce out-of-pocket payments. Health 2020's goal of accelerating the health gain and lowering inequalities offers a platform for pursuing universal health coverage in the Region.
- Many countries have made good progress in implementing health workforce policies. Nevertheless, further effort is required in some countries to improve health workforce data consolidation and planning, in order to develop targeted health workforce strategies that better align with patient and population needs. More work is also required to address persistent silos and to align the competencies, research and organization of providers with patient needs. These are areas that feature strongly in Health 2020.
- Countries are increasingly aware of the need for priority-setting processes to improve the effectiveness and efficiency of spending on pharmaceuticals and other health

technologies. Health technology assessment continues to develop across the Region. Cross-national collaboration is emerging as a way forward in some areas, particularly as countries struggle to afford new high-cost medicines. Health 2020 offers a platform for ensuring that health technologies and pharmaceuticals also respond to people's needs and keep pace with innovations in these areas.

- The Tallinn Charter highlights the importance of using evidence to inform decision-making, particularly as a means of promoting equity, addressing inefficiencies and ensuring that investment in health offers value. Countries continue to make strides in this regard, but the routine collection and application of disaggregated information is still lacking in many jurisdictions. This is an area that continues to be strengthened by Health 2020.
- An important call under the Charter is for improved cross-national learning. The WHO Regional Office for Europe has facilitated this by leveraging its convening power to provide opportunities, engage key partners, foster networks and develop collaborative processes and tools. It has also played an important role in knowledge brokering by providing direct technical assistance to an increasing number of countries and by supporting the work of the European Observatory on Health Systems and Policies. The role of the Regional Office in helping countries support the values of the Charter to achieve the Health 2020 goals has been cited as crucial to health system strengthening activities in the Region.
- Despite the progress made in many areas of health system strengthening since the endorsement of the Charter, more work needs to be done with respect to broader systems thinking and approaches to transformative change. Health 2020 provides ways forward through its whole-of-government and whole-of-society approaches and its emphasis on improved governance for health.
- Actions to strengthen health systems in the European Region continue to embrace the values of the Tallinn Charter. The Charter's focus on solidarity, equity, participation and accountability for the performance of health systems provides a relevant guide for strengthening people-centred health systems in the context of Health 2020. Through consultation with Member States, the health workforce, health technologies, pharmaceuticals and health information have been recognized as essential enablers for work in two key strategic directions of the Regional Office:
 - transforming health services to meet the challenges of the 21st century;
 - moving towards universal health coverage for a European Region free of impoverishing out-of-pocket health expenditures.

I. INTRODUCTION

The WHO European Ministerial Conference on Health Systems: “Health Systems, Health and Wealth”, held in Tallinn, Estonia, on 25–27 June 2008, marked a milestone in strengthening health systems in the WHO European Region. The Conference, the adoption of the Tallinn Charter (1) and its endorsement by the WHO Regional Committee for Europe in September 2008 (resolution EUR/RC58/R4) were a direct response to increasing evidence that investing in health systems both has an intrinsic value and contributes directly to population health and economic wealth. These in turn contribute to societal well-being and stability. The Tallinn Charter was also an important milestone because it not only signalled the importance that Member States attach to health systems and the definition of their aims but also stressed the need to assess health system performance regularly as a means of promoting transparency and accountability and of driving improvements. It represents a shared commitment to a values-driven agenda for strengthening health systems.

Background

Since the 1996 Ljubljana Charter on Reforming Health Care (2), the WHO European Region has had consensus on the need to base reforms on stronger evidence. Moreover, the focus on cost containment and financing has given way to a new paradigm in which countries pursue both health and wealth in synergy, through such means as careful investment in health systems. The Ministerial Conference in Tallinn, which was supported by considerable research and evidence, made clear that wealth can contribute to greater population health – wealthier people and countries have longer life expectancies – and that it can do so in several ways. For example, people in good health are more productive, with less absenteeism, and are able to work in later years, representing a contribution to the economy. On the other hand, research – also presented at the Tallinn Conference – shows that failure to reduce adult mortality acts as a brake to economic growth, and failure to tackle health inequalities results in substantial economic costs.

Health and health systems were also shown to have a reciprocal relationship. Research has long shown that modern health systems contribute to important reductions in avoidable mortality; the Black report and the Wanless report from the United Kingdom of Great Britain and Northern Ireland have been especially influential here (3, 4). The latter shows that a fully engaged scenario – in which prevention and effective early treatment receive priority – would substantially reduce future costs to the health system. The evidence presented at the Tallinn Conference also demonstrates the health systems–wealth relationship, showing both that wealthier countries can afford better health systems and that those health systems can contribute to wealth by, for example, attracting investment to regional development programmes (5).

A further message to emerge from the Tallinn Conference and Charter was the clear human rights component of strengthening health systems. A robust health system is essential to realizing all people’s right to health. It helps to improve health outcomes and to reduce inequities between and within countries, including the growing east–west health gradient in the European Region.

The Tallinn Charter, therefore, emerged as a commitment initiated by Member States to deliver better health outcomes and to ensure a more efficient use of resources in the face of changing demands and demographics. It was developed with three aims: 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 support to countries. The Charter sets out the values and principles underlying health system development in the European Region and the contribution of health to societal well-being. It aims to convey a common understanding of health systems and what they seek to achieve, and to elicit explicit commitments by countries to improve the performance of their health systems, moving from values to action. Its key messages are that:

- health systems involve more than health care, since effective health systems promote both health and wealth;
- investing in health is an investment in future human development; and
- well functioning health systems are essential for any society to improve health and to attain health equity (1).

The seven commitments for action set out in the Tallinn Charter were to:

1. 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;
2. invest in health systems and foster investment across sectors that influence health, using evidence on the links between socioeconomic development and health;
3. promote transparency and be accountable for health system performance to achieve measurable results;
4. make health systems more responsive to people's needs, preferences and expectations, while recognizing their rights and responsibilities with regard to their own health;
5. engage stakeholders in policy development and implementation;
6. foster cross-country learning and cooperation on the design and implementation of health system reforms at national and subnational levels; and
7. ensure that health systems are prepared and able to respond to crises, and that countries collaborate with each other and enforce the International Health Regulations (IHR).

The Charter was formally endorsed by Member States during the 58th session of the WHO Regional Committee for Europe, with resolution EUR/RC58/R4 on stewardship/governance of health systems in the Region. The Regional Committee requested that the Regional Director “report to the Regional Committee in 2011 and again, with a final report, in 2015 on the support provided by the WHO Regional Office for Europe and the progress accomplished by Member States in the framework of the follow-up to the WHO European Ministerial Conference on Health Systems held in Tallinn, June 2008”.

In 2011 an interim report on implementation of the Tallinn Charter was presented to Member States during the 61st session of the Regional Committee (6). A summary of this report will be presented to the 65th session, to be held in Vilnius, Lithuania

Methodology

Purpose and objectives

The purpose of this report is to collate and present the ways in which the Tallinn Charter has been operationalized in health system strengthening activities across the WHO European Region, with an emphasis on those activities and directions reported by countries themselves. The report was guided by the overall question: “To what extent have the Tallinn Charter commitments influenced health system strengthening by Member States and the Regional Office?” Acknowledging that direct attribution of specific policies or outcomes to the Tallinn Charter is not possible, the objectives of the final report were to:

- assemble from around the Region relevant knowledge and experience of integrating the commitments of the Tallinn Charter;
- analyse this in terms of how Member States’ commitments to the Charter have strengthened health system performance; and
- provide evidence on actions and initiatives taken by countries in line with the Charter, thereby informing the planning of future health system strengthening in the Region.

Close collaboration with Member States

A core group of representatives of Member States (Belgium, Estonia, France, Germany, Kazakhstan, Norway, Slovenia and the United Kingdom) oversaw the planning, approach and writing of the final report. The group met with the Regional Office’s Division of Health Systems and Public Health (DSP) three times:

- at the Sixty-seventh World Health Assembly in Geneva, Switzerland, in May 2014;
- during the 64th session of the WHO Regional Committee for Europe in Copenhagen, Denmark, in September 2014;
- at the Sixty-eighth World Health Assembly in Geneva, Switzerland, in May 2015.

The core group was also consulted on various occasions by email to develop the questionnaire and review the final report before presentation at the Regional Committee.

In addition to the meetings between the DSP and the core group, the SCRC was also engaged in the planning and approval of the final report. During the first session of the Twenty-second SCRC, held in Helsinki, Finland, in December 2014, a team from the DSP presented the approach and reported on the progress made in compiling the report. The SCRC Member States approved a summary of the final report at the fourth session of the Twenty second SCRC in Geneva, Switzerland, in May 2015 for presentation at the 65th session of the WHO Regional Committee for Europe in Vilnius, Lithuania, in September 2015.

The information collected for the final report was shared with the team preparing a strategic paper on priorities for health system strengthening in the WHO European Region 2015–2020 (document EUR/RC65/13), to be presented at the 65th session of the WHO Regional Committee for Europe.

Sources of information

A number of key information sources were used to gather the requisite knowledge and experience from around the Region. The most important was a web-based consultation, undertaken in August–October 2014, during which a questionnaire was circulated to countries asking about their health system strengthening work since the Tallinn Charter

came into force. The questionnaire was approved by a core group of Member States engaged to advise on the process. Of the 53 Member States in the Region 40 submitted responses to the questionnaire – an extremely high response rate, suggesting the importance and continued relevance of the Charter and the values it espouses.

A purposive and transparent targeted review was undertaken of the literature on health systems and the Tallinn Charter in the European Region since 2008. This comprised relevant journals, WHO publications (including action plans and frameworks for action), regional and national strategy documents (such as health system performance assessments (HSPAs), national health strategies and plans, regional and programmatic strategy documents), European Observatory on Health Systems and Policies publications and reports from the pre-Tallinn meetings.¹ The interim report on implementation of the Tallinn Charter also provided valuable information – particularly the results of a questionnaire issued to countries to inform that report (6). The literature review identified current projects pursued by countries and Regional Office programmes to strengthen health systems.

Semi-structured interviews were performed with Regional Office programme managers from all divisions. A question guide was prepared to facilitate discussion around the Charter and health system strengthening activities, as well as the Charter's potential impact in areas outside the health system. This aimed to assess both the impact of the Charter in other areas to reflect the cross-cutting nature of health systems and the WHO Secretariat's work in implementing the Charter as the second element called for under the resolution.

Organizing framework and rationale

This report is organized and presented according to the seven commitments of the Tallinn Charter. Each is discussed in terms of the four core functions of health systems outlined in the Charter, based on those initially identified in the 2000 world health report (7): delivering health systems to individuals and to populations, financing the system, creation of resources and stewardship. The report's focus on how activities reported by Member States under each commitment have or have not strengthened the four health system functions marks its fundamental difference from the interim report (6).

The cross-referencing approach helps to make explicit the links between the commitments outlined in the Charter and health systems, which has three main benefits. First, while the Charter clearly defines the boundaries of health systems and describes the various activities and functions they must perform (see Box 1), an assessment exploring activities across all four core health system functions helps to develop understanding of the functions themselves.

Second, during the pre-Tallinn meetings it was agreed that interpreting health system strengthening in relation to strengthening of the core functions would be the way to assess how the Charter's commitments were translated from values to actions. Focusing on the four core functions enables systematic assessment of the performance of health systems, in turn allowing for more effective categorization of health system strategies. In this way, the report's format responds to the expressed needs of Member States to

1 Two consultative meetings were held in Vienna on 24–25 August 2006 and in Barcelona on 30–31 October 2006 in preparation for the 2008 Tallinn Conference. Four preparatory meetings were held in Brussels on 29–30 March 2007, in Bled on 19–20 November 2007, in Rome on 3–4 April 2008 and in Brussels on 6 June 2008.

Box 1. Tallinn Charter aims and actions by health system function

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.²
- 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 assessments should be used to support more informed decision-making.

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.

Source: Tallinn Charter (1).

clarify health targets that may be used for inspirational (political), managerial (policy) and technical (practice) purposes. Such a target-based approach to organizing Member

² 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 the WHO Regional Committee for Europe's resolution on health workforce policies in the European Region (EUR/RC57/R1).

State-reported activities can also provide a foundation from which the understanding of health systems can be enriched.

Third, in assessing progress across the four core health system functions, links between the functions themselves can also be made. Effective reform requires acknowledgement of these links and the interdependence between health system functions (5).

The terminology throughout this report is therefore consistent with that of the Tallinn Charter, with one slight modification. To facilitate discussion and understanding of the very diverse area of “resources for health” (which in the Charter includes pharmaceuticals, health technologies, information systems and human resources), the report divides this function into two subsections – human resources for health and health technologies and pharmaceuticals (HTP) – in line with WHO’s framework for action for strengthening health systems (8). Furthermore, since the 2008 Tallinn Conference, programmatic priorities and Member State activities have highlighted the fact that the function of generating resources needs to be balanced with guidance on how to manage those resources. Thus, this report focuses its analysis not only on the ways in which human resources for health and HTP are generated but also on their impact.

Coding matrix

Based on the meetings leading to the signing of the Tallinn Charter, along with bilateral conversations with a team of experts (9) and consultation with DSP programme managers, a matrix was developed to translate the Charter’s seven commitments into activities that represent optimally functioning health systems (see Fig. 1). This matrix was used to code the consultation questionnaire information submitted by countries. It may also serve as a guide and platform for future activities of the Regional Office and in countries. This approach was approved by the core group of Member States as a useful way of examining the information from countries and as a guide to the structure of the final report. Given that the Tallinn Charter is specific to health systems, this approach enables a more detailed understanding of the third priority area of Health 2020, the new European health policy framework developed four years after the Tallinn Charter: strengthening people-centred health systems, public health capacity and emergency preparedness, surveillance and response (10).

Once the information was analysed, key messages were identified and agreed upon in collaboration with programme managers from the DSP and several health system strengthening experts. The report’s content was validated by a select group of programme managers, experts and the core group of Member States.

Structure of the report

Following this introduction, the next chapter provides a brief overview of developments in the Region since the signing of the Charter, including developments in improving health outcomes and health systems. The chapter also explores how health systems are positioned in relation to Health 2020, which was discussed at the high-level meeting held to mark the five-year anniversary of the signing of the Tallinn Charter (11).

The following chapters run through each Charter commitment, providing an account of the trends identified from responses to the consultation questionnaire. Each commitment

Fig. 1. Coding matrix: the Tallinn Charter commitments and the functions of health systems

Tallinn commitments	Core health system functions					Health 2020: people-centred health systems
	Delivering health services	Health system financing	Human resources for health	Medical products and technologies	Stewardship/governance	
1. Promote shared values of solidarity, equity and participation	→					Health 2020: people-centred health systems
2. Invest in health systems and foster investment across sectors	→					
3. Promote transparency and accountability	→					
4. Make health systems more responsive	→					
5. Engage stakeholders	→					
6. Foster cross-country learning	→					
7. Ensure that health systems are prepared	→					

clusters the trends in terms of how the activities serve to strengthen the four core functions. This provides an operational approach to understand what can be built on or strengthened in the Region. The examples presented under each commitment should not be considered recommended practices but are rather illustrative of the diversity of responses across the Region within the trends identified.

The report concludes with lessons learned for the future of health system strengthening in the Region. These have informed a separate paper on priorities for health system strengthening in the WHO European Region 2015–2020 (document EUR/RC65/13), to be presented at the 65th session of the Regional Committee for Europe in Vilnius, Lithuania, in September 2015. This report is based on further research, consultation with Member States and expert and partner input on future health system directions in the Region (9). It will be presented with an accompanying resolution at the 65th session of the Regional Committee for Europe.

Limitations

The report has several limitations. First, as mentioned earlier, it is difficult to attribute any changes since 2008 directly to the Tallinn Charter. Second, while all countries received the same questionnaire, which provided a brief explanation of the Charter, respondents differed in their level of familiarity with the Charter and their definitions of terms. Third, the information provided varied in its completeness and the examples given. Fourth, countries often reported with an emphasis on the changes introduced to fulfil the Tallinn Charter commitments, and did not report on those changes or inactions that might not be in line with the commitments. Fifth, the need to represent all 53 Member States in the Region, combined with the need to capture the diversity of initiatives reported, meant that detailed analysis was not possible.

HEALTH AND RELATED DEVELOPMENTS IN THE REGION SINCE TALLINN

The global economic crisis

Shortly after the Tallinn Conference the economic crisis struck the European Region and it became clear that in many countries the commitments made in the Charter would be put to the test. The onset of the crisis in 2008 resulted in a dramatic initial economic shock: real gross domestic product per capita declined by 4.5% across the Region in 2009. As a result, unemployment increased sharply; within the European Union (EU) alone it rose from an annual average of 7.0% in 2008 to 10.2% in 2014, with a peak of 10.9% in 2013 (12). Meanwhile, for nearly half the countries in the Region public expenditure on health as a percentage of total government expenditure remained stagnant or even decreased (see Table 1). For many countries the economic crisis triggered a collapse of credit markets, leading in many cases to government bank bailouts and in turn to a rapid drop in economic activity and rising unemployment. Some countries have experienced particularly large increases in unemployment, especially among younger people. This has led to lower revenues for governments as a result of falling payroll and other tax revenues. Growing unemployment has also put pressure on governments to increase public spending on social security programmes.

Table 1. Public expenditure on health as a percentage of total government expenditure in the European Region

Country	2008	2012	Difference 2008–2012
Belarus	7.88	13.22	5.34
Monaco	15.80	18.82	3.02
Kazakhstan	8.32	10.90	2.58
Bosnia and Herzegovina	14.06	16.60	2.54
Iceland	13.36	15.72	2.36
Tajikistan	5.04	6.82	1.78
Albania	8.38	9.86	1.48
Uzbekistan	10.64	11.76	1.12
Bulgaria	12.32	13.30	0.98
Malta	18.76	19.72	0.96
Netherlands	13.68	14.62	0.94
Czech Republic	7.00	7.86	0.86
Armenia	15.22	16.06	0.84
United Kingdom	3.08	3.88	0.80
Azerbaijan	16.24	16.94	0.70
Austria	8.36	9.00	0.64

Table 1. Contd.

Country	2008	2012	Difference 2008–2012
Germany	18.56	19.12	0.56
Sweden	14.54	15.10	0.56
Georgia	4.78	5.22	0.44
Montenegro	9.68	9.96	0.28
Republic of Moldova	12.98	13.26	0.28
Russian Federation	10.08	10.32	0.24
Israel	10.22	10.38	0.16
Cyprus	6.78	6.88	0.10
Hungary	10.16	10.26	0.10
Belgium	14.92	14.96	0.04
France	15.90	15.94	0.04
Andorra	0.00	0.00	0.00
Turkey	12.80	12.80	0.00
Turkmenistan	8.68	8.68	0.00
Romania	11.34	11.28	-0.06
Ukraine	11.62	11.54	-0.08
Lithuania	12.84	12.74	-0.10
Estonia	11.88	11.72	-0.16
Finland	12.58	12.32	-0.26
Switzerland	20.90	20.62	-0.28
Italy	14.44	14.16	-0.28
Poland	11.44	11.14	-0.30
The former Yugoslav Republic of Macedonia	14.04	13.58	-0.46
San Marino	13.64	13.14	-0.50
Denmark	16.74	16.08	-0.66
Serbia	14.08	13.36	-0.72
Spain	15.76	15.04	-0.72
Slovenia	13.94	13.10	-0.84
Slovakia	15.58	14.70	-0.88
Kyrgyzstan	13.06	12.16	-0.90
Norway	19.14	17.76	-1.38
Greece	12.96	11.44	-1.52
Latvia	10.56	8.88	-1.68
Portugal	14.90	12.48	-2.42
Croatia	17.74	15.06	-2.68
Luxembourg	16.60	13.48	-3.12
Ireland	15.86	12.38	-3.48
European Region	13.21	13.40	0.19

Source: European Health for All database (13).

The incidence of infectious diseases (such as HIV infections) has increased sharply in some of the hardest-hit countries, where preventive programmes (like needle exchange) and early treatment services have been scaled back as a result of budget cuts (14, 15). Falling household incomes also have an effect on unhealthy behaviours such as harmful levels of smoking and alcohol consumption. Moreover, certain health effects do not manifest themselves immediately. These few examples demonstrate the importance of protecting preventive health services, for which demand increases during times of economic crisis. Protecting the poor and vulnerable from the financial risks of accessing care at a time of increased demand is similarly critical, to avoid further impoverishment and an elevated burden of disease.

The choices countries could or would make for their health systems over the years following 2008 – and how they would defend those choices – were therefore shaped not only by the Tallinn Charter commitments but also by the economic crisis. This is especially the case for those countries in receipt of bailouts from the “troika”, which consists of the European Central Bank, European Commission (EC) and International Monetary Fund. This three-part commission is charged with monitoring the European debt crisis and is responsible for making recommendations to help solve the crisis. Countries with sufficient reserves or the willingness to increase borrowing (deficit financing) have been able to deal with the resulting fiscal imbalance without having to take drastic measures. Nevertheless, the health and social sectors are particularly vulnerable to budget cuts during times of economic downturn because of both their size within any government’s budget and the often relatively weak position of health ministries.

A high-level meeting was convened jointly by the WHO Regional Office for Europe and the Government of Norway in Oslo in April 2009 (16). This was the first attempt by WHO to reflect on responses to the economic crisis and provide guidance to countries on how best to navigate through difficult times. A set of recommendations was proposed for guiding pro-health and “pro-poor” policy responses; these were in line with and driven by the Tallinn Charter commitments. Later in 2009, the Regional Committee adopted resolution EUR/RC59/R3, urging Member States to ensure that their health systems continue to protect the most vulnerable; to demonstrate effectiveness in delivering personal and population services; and to behave as wise economic actors in terms of investment, expenditure and employment.

Affected European countries have been navigating the crisis for seven years at the time of writing, indicating its prolonged nature. The tight fiscal context and high unemployment are expected to continue in the medium term. Two broad observations stand out clearly from the evidence. First, the crisis has adversely affected many social determinants of health – notably, income, employment and levels of public spending on health and other social sectors. In several countries the crisis has had far-reaching social and political consequences. While more evidence is needed to comprehend fully the impact of the crisis on national health indicators, current findings indicate that it has contributed significantly to an increase in health inequalities between population groups and across the Region (17).

Second, both the fiscal policy response of a country (i.e. the extent to which it follows a path of austerity versus one of countercyclical spending) and the health policy response are important in ensuring that effective social safety nets are in place and that access to needed services is protected, as well as the quality of those services. Given that health

needs increase when unemployment rises and household incomes fall, if these policy responses are unable to maintain safety nets or protect access to high-quality services – especially for more vulnerable groups – they may affect population health. For example, although data limitations and challenges exist when attributing certain health effects to the crisis, it is clear that mental health is highly sensitive to economic downturns, both increasing the likelihood of falling sick and slowing recovery from illness. Across the EU, suicides among those aged under 65 years have also been increasing since 2007, reversing a previous downward trend (18). Both unemployment and the fear of unemployment are major contributing factors to these trends (19).

Health 2020: the new European health policy framework

The WHO Regional Office for Europe has engaged intensively with Member States to make effective policy decisions that improve health and reduce inequalities during the crisis period. The new European health policy framework, Health 2020, is the foundation of this engagement (10). Health 2020 seeks to improve significantly the health and well-being of populations, reduce health inequalities, strengthen public health and ensure sustainable people-centred health systems. It is aimed at the whole of government and the whole of society, envisaging actions and outcomes far beyond the boundaries of the health sector and outside the remit of the ministry of health. Health 2020 proposes reaching out and working with other ministries, departments, sectors, stakeholders and civil society organizations, as well as with citizens, patients and consumers. Progress towards all these goals will be achieved by policy action in four areas: investing in health through a life-course approach and empowering people; tackling Europe's major health challenges of noncommunicable and communicable diseases; strengthening people-centred health systems and public health capacities, including preparedness and response capacity for dealing with emergencies; and creating resilient communities and supportive environments.

In identifying health systems as one of its four policy action areas, Health 2020 reaffirms the central tenet of the Tallinn Charter: investing in health systems and their improved performance as a means to improve the health of all members of society. The Health 2020 policy framework goes further, however, by challenging health systems to be more people-centred, part of a whole-of-government approach to improving health, aligned towards strengthening public health and contributing to the reduction of social inequities over the life-course. In this way, Health 2020 has emerged as the most comprehensive response to unaddressed health concerns in the Region.

Reaffirming intersectoral collaboration in promoting public health

Health 2020 builds on the recognition and strong evidence that any strategy to promote population health needs to take a broad perspective, involving actions both within and outside the health system (20). While good evidence exists that a substantial reduction in avoidable mortality might be achieved through preventive measures delivered within the health care system, the socioeconomic environment in which individuals live is a major determinant of health and continues to be challenging, creating a substantial negative impact on the risk of premature mortality and avoidable morbidity (21).

A broad approach to promoting population health involves a combination of upstream and downstream interventions. The former include action on the “causes of the causes”, such as income support, improvements in housing or increasing the number of years in education. Although many of these actions are delivered and funded by agencies outside the health system, it is critical that their health impacts are monitored and that the health system emphasizes these impacts in policy debates. Other upstream determinants include population-based prevention programmes, such as tobacco and alcohol control policies; water and air quality monitoring; and legislative, regulatory and other safety measures against accidents and injury. Downstream measures include individually targeted measures, such as advice on lifestyle (22).

At the time of signing the Tallinn Charter, Member States shared an understanding that public health was located both within and outside the health system. For this reason, the second commitment calls on stewards of health systems to practise more intersectoral collaboration. It appears from the responses to the consultation questionnaire that most countries are trying in various ways to include intersectoral collaboration within the mandate of their health ministries. Based on their responses, however, it is clear that Health 2020 has also been instrumental in targeting decision-makers beyond the health system, and has initiated a process of translating health priorities into all sectoral policies. In the process, Health 2020 has drawn attention to an important question that must be addressed by all governments striving to improve health: who is ultimately accountable for public health? That this remains a challenging question to answer was apparent during the high-level meeting held to mark the five-year anniversary of the signing of the Tallinn Charter (11), at which participants reflected on the need for public health advocates to come together as a single community to accept responsibility. The meeting also called for more dedicated public health training and a greater recognition of the importance of supporting the discipline as a career choice.

Strengthening evidence-informed decision-making in health policy

Another important development since the signing of the Tallinn Charter is the increased importance some countries have placed on the use of evidence to inform decision-making, particularly as a means of better targeting – and, in turn, justifying – investments in health. Health research capacity in some parts of the Region has been very limited (23), although there are signs that this is changing. With rising costs and financial pressures, difficult decisions are required about which interventions and services an affordable and cost-effective health system should provide. Politically robust, evidence-informed and transparent processes also help to shield decisions from special interests and to foster public acceptability. Data disaggregated according to income level, geographical location and sex (to name but a few) help decision-makers to target health policies and interventions more effectively and responsibly.

Countries that have achieved a shift in culture towards a more evidence-informed approach have succeeded in establishing three key “pillars” over time: regular demand for health evidence by policy-makers; capacity-building to produce high-quality health evidence; and sustainable institutional solutions linking demand and supply. The first pillar marks a change in policy-making culture, whereby policy-makers regularly seek evidence prior to decision-making. WHO has been generating demand for evidence-

informed health policy through an ongoing dialogue with Member States on various aspects of health system strengthening, and has been invited to testify in front of national legislatures (including Latvia and Kyrgyzstan) on key aspects of health financing policy. In some cases, WHO and Member States have agreed to strengthen policy development by placing “resident” policy advisers and analysts in WHO country offices to work closely with ministries of health (such as in Kyrgyzstan in 2000–2009, Azerbaijan in 2006–2008, Tajikistan since 2006 and the Republic of Moldova since 2011). This allows long-term relationships to be forged with policy-makers within and outside the health sector; it also facilitates demonstrations of evidence use in making better decisions and conducting high-quality policy dialogue with key stakeholders such as the government, parliament and nongovernmental sector.

The second pillar is increased capacity to produce high-quality research and evidence, performance assessments, policy analysis and sector monitoring. A popular approach to capacity-building has used topical courses, such as international and country-level courses in health system strengthening (including flagship courses undertaken in partnership with the World Bank Institute in Estonia, Hungary, Kyrgyzstan and Spain), health sector monitoring (in Kyrgyzstan and the Republic of Moldova), European Observatory on Health Systems and Policies-run summer schools and various aspects of policy analysis. Another approach has engaged in joint analytical work with countries. Examples of such projects have examined improving financial protection in Kyrgyzstan through reducing informal payments, the impact of the basic benefit package on utilization and patient expenditures in Tajikistan and extending population coverage with health insurance in the Republic of Moldova. In addition, WHO has guided the design of sectoral monitoring instruments in Hungary, Kyrgyzstan, the Republic of Moldova and Tajikistan. These joint analytical activities provide the opportunity for capacity-building throughout the health sector, through on-the-job training and by capitalizing on learning-by-doing processes. A further instrument to improve the quality of health evidence is facilitating peer-to-peer learning exchanges among countries. For example, Kyrgyz policy analysts provided support to counterparts in Tajikistan on a number of studies and also hosted a team from Azerbaijan when the policy analysis unit in the health ministry there was established, to share experiences on institutional issues and work processes. WHO has also worked to strengthen country health system decision-making in the Region through its collaborating centres (24), such as the Pharmaceutical Pricing and Reimbursement Information network (25). With the network’s help, WHO has supported several Member States – including Cyprus, Estonia, Greece, the Republic of Moldova and Ukraine – in developing national essential medicines lists and medicines reimbursement policies. Other collaborations have taken place with the London School of Economics, London School of Hygiene and Tropical Medicine and Technical University of Berlin.

The third pillar involves institutional development: putting in place sustainable institutional arrangements where demand for health evidence is articulated; where it is satisfied through the supply of high-quality evidence; and where knowledge translation platforms create a bridge between evidence and policy. Several countries have established or are in the process of establishing policy analysis or sectoral monitoring units within their health ministries. In 2013 the Ministry of Social Affairs in Estonia, with the Estonian Research Council, commissioned the Academy of Sciences to develop a strategy on health research, development and innovation. The strategy supports health system development and evidence-based policy-making. Experience suggests that where there is high-level political commitment to evidence-informed policy-making, these units

are fully staffed, have clear terms of reference and produce useful work for the entire ministry and other health sector agencies. Institutional assessments have been carried out in several countries (Azerbaijan, Kyrgyzstan, Republic of Moldova and Tajikistan) to rationalize governance arrangements and identify the appropriate approach to integrating evidence into the policy process. Several countries have started to develop information systems to track the training of nurses and continuing education courses taken by doctors. Kyrgyzstan is developing a human resources planning information system; the Republic of Moldova has developed and implemented an information system on human resources for health; Serbia has established a database of personnel in state health institutions for use in policy planning; and Spain has created a state register of health professionals as a critical tool for workforce planning and mobility mapping. Different countries opt for diverse arrangements: no single model fits all.

Engagement in strengthening capacities and institutions for evidence-informed policy development has delivered synergies with other areas of health system strengthening. Sector planning and the development of national health strategies and plans (NHSPs) benefit greatly from strong sector monitoring, good HSPAs reports and analytical work. Health management training courses can integrate the results of sector monitoring and policy analysis into their curricula and ensure that knowledge is disseminated to both senior managers and health facility managers. Finally, a regular sector monitoring exercise with agreed indicators and targets matching the objectives of the NHSP is a powerful tool for sector coordination. It reduces the burden on the ministry of health by reporting in a number of ways to various development partners, and it allows for better harmonization and alignment of development assistance.

Resilience of the health system

In addition to the issues for the health system posed by the economic crisis, a great deal more has changed since the signing of the Tallinn Charter. In 2014 the Ebola outbreak challenged the African Region in previously unimaginable ways. While not nearly as affected by the outbreak as the African Region, countries in the European Region were nevertheless forced to reflect on their preparedness should the outbreak spread or a similar disaster strike their Region.

The European Region has also faced its own violent, environmental and biological or epidemiological challenges. Between 1990 and 2010 approximately 47 million people in the Region were directly affected by natural disasters. These included 719 accidents, 442 floods, 159 extreme temperature events, 315 storms, 107 earthquakes, 36 droughts, 77 wild fires and 59 landslides and avalanches, resulting in over 132 000 deaths. Other severe events of the recent past include the Chernobyl nuclear power plant accident in 1986, which the United Nations estimates affected several million people, and the Marmara earthquake that killed nearly 18 000 people and injured close to 45 000 people in Turkey in 1999. In addition, a series of violent wars and conflicts in the Region since 1990 has contributed to vast political, social and human consequences and resulted in the deaths of over 300 000 people. Most recently, and in the information submitted for this report, countries identified the Ebola crisis, terrorist threats, the security crises in Georgia and Ukraine and large influxes of migrants from the Syrian Arab Republic and northern Africa as the primary concerns that have brought the importance of resilient health systems into focus.

To respond effectively to the growing complexity of health security challenges, it has become clearer than ever that strengthened, well prepared and well managed health systems can effectively contribute to preventing health events from triggering a security crisis. The close collaboration of governments, international organizations, civil society, the private sector and other partners is of the utmost importance. Effective crisis preparedness and response are governed by a number of cross-cutting strategic principles that WHO encourages Member States to adopt. These relate to the all-hazard approach, the whole-health approach and the multidisciplinary (intrasectoral) approach, but also to a multisectoral and comprehensive approach. WHO is reforming its emergency response operations through the updated emergency response framework, a policy document that governs WHO's actions in emergencies with public health consequences (26).

In addition, WHO has a unique international mandate from its Member States to promote and support the revised IHR (27), as revised by World Health Assembly resolution WHA58.3, which was approved at the Fifty-eighth World Health Assembly in May 2005. The revised IHR have a much broader scope than the first edition of 1969, which focused on the international notification of specific communicable diseases. They provide a new legal framework for strengthening surveillance and response capacity and protecting the public from acute health threats with the potential to spread internationally, affect human health negatively and interfere with international trade and travel. States Parties to the IHR are now obliged to assess and notify WHO of any event of potential international public health concern, irrespective of its cause (whether biological, chemical or radionuclear) and origin (whether accidental or deliberate). The criteria for assessing the implications of any such event are outlined in annex 2 of the IHR. These include health-related events that are unusual or severe, may have a significant impact on public health, may spread across borders and may affect freedom of movement (of goods or people).

COMMITMENT I

The first Tallinn commitment is 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.

Main messages

- Countries reported using policy tools to reorient services towards outpatient care, primary care and public health. Public health services and infrastructures, however, remain weak and outdated in many parts of the European Region. Moreover, funding for public health has been declining.
- Economic and social distress affect attitudes to solidarity. To promote solidarity and equity, countries have reported health system changes to respond to the needs of vulnerable groups, including measures to extend coverage and create and sustain universality in entitlements. Despite these measures, 1.5 million people have unmet needs for health care in the Region. It is therefore important to promote the Tallinn Charter and its explicit commitment to solidarity, equity and participation as an important instrument in shaping policy responses to the economic crisis.
- Good progress has been observed in many European countries in reviewing health workforce needs and developing and implementing policies, strategies and plans as a critical component of health system strengthening. The availability, accessibility, acceptability and quality (AAAQ) framework (28), recently endorsed by the Third Global Forum on Health Workforce, will be an important tool in the coming years to guide such policies and strategies.
- All countries have undertaken or are undertaking policy reform measures in the pharmaceutical area, as awareness increases of the need for priority-setting processes to improve efficiency in spending on HTP. Countries have been particularly active in prioritization exercises like horizon scanning and health technology assessments (HTAs). In the area of intellectual property rights, accession countries to the EU may face issues such as patent protection. There remains, therefore, a need to be mindful of sustaining access to medicines.
- A variety of policy tools are used across the Region to set goals and objectives (NHSPs, legislation and regulations). By embedding their NHSPs within the broader context of Health 2020, several countries have demonstrated commitment to addressing the broader context of public health. They reported use of these policy tools to address population health and the needs of the poor and vulnerable.

This first commitment stands apart from the subsequent commitments in binding Member States to a set of values rather than activities. Since these values are cross-cutting and underpin all other commitments, they are reviewed only in terms of how countries have articulated them through national and subnational health plans and policy instruments. This commitment captures the important consensus that ministries of health (the stewards of health systems) must make decisions that promote solidarity, equity and participation through the policies, resource allocations and actions they pursue to improve health outcomes in their countries.

The Tallinn Charter also clearly emphasizes that, to avoid undermining and threatening the virtuous cycle of health and wealth that contributes to societal well-being, countries must pay special attention to their poorest and most vulnerable groups. Variations in health outcomes continue to exist between men and women, urban and rural inhabitants, local and immigrant populations and population groups classified according to many other characteristics. The health divide between population groups is also growing in many parts of the European Region (17, 29). Rich and poor countries alike face substantial inequalities in health, on both relative and absolute scales (30). Individuals with less education, in lower occupational groups or with lower incomes continue to be clearly associated with higher risks of ill health, higher prevalence of multimorbidities and mortality at a younger age (5).

In spite of this challenging context, countries across the Region have taken important and significant steps in improving health outcomes under the banner of this first commitment. The following section looks at how they have operationalized its values in their NHSPs and policy instruments. At a time when substantial inequalities continue to prevail and challenge the state of health and well-being, these policies and strategies have proved to be particularly relevant for the European Region (5, 10), establishing the goals and objectives against which health systems can begin to identify the measures by which they will direct, plan, implement and evaluate efforts (31). That these goals and priorities are phrased in terms of the four core health system functions is also important for monitoring and evaluation of progress in these areas. A lack of such priorities leads to arbitrary decisions and/or no progress at all. As these priorities are refined into targets for action and made public they become an important tool for fostering greater transparency and accountability at both the national and regional levels.

Reorienting service delivery to strengthen primary care and public health

The reality is that health is mostly created in homes, communities and workplaces; only a minority of ill health can be repaired in clinics and hospitals. Primary care and public health address health-promoting environments and workplaces and primary prevention, such as nutrition education, immunization, antenatal care, physical activity, smoking prevention and social policies that influence literacy, employment, crime, housing quality, and community well-being. Thus, by reorienting services to primary care and public health, countries are making health services more accessible to individuals and populations, minimizing the burden of illness, especially for vulnerable groups (32).

Across the European Region countries are creating policy tools to address public health and reorient services in that direction. Public health services and infrastructures, however, remain weak and outdated in many parts of the Region, and their funding has been declining. Nevertheless, several countries, including Armenia, Germany, Slovenia and the former Yugoslav Republic of Macedonia, are showing signs of putting in place policies to plan for and provide public health interventions. Countries including Bosnia and Herzegovina, Portugal, the Republic of Moldova, Slovakia and Slovenia have initiated processes to strengthen public health capacities, focusing on new funding mechanisms, organizational reform and strengthening the public health workforce. Austria has prepared a strategy on health promotion, accompanied by an influx of funds to finance nationwide measures focusing on the issue of nutrition. Azerbaijan has established a public health

and reform centre within the ministry of health, which has invested in noncommunicable disease (NCD) risk factor research to identify key areas for interventions. The centre also develops health promotion campaigns and produces clinical guidelines and practice recommendations on various public health-related issues. The Czech Republic has approved a strategy for health protection and promotion and primary disease prevention. A new conceptual plan for development of public health has been adopted in Tajikistan: it focuses on improving the quality of public health services and preparing the public health workforce to realize the field's potential.

Countries are also using policy tools to reorient services towards primary care and outpatient care. Stronger primary care services are reported to be a means to control costs: they are associated with better population health, lower rates of hospitalizations, lower socioeconomic inequality and thus better health outcomes (33). Austria, Switzerland, Tajikistan and Uzbekistan have developed new policies to steer the development of primary care since the adoption of the Tallinn Charter. Kazakhstan's health care development programme for 2011–2015 aims to improve population health by various means, including strengthening intersectoral cooperation and improving access to primary health care. Ukraine has introduced health care reform to improve access to primary care services through primary health care centres – which are legislated to serve citizens, irrespective of place of residence – and has decentralized the oversight of these services to municipalities to improve their responsiveness. The law states that these centres are to include outpatient clinics and feldsher/midwife stations that provide consultations, diagnostic and treatment services, trauma services, toxicology services and a range of preventive and reproductive services. The process of establishing the centres and their units is ongoing. The service delivery function of health systems is thus increasingly concerned with how inputs and services are organized and managed to ensure access, quality, safety and continuity of care across health conditions, across different locations and over time.

Countries of central and eastern Europe that belonged to the former Soviet Union have undergone the most dramatic reforms in the area of primary care as the old Semashko types of health care system have been completely redeveloped. Primary care development has been an answer to the challenge of creating more effective and responsive health care systems in these countries. A number have introduced a primary care system with family doctors in a gatekeeping position, while some countries in western Europe made much more modest steps towards a stronger position for primary care (34–38).

As countries increasingly reorient services to primary care, they have started to recognize the importance of strengthening these services by improving continuity of care, organization of providers and quality of services. Kyrgyzstan is planning further reforms to increase the effectiveness and quality of primary care services, focusing on extending and increasing the qualifications of family doctors and nurses; improving the technical resources and extending the management and financial autonomy of family practices; and introducing performance-based payment mechanisms. The Republic of Moldova has clearly defined primary health care policies that were previously set as general priorities in its national health policy and strategy for 2007–2021 and health care system development plan for 2008–2017. The focus is now on development of primary care services and the management structures of the system; greater autonomy has been provided to service providers, accompanied by corresponding changes in financing. Spain has implemented a strategy for addressing chronic conditions, launched in 2012 by the ministry of health in consultation with the 17 regional authorities. The initiative is

a response to the rising number of older people, the increasing number of consultations for chronic conditions and the need to move away from acute resolution of pathologies towards a better coordinated and more interdisciplinary preventive approach involving social workers and patients. The guiding principles of the strategy included a patient-oriented design, a life-course perspective and a focus on the social determinants of health, primary health care, patient empowerment and integration of health services. Six strategic lines of approach were identified: health promotion, prevention of medical conditions and chronic limitation of activity, continuity of care, reorientation of health care, health equity and equal treatment, and the promotion of integrated health research and innovation. The strategy complements and enhances initiatives already under way in the regions, which have the executive role in health and social care.

Making explicit the commitment to solidarity through health financing

While most questionnaire responses reported on the introduction of health system changes to respond to the needs of vulnerable people and inclusion of measures to extend coverage and create and sustain universality in entitlements, 1.5 million people in the Region still have unmet health care needs. It is therefore important to promote the Tallinn Charter and its explicit commitment to solidarity, equity and participation as an important instrument in shaping policy responses to the economic crisis.

The European Region has several examples of countries that have expanded benefits for vulnerable groups. Austria, France, Ireland, Italy and the Republic of Moldova have all extended coverage in the area of pharmaceuticals for low-income groups. Croatia has reduced user charges, while Hungary and Italy have abolished them completely. Several countries reported expanding statutory coverage for previously uninsured groups of people (Belarus, Bosnia and Herzegovina, Georgia, the Republic of Moldova) or introducing universal health coverage (the former Yugoslav Republic of Macedonia). The countries of the former Soviet Union in particular are expanding eligibility for benefits to targeted populations groups (39). Estonia has extended entitlement to health insurance benefits to the long-term unemployed who are registered and actively seeking employment; this measure has greatly contributed to protecting the growing number of unemployed people during the economic crisis. Georgia has introduced a state universal health care programme in 2013, intended to fund health care services for people without health insurance. The programme covers primary care, emergency care and some elective inpatient services. In the Republic of Moldova the government has passed two new pieces of legislation that extend benefits to the most vulnerable. The first, adopted in 2009, ensures that all those registered as poor automatically received fully subsidized health insurance (40); it also includes further measures to ensure that employers make health insurance contributions on behalf of their employees. The second, passed in 2010, extends full primary health care services to all citizens, irrespective of their status under the national health insurance programme. This amendment, which effectively ensures universal access for all Moldovans to essential services, includes outpatient medicines at subsidized rates and emergency ambulatory care. In Slovenia amendments to the law on health care and health insurance introduced in 2008 gave approximately 100 000 citizens in the lowest income brackets the right to have their voluntary health insurance premium paid from the state budget. Voluntary health insurance in Slovenia covers user charges for publicly financed health benefits; this measure – which reduces

financial barriers – partially reversed the previously regressive system where premiums were completely independent of incomes. A key factor in the success of these changes was alignment of the policy to extend coverage with the resources needed to enable implementation. Turkey's "Health transformation" programme has merged the benefits of different insurance arrangements under a single national universal coverage scheme (including subsidized coverage for people with low incomes) and provides conditional cash transfers to pregnant women to promote antenatal care.

Evidence shows that the Roma population is less likely to have health insurance in many countries in central and south-eastern Europe (41). Although no published evaluations have yet been undertaken, Serbia has a policy that provides coverage for the unemployed Roma population living in poor "traditional" settlements. Its implementation is facilitated by an outreach programme through Roma health mediators, who facilitate registration with the health insurance fund. A WHO mission in 2010 found that significant barriers to access for the Roma still remain, however, and suggested practical actions to make this excellent pro-poor policy more effective: in line with the Tallinn Charter commitments, the Regional Office recommended the extension of the benefit entitlement to long-term unemployed people, especially during the economic crisis.

Despite the potential of economic and social distress to affect attitudes to solidarity, the Tallinn Charter has proved to be a reference point for policy responses to the economic crisis. It has guided various countries (including Austria, the Czech Republic, Estonia, France, Lithuania and the United Kingdom) to avoid indiscriminate cuts in public spending on health and social welfare, as these increase poverty and reduce the health of the population. One such example is Estonia where, despite the economic crisis, budget cuts have excluded needle exchange programmes, thereby controlling the rates of HIV and related transmittable diseases. In other countries indiscriminate cuts have unfortunately led to rising rates of infectious diseases and NCDs (42) and left at least 1.5 million people in the Region with unmet health care needs (43).

Countries have increased efforts to promote redistributive revenue collection to improve solidarity. For example, Denmark, Ireland and Portugal have abolished or reduced tax subsidies for voluntary health insurance or out-of-pocket payments that largely benefited wealthier groups of people. Montenegro and the Republic of Moldova have selectively reduced contributions for poorer people, while France and Romania have selectively increased contributions for richer people. Bulgaria, the Netherlands and Slovakia have raised contribution ceilings. Several countries – including Albania, Austria, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Cyprus, the Czech Republic, Estonia, Georgia, Germany, Hungary, Israel, Italy, Kazakhstan, Monaco, the Netherlands, Poland, the Republic of Moldova, Serbia, Sweden, Switzerland, Tajikistan, Turkey, the United Kingdom and Uzbekistan – have increased priority to health in government budget allocations, including the funding of social health insurance.

Countries have also devoted greater attention to the potentially impoverishing effects of high levels of out-of-pocket payments for health services: many have striven to reduce user charges and other forms of out-of-pocket payments, and most have targeted vulnerable groups (44). Austria has introduced a general ceiling for prescription fees (2% of annual net income) and provided full exemption from prescription fees for vulnerable people such as those on low incomes or with chronic illnesses, as well as introducing a needs-based minimum benefit system to ensure a means of subsistence and housing in case of

income loss. Belgium, Bosnia and Herzegovina and Serbia have introduced exemptions from user charges and service fees for health services for populations below the poverty line. These countries reported continual monitoring of poverty levels and adjustment of the poverty threshold accordingly if further exemptions and benefits are necessary to meet the health needs of the population. The Czech Republic has recently cancelled a selection of user charges for inpatient care; annulment of other similar fees is in process. Estonia and Ukraine's questionnaire responses reported on work to prolong coverage of HIV treatment after the exit of the Global Fund to Fight AIDS, Tuberculosis and Malaria, which previously covered user charges for essential medicines. By continuing to cover HIV treatment, Estonia and Ukraine have demonstrated a commitment to solidarity and securing access to care for the vulnerable. Kyrgyzstan has gradually increased funding for health care service provision and reduced the volume of user charges, especially in secondary and tertiary care for its most vulnerable groups. Latvia has introduced legal instruments to hold both practitioners and patients accountable should unregulated out-of-pocket payments or bribes be received or offered. In Lithuania and Slovenia health care services are now covered financially at primary, secondary and tertiary levels, with differential levels of user charges and their waivers defined either by service or by population group. Poland defined a basic benefit package in 2009, under which the majority of health care services are covered entirely from public sources. In Turkmenistan the United Nations Population Fund has been working with the ministry of health to ensure that costs for access to reproductive health services are covered. The Fund is in the process of phasing out the project and Turkmenistan has been working to maintain this coverage to avoid reintroducing user charges.

Setting goals and targets to address health workforce needs

One of the most important areas in need of development has been planning a sustainable health workforce. Good progress has been observed in many European countries in the implementation of resolutions EUR/RC57/R1 and EUR/RC59/R4 on health workforce policies, urging Member States to increase their efforts to develop and implement health workforce policies, strategies and plans as a critical component of health system strengthening. The Regional Office and European Member States have played a leading role in developing the WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted by the Sixty-third World Health Assembly in 2010 (resolution WHA63.16), which establishes and promotes ethical principles for the international recruitment of health personnel as part of strengthening health systems (45).

While implementation of and reporting on the Code form one very important way to assess the health workforce, the design of a national strategy that directs all stakeholders on both how to steer the health workforce so that it is available, accessible, acceptable and of high quality and how to support its needs is of primary importance. The AAAO framework, recently endorsed by the Third Global Forum on Health Workforce, will be an important tool in the coming years to guide such policies and strategies (28).³ To date, several countries have been working to develop strategies for human resources for health: Belgium, Finland, Italy, Norway, the Republic of Moldova, Turkey and the United Kingdom have reported significant activity in this area. The need for a comprehensive human resources planning system has been recognized in the Czech Republic but implementation has not yet been

³ At the time of writing, only Ireland has translated this framework into its own health workforce strategy.

possible. The country's questionnaire response notes that the need to ensure adequate numbers and an appropriate skill mix of health workers to meet both current and future needs is high on the political agenda, especially in view of current workforce mobility. Latvia has initiated development of a comprehensive human resources strategy for the health sector to 2020. Montenegro has developed a human resources plan to carry the country through to 2022, with goals to provide competent, skilled, knowledgeable and motivated health workers. The plan also takes into account adequate distribution of the workforce by geographical region, health care level and health specialty according to epidemiological needs. The Republic of Moldova has created a comprehensive human resources development plan for the health sector under the umbrella of a wider health system development plan. Among the plan's priorities is increasing the prestige of the primary care workforce, strengthening their capacity, motivating them, ensuring they receive adequate funding and strengthening the physical resources available to them, including information technologies. An important focus has been placed on strengthening the capacity of family doctors, including institutional management and revision of the initial training curricula for family doctors and nurses. The country's public health strategy also has an added focus on developing its workforce by prioritizing the rebalancing of human resources to correspond with existing priorities (for instance, by training more public health specialists in the prevention of NCDs). Reorientation of the health workforce towards primary care is being threatened throughout the Region, however, by an ageing health workforce (33). In the former Yugoslav Republic of Macedonia a significant example of the country's retention policy for human resources in health offers a subsidy for primary care providers such as general practitioners (GPs) and pharmacies that remain in underserved – mostly rural, underpopulated and hard-to-reach – places. Many countries, including Portugal, the Republic of Moldova, Slovakia and Slovenia, are devoting particular attention to strengthening the public health workforce. Several south-eastern European countries have developed and adopted the South East Europe (SEE) 2020 strategy, aimed at creating jobs and prosperity in Europe (46). The strategy has a chapter on health and contains a specific plan for creating jobs in the health care sector.

Ensuring equitable access to high-quality medical products

All European countries have undertaken policy reform measures in the area of pharmaceuticals and are continuing to do so – the area is very dynamic and it is therefore impossible for this report to give a complete list. Pharmaceutical reforms across the Region have included many policy changes, such as price reductions, use of discounts, rebates, claw-backs, renegotiation of distribution remuneration, VAT changes and reimbursement procedures. In general, in high-income countries the overall purpose has been to control public pharmaceutical expenditure (cost containment). In middle-income countries the focus has been on increasing access, but in some countries out-of-pocket payments for medical products are still high – particularly in central European countries and the newly independent states. All EU accession countries are in the process of updating their pharmaceutical systems to match those of the EU. These countries may face issues related to patent protection in the area of intellectual property rights; therefore, subregional collaboration and collaboration with the European Patent Office should be carried out in a way that is mindful of sustaining access to medicines. Generally, most questionnaire responses reported on work towards enabling the best possible outcomes through increased access and greater attention to exploring the use of generics.

While some European countries have not traditionally engaged in active priority-setting for access to HTP, such policies are increasingly seen as critical for improving efficiency in spending while maintaining an appropriate balance between access and cost-effectiveness. Countries with HTP policies are prioritizing affordability, access, equity, quality and innovation: the policies are helping to balance the demand for new medicines and the financial impact of their introduction. In some countries policy reforms have been substantial, affecting the entire life-course of HTP. A new law on medicines in Armenia was developed in 2012 to improve regulatory functions related to marketing authorization, import control, price regulation, clinical trials regulation, advertising, pharmacovigilance and quality control. Estonia has also undertaken overall pharmaceutical reform, and the ministry of social affairs is working on a national medicines policy to anticipate the many challenges ahead, particularly in the area of pharmaceutical expenditure. The Republic of Moldova's new medicines policy covers authorization, financing, pricing and procurement. Assessments of the pharmaceuticals market were conducted with the support of WHO both before and during the reform of this policy to support it with up-to-date evidence. These focused on possible barriers to availability and affordability of essential medicines, comparisons of prescription medicine prices with those in other countries, prevailing practices in prescribing generic and brand medicines, the components of medicine prices and procurement.

One way of controlling pharmaceutical expenditure is through increasing support for generic drugs. Hungary has launched a reform of the pharmaceutical market to rationalize medication use and strengthen the competitive environment for generics in the context of the global economic crisis. The decision was made to address both the short- and long-term challenges of the crisis, as well as modernization needs. Financial measures include major cuts in the pharmaceutical budget, but these have been offset by modifications in payment obligations by pharmaceutical producers, enhanced generic competition, requirements enforcing patient compliance, a revision of pharmaceutical treatment protocols, a change in subsidy volumes and the introduction of international nonproprietary name prescriptions for selected active ingredients. As a result, prices of pharmaceuticals have decreased, financial burdens on patients have not increased and a number of new innovative drugs have been included in the reimbursement scheme. Ireland has implemented a series of reforms in recent years, which include a system of generic substitution and reference pricing. Price cuts, reductions in pharmacy fees and increases in user charges for patients have also been introduced. These changes have resulted in reductions in the prices of thousands of medicines, with reductions in the order of 30% per item reimbursed achieved between 2009 and 2013. Tajikistan has recently introduced a regulation that makes generic prescriptions mandatory.

Ensuring long-term sustainability of and access to HTP is one of the biggest challenges for health systems in Europe and worldwide. Decision-makers are increasingly faced with difficult choices in respect of new HTP. Nevertheless, more than half of the questionnaire responses reported on efforts to guarantee equal access to essential HTP. In 2012 Kyrgyzstan, Turkmenistan and Ukraine received technical assistance from the Regional Office to revise their essential medicines lists to make their medicines more affordable to the population. Bulgaria, Malta, Montenegro, the Republic of Moldova, Slovakia and the former Yugoslav Republic of Macedonia also reported that access to pharmaceuticals is improving.

Several countries have focused on reform of their drug formularies. In Belarus the formulary includes all pharmaceuticals allowed for use in the country, which all need to be screened

for effectiveness and safety, as well as for acceptability in cost and value in terms of available health care funding. The formulary is linked to the essential medicines list, annual plans of central procurement, treatment protocols and care pathways. Kyrgyzstan reported a reform focused on creating a quality assurance system for pharmaceuticals in the country. Its main stages include the introduction of registration of pharmaceuticals for use in the country; assessment of their safety, quality and effectiveness; licensing of all activities in the pharmaceutical sector; and inspection of the sector. Lithuania is developing a regulation on clinical trials of medicinal products for human use and legislation in the field of medical devices. Turkey has created a new and efficient pharmaceutical management system, and has hosted a number of regional WHO-organized events supporting medical product regulation, including training of focal points from national regulatory agencies in the use of the surveillance and monitoring system to report substandard/spurious/falsely labelled/falsified and counterfeit medical products to WHO. Turkmenistan is also engaging in collaborations with the WHO to improve the pharmaceutical regulatory system. Uzbekistan is developing a quality control system for pharmaceuticals.

Quality mechanisms include regulation of the medical product supply chain, including medical technologies, so that the trade and utilization of these products can be monitored. In an attempt to develop systems and processes to optimize the entry and use of HTP, regulation and legislation have been important mechanisms both for countries with already well developed medicine policy and regulation traditions and for those with less mature systems. Armenia has initiated reforms in the medicines regulation sector to establish a system that can be adapted continually to take into account global scientific and technical progress. According to new legislation, medicines sold in Armenia must be assessed and registered. A good manufacturing practice guideline has been adopted and harmonized with EU standards, and an inspectorate has been established within the ministry of health's Scientific Centre of Drug and Medical Technology Expertise. The guideline is implemented in all national pharmaceutical companies. The Republic of Moldova's new medicines policy covers authorization, financing, pricing and procurement; only medicines authorized and registered in the state nomenclature can be imported and doctors prescribe medicines using the international nonproprietary name for the drug's active agent. A medicines and medical devices agency was created and a management information system for medical devices implemented by the ministry of health to improve stewardship of the system. Serbia has developed a database of equipment of national importance, used to ensure the availability of such equipment.

In the interests of improving access to innovation and the most relevant technologies, countries have been particularly active in prioritization exercises like horizon scanning and HTAs. HTAs have mainly been used in the area of pharmaceuticals and to devise clinical guidelines; they have also been used to define benefit packages, although in a more limited way owing to political and technical challenges (39). This area is dominated by the expertise of countries such as the United Kingdom, with its National Institute for Health and Care Excellence (NICE), and France, with its National Authority for Health (Haute Autorité de Santé: HAS). A recent Regional Office report on access to new medicines in Europe (47) summarizes European countries' efforts on horizon scanning and forecasting for the introduction of medical products, and lists HTA initiatives across countries. This is explored further in the chapter on the third Tallinn commitment.

Aligning health systems with the goals of Health 2020

The stewards of health systems (usually ministries of health) are responsible for developing NHSPs or equivalent documents to provide direction and coherence to their efforts in improving the health of their populations (48); to that end, many countries in the Region have developed new national and subnational health strategies, plans and equivalent documents (49). Countries including Austria, Germany, Italy, Spain and the United Kingdom have decentralized the health policy-making process, while countries including Estonia, France, Latvia, Lithuania, the Republic of Moldova and Tajikistan have maintained more or less national policies. To the extent that they apply the principles and values of health systems to strategic health goals, objectives and targets, these strategies and plans serve as tools to enhance accountability in the health sector. Other mechanisms through which countries in the Region set national health goals and objectives include policy instruments such as national health targets, sets of national health priorities or focus areas, and objectives and targets for the health system embedded within a wider multisectoral reform programme. In several countries efforts to improve and refine the process of priority-setting itself continue to be an important aspect of the development of an NHSP. A different approach taken by some countries involves setting institutional performance objectives that affect the strategic directions of their health systems in those areas in which the ministry of health has a mandate for planning. Sometimes health goals and objectives are defined through health system reform programmes; other mechanisms by which they are set include legislation and regulation.

Several countries have used their national and regional health strategies or plans to position their health systems within the broader context of Health 2020 to strengthen public health, in order to address health inequities. Some, for example, include language that focuses attention on vulnerable groups. Azerbaijan reported on the success of its poverty reduction programme for 2008–2015, which includes social protection and improved access to and affordability of high-quality health services and education. Based on the questionnaire responses, however, it is unclear how these policies will prioritize either the research and evidence needed to understand inequalities related to health behaviour and services or the building of community support for health equity (such as through communication campaigns and awareness-raising). At the beginning of 2013 Bulgaria's Council of Ministers adopted a national strategy for reducing poverty and promoting social inclusion by 2020. It is intended to build and implement a single, coherent and sustainable policy on social inclusion to improve the lives of citizens. The focus is reported to be on the quality of life of vulnerable groups in Bulgarian society, including particular emphasis on high-school dropouts and older people. In France, to manage the unequal distribution of health professionals and address inequalities in access to care, the ministry of health drafted a new bill to focus on "territory health". The strategy has three strong objectives: updating initial training for doctors, improving health professionals' conditions for practice and investing in isolated areas. These objectives are accompanied by 12 commitments and were presented to parliament in the first half of 2015. Latvia's public health strategy for 2014–2020, adopted by the government in 2014, clearly identifies two of its main targets as prevention of injustice in health and ensuring equal opportunities for all Latvian residents in health promotion and health care. Norway's national strategy for immigrants' health for 2013–2017 places particular emphasis on the role of the health workforce in guaranteeing access for immigrants. One of three strategic targets of Poland's national health programme for 2007–2015 is reducing inequalities in health and access to health services. This target was identified as a result

of the preparation of two reports based on empirical analyses of social inequalities in health and of health and socioeconomic characteristics of district-level populations in Poland; both reports were prepared by multidisciplinary teams of Polish experts in close cooperation with WHO. Poland has also introduced regional maps of health care needs, which help the government to identify regional disparities and target assistance. The Russian Federation reported paying particular attention to equity of services and the needs of vulnerable groups. To this end, the country has developed and adopted a variety of programmes and resolutions, including a programme of supplemental drug coverage applied in outpatient and inpatient facilities.

Several countries have explicitly reinforced the importance of whole-of-government and whole-of-society approaches emanating from Health 2020, reflecting a reassuring trend and the relevance of the Health 2020 policy framework. This is the case with the NHSPs in Croatia, Hungary, Israel (50), Latvia, Lithuania, the Russian Federation and Ukraine. The Croatian health strategy for 2012–2020 is an umbrella document that spells out specific priorities, goals and measures to be taken up to 2020, with a main contextual objective of addressing challenges and opportunities linked to the country's accession to the EU in July 2013. The strategy takes its inspiration from Health 2020 in several ways: the fundamental values and principles of the strategy are consistent with those of the European health policy framework; collaboration with other sectors is spelt out as an explicit objective; and the time horizon was chosen to parallel Health 2020. The Czech Republic has prepared a national strategy for health protection and promotion and disease prevention related to Health 2020, adopted by the government and parliament in 2014. This aims to enhance the health-protection and -promotion and disease-prevention system and initiate efficient and sustainable mechanisms to improve the health of the population. It confirms the holistic approach to health and the health-in-all-policies principle, where health is recognized a major societal and economic resource and asset. Similarly, the health programme for 2014–2025 adopted by the Lithuanian parliament was inspired by Health 2020. It incorporates a wide number of public health areas, including a life-course approach and emphasis on the wider determinants of health. Important approaches for improving population health and reducing inequalities are in line with best practices in Europe and internationally, and links between the social and environmental determinants of health and the life-course approach are articulated. Its strategic aim is to achieve better health and longer life for Lithuanian population and to reduce inequalities in health. In 2013 Norway's parliament adopted a new national health-in-all-policies strategy, described in the white paper entitled "Good health – common responsibility", to pursue the redefinition of national health goals after its 2007–2010 national health plan.

These strategies are even more effective where the health policies are not only framed within Health 2020 principles but also integrated in larger national development plans. The aims of Finland's social and health policy are set out in the country's national development plan, entitled "Socially sustainable Finland 2020". Its vision is that in 2020 Finland will be a socially sustainable and vibrant society, in which equality; mental and material well-being; gender equality; and economic, social and ecological sustainability contribute to the balanced development of society. Latvia's main policy planning document for the health system is its public health strategy for 2014–2020 – a medium-term plan, based on Health 2020, which has been synchronized with the country's national development plan for 2020 and the new EU financial programming period.

COMMITMENT 2

The second Tallinn commitment is to invest in health systems and foster investment across sectors that influence health, using evidence on the links between socioeconomic development and health.

Main messages

- Countries across the European Region increasingly report that they are delivering health services in non-traditional settings (such as schools, workplaces, housing initiatives and community services). Several have been particularly active in collaborating with other sectors to address child health and services for older people.
- Intersectoral collaboration has served as a means of aligning financial flows in the context of investment planning, with flows linked to statutory objectives. This sort of joint financing strengthens commitment by partners, thereby providing more certainty around funding.
- Intersectoral collaboration to address health workforce challenges at the global, regional, subregional and country levels is growing. A majority of the intersectoral efforts to benefit the health workforce have involved close collaboration between ministries of health, finance, employment and education. In some countries intersectoral collaboration has also improved the workplace for the health workforce.
- Most countries have increased collaboration between the ministry of health and the trade sector to optimize the accessibility, availability, acceptability and quality of HTP. Several countries are actively supporting transfer of knowledge between research institutions and industry to facilitate access to new medical products.
- To better manage and prevent diseases, countries have also improved availability of HTP at prices that are affordable to governments through intersectoral collaboration. This has not always been possible, however, for some newer medical products.
- International frameworks have been particularly useful for implementing cross-sector health-promoting policies. In particular, countries have been active in coordinating actions across sectors to alter patterns in smoking, alcohol consumption, obesity, road traffic injuries and poor nutrition.
- Interdepartmental committees and shared planning and priority-setting are common tools for engaging intersectoral collaboration.
- Some countries have taken the lead in providing guidance to other sectors on improving health through health impact assessments (HIAs) and health equity impact assessments.

Intersectoral collaboration initiated and/or steered by ministries of health was among the actions most reported in the questionnaire responses. Countries across the European Region have clearly recognized that health systems must engage in intersectoral collaboration to improve health outcomes. The analysis and assessment of reported activities under this second commitment focuses on those in which the minister of health is the primary steward and holds a catalytic and/or implementation role.

As the questionnaire responses were processed it became clear that intersectoral collaboration benefits the health system in various ways to strengthen its own core functions of delivering services, financing the health system and generating and steering resources.

Targeting non-traditional settings for delivery of health services

The reality is that individuals' health is mostly sustained in homes and communities, while clinical settings and clinicians sustain and manage health needs for only certain stages of the lifespan or a minority of the population (32). It is therefore essential for ministries of health to coordinate health service priority-setting with other sectors (especially education, labour, housing and environment). Indeed, countries across the European Region have reported that they are increasing access to and appropriateness and effectiveness of health services in non-traditional settings in collaboration with various other sectors (such as through school health initiatives, occupational health services, housing initiatives and community services). Several countries have been particularly active in collaborating with other sectors to address child health and services for older people. Failing to implement such services along the continuum of the life-course or to address multimorbidities, however, runs the risk of these efforts being short-lived and unsustainable. In Cyprus the ministry of health has been collaborating with the ministry of education and culture to offer school health services such as screening, immunization and oral examinations. In addition, health promotion and educational programmes are offered for HIV and sexually transmitted diseases in secondary schools and for smoking, healthy eating, cardiovascular health and accident prevention in primary schools. In the Czech Republic meal programmes at schools have been organized in collaboration with the ministry of education, youth and sports, accompanied by health campaigns and social marketing tools. Health-promoting environments in schools are also being enhanced by the availability of healthier options in vending machines and school canteens. Finland's food and nutrition policy directs schools to provide healthy meals to all children and adolescents free of charge in primary and secondary schools, kindergartens and day care centres, and subsidized meals to students and at workplaces. Nutrition, cooking and health education is a compulsory part of basic Finnish education. The ministry of health in Latvia is collaborating with the ministries of agriculture and education and science to implement school milk and fruit support programmes. It is also working with the Centre for Disease Prevention and Control, the food and veterinary service and the ministries of agriculture and education and science to implement a national healthy schools programme, promoting healthy dietary habits and physical activity. Poland has invested in health care infrastructure to support the building of playing fields and sports facilities for children.

Settings outside the health system have also been reported as important for delivery of services to elderly people. Among those engaged in this process are the social services sector, which contracts home care services in the Netherlands and the United Kingdom, and telehealth services. In Denmark and Norway municipalities have been active in developing home-based rehabilitation. They work with volunteer services to create healthy living and a range of social programmes for elderly people; services have also been introduced in nursing homes (35).

Aligning financial flows within and between sectors

The problems of fragmented, inflexible funding structures and poor collaboration across sectors on the management of chronic health problems and disabilities, combined with the challenge of sustaining initiatives in the areas of health promotion and public health, have spurred the development of joint budgeting initiatives in high-income countries

(51). Joint budgets have also been seen as a route to efficiency savings and give more choice to service users in those models where they are given direct control of budgets. Examples of joint budgeting and discussion in policy documents in the health sphere can be identified in a number of countries, including England, Finland, France, Germany, Ireland, Italy, the Netherlands, Norway and Sweden.

Intersectoral collaboration has served as a means of aligning financial flows in the context of investment planning, with flows linked to statutory objectives. This sort of joint financing strengthens commitment by partners, thereby providing more certainty around funding. In Finland financing for public health policy is ensured by a budget specified through intersectoral action plans such as the national action plan to reduce health inequalities of 2008. In France the areas of mental health and long-term care have experienced a particularly high level of financial alignment between the ministries of health and social care. Germany has recently adopted a new public health law that increases funding for health promotion and disease prevention, with contributions from the social health insurance fund, social pension fund, social injuries fund and long-term nursing care fund. In the United Kingdom new measures have been taken to support collaboration and alignment of investment planning with statutory objectives, through which resources flow to support the reduction of health inequalities. Two management mechanisms have been established: the first includes cross-cutting spending reviews related to the inequality reduction targets; the second is a process for reaching agreement between central government and its departments on the one hand and local levels on the other, to attain broad national objectives. These public service agreements are linked with spending reviews and provide the framework through which departments, local authorities and other local organizations agree on targets for steering and coordinating public action. In this way health and well-being are incorporated in national policy.

A feature of many of these initiatives is that they focus on easily identifiable population groups that have a clear need not only for health care services but also for support from services such as social care, education, housing and employment. Continuity of care and support for these population groups requires a coordinated approach across sectors and schemes. Initiatives have often been set up with the explicit aim of overcoming the fragmentation in funding and service provision that has hindered the development of seamless care pathways.

Sweden and the four parts that make up the United Kingdom have been particularly prominent in the joint funding of services and programmes to support older people who may be frail, as well as those who have physical disabilities or chronic health problems, including mental health needs (52). Pooled budgets have also been used to help develop joint approaches to rehabilitation and returning to work for individuals with chronic health problems, as in the case of those with musculoskeletal health problems in Sweden, where the health, social insurance and social work sectors have worked together to address this issue. In England, Scotland and Wales road safety initiatives have also brought together partners from the health, transport, child and safety sectors.

Despite much discussion and policy documentation on collaboration and joint funding (51), only a small number of countries reported on this topic in the questionnaire responses. Cofinancing can propagate sustainable change in policies across sectors by building shared financial responsibility and ownership. Arguably, economic downturns may impede the mobilization of funding.

An important activity that reflects a commitment to the Tallinn Charter is the monitoring of how far poor people's health has suffered as a result of changes in health budgets. To date, only Ireland reports having conducted such an assessment.

Securing the health workforce across sectors

Intersectoral collaboration can help countries to plan a more sustainable health workforce, particularly because its demand and supply is heavily influenced by a range of factors outside the health system. Debates on scenarios for the future should take into account the spectrum of drivers shaping the workforce, including changing health needs, demographic trends such as ageing, mobility of populations including the health workforce itself, changing consumer expectations, growth in private health services and the global labour market for health workers. Countries can engage with other sectors to develop and strengthen health workforce information systems to facilitate labour market analysis and health workforce forecasting and planning within and outside the country.

A majority of the intersectoral efforts benefiting the health workforce have involved close collaboration between ministries of health, finance, employment and education. Planning and forecasting that engages different sectors can help decision-makers to anticipate these changes and adjust plans to generate and steer the health workforce accordingly. For example, Finland engages in multisectoral cooperation at the national level to integrate health workforce issues into all social and health development programmes adopted by the government. The national framework for monitoring supply and demand of health workforce requirements is a crucial tool in planning for future needs. A well functioning monitoring system for stocks and flows, a tradition of partnership and multisectoral working, anticipation and planning to support political decision-making, encouraging young people to seek higher education and engaging closely with the ministry of education and culture have all been crucial to Finland's success. Long-term forecast reports on health workforce needs are produced by the ministry of finance jointly with the ministries of health, education, culture and employment.

A majority of the intersectoral efforts reported in the European Region involve aligning rapidly changing needs with the education of the health workforce. The ministry of health in the Czech Republic has been working closely with the ministries of education and finance to increase funding for continuing and lifelong learning opportunities and to improve the health sector's ability to determine education opportunities based on the needs of its workforce. The ministry of health has also been engaged other ministries to improve the legal instruments that protect the health workforce and secure safety in the workplace. It has collaborated with the ministry of labour not only to increase wages by 15% but also to improve compliance with the country's labour code to ensure that nurses are not experiencing burn-out as a result of staffing shortages. The government has also started to establish nurseries in hospitals so that the health workforce has easy access to childcare and to facilitate the return to work from maternity leave. The intersectoral SEE 2020 strategy, which applies to the candidates for EU accession in south-eastern Europe (Albania, Bosnia and Herzegovina, Montenegro, the Republic of Moldova, Serbia and the former Yugoslav Republic of Macedonia) is another example of an intersectoral initiative aimed at creating jobs in the health care sector (46).

Fostering collaboration for improved research and development of HTP

As noted above the area of HTP has experienced tremendous reform. Enormous variation exists among the 53 countries in the European Region in their efforts to increase access to essential medical products. Common to all, however, has been increased collaboration between the ministry of health and the trade sector to optimize the accessibility, availability, acceptability and quality of HTP.

The development of e-health and HTAs is becoming an increasingly important focus area for intersectoral collaboration. In July 2014 Estonia established an intersectoral task force, including representatives of different ministries, the Estonian health insurance fund and academia, patients and health and private sector representatives, to develop a national e-health strategy, to be delivered by November 2015.

Strengthening stewardship

Stewardship has been strengthened most notably by intersectoral collaboration: other sectors have implemented policies that maximize health gains, subsequently improving health outcomes and minimizing the burden of disease (53). International frameworks have been particularly useful for implementing cross-sector health-promoting policies (such as control of tobacco and alcohol consumption, violence and injury prevention, road safety and so on) as they provide evidence-informed guidance on high-impact, cost-effective, affordable and feasible interventions.

Several countries have been active in coordinating actions across sectors to shift tobacco consumption patterns. Across the European Region, for example, 47 countries have used the WHO Framework Convention on Tobacco Control (WHO FCTC) to inform their cross-sector policies on tobacco. Belarus raises tobacco product prices annually. A consistent policy is being implemented to unify the prices of tobacco products gradually in the EU Customs Union countries.⁴ A presidential decree on the state regulation of production, trade and consumption of tobacco and tobacco products also defines public places in Belarus where smoking is prohibited (excluding specially designated places), including health care, culture, education and sports facilities; trade and consumer services; all types of public transport; and similar. Estonia has raised the excise duty on tobacco on six occasions since the beginning of 2008. Slovakia changed its excise duty taxes on tobacco products on 1 October 2013, resulting in an 89% tax burden on cigarettes: Slovakia, Hungary and Israel rank as the three countries in the European Region with the highest tax burden on tobacco products. Turkmenistan ratified the WHO FCTC in May 2011 and joined the Protocol to Eliminate Illicit Trade in Tobacco Products in August 2014. In accordance with the requirements of the FCTC, a national action plan for tobacco control for 2012–2016 has been developed and implemented jointly with the WHO Regional Office for Europe. Fines are charged for smoking in public places and selling or giving tobacco products to people under the age of 18 is prohibited. New standards for packaging and labelling of tobacco products came into effect in July 2011, and labelling illustrating the harms of smoking will be introduced in 2015. A ban on any direct advertising came into force in 2011 and from 2016 all types of indirect advertising will also be prohibited. Since

⁴ This includes all EU Member States and neighbouring countries Andorra, Monaco, San Marino and Turkey.

2011 there has been a threefold increase in prices for cigarettes; tobacco products are also marked up by a rate of 30% of the manufacturer's price.

Countries have coordinated action across sectors to shift alcohol consumption patterns. This has primarily been achieved through taxation, regulations for packaging and labels, educational campaigns, advertisement bans and cessation measures. In 2011 Scotland introduced an alcohol act to reduce alcohol consumption through a ban on quantity-based discounts and restrictions on the display and promotion of alcohol in public spaces. This has led to a 2.6% reduction in off-trade alcohol sales per adult after one year, with multisectoral implementation involving the health and education sectors, police force and private sector.

Countries have also worked at addressing obesity, poor nutrition and road traffic injuries through intersectoral efforts. In Cyprus the ministries of health, agriculture, natural resources and environment, commerce, industry and tourism and education and culture are collaborating in food safety and healthy diet promotion. A number of campaigns have been undertaken with the Cyprus Consumer Association to increase public awareness of the risks of food poisoning and the preventive measures that can be taken throughout the food production process. In the Czech Republic the ministry of health is a party to a national strategy to develop cycling, developed by the ministry of transport; this focuses on promotion of sustainable and ecological methods of transportation such as cycling and relevant infrastructure development. In 2012 Hungary introduced a public health product tax to limit the consumption of unhealthy foods and increase health care revenues. The taxed products are soft drinks, energy drinks, prepackaged sweet goods, salty snacks, flavourings, flavoured beers, alcoholic refreshments and jams, if their sugar, salt or caffeine contents reach a determined level. Furthermore, in 2014 a new public health regulation came into effect to control the quantity of trans fats (unsaturated fats) in food. Sale of foods in which 100 g of the total fats contains more than 2 g of trans fats is now prohibited. The regulation provides a 12-month grace period for those prepackaged foods produced before its enactment. It applies to oils, fats and fat emulsions but not to trans fats naturally found in animal fats. Slovenia has been tackling the obesity epidemic through coordinated action from multiple sectors including the health, education, agriculture, sports, transport and private sectors under the leadership of the ministries of health and education. These ministries have taken action to promote healthy lifestyles and increase health food production and distribution. Notably, the ministry of health developed the "Let's Live Healthily" programme to promote healthy lifestyles among adults in rural communities and introduced health nutrition guidelines in hospital, schools, resorts and retirement homes. Discussions were also initiated with the food industry in 2009 to reduce salt and sugar content in food. Sweden is among the countries with the lowest number of traffic fatalities in relation to population size. The country's success is based on its decision to eliminate human death or lifelong suffering as a result of road traffic injuries. In 2009 the Swedish Parliament took action that was expected to decrease the number of road traffic injuries by 50% by 2020. The Swedish Transport Administration published an analysis of road safety trends in 2013, which reported a national total of 260 deaths as a result of road traffic accidents: this is a 9% reduction from 2012 and the lowest number of annual road deaths in recent history.

Interdepartmental committees are a common organizational form for intersectoral collaboration. These promote understanding of different responsibilities; however, they can add organizational complexity. In England a cabinet subcommittee has been

established under the responsibility of the minister of public health to ensure that different government departments contributed to the national inequality reduction targets. A health inequality unit has also been established within the ministry of health to support the strategy and targets for reductions in health inequality.

Several procedural tools to support intersectoral collaboration have also been observed in the European Region. Shared planning and priority-setting allow sharing of goals as an important condition for the success of collaborative work. The most common example of intersectoral priority-setting has been noted between the social and health sectors. Armenia, Estonia, Finland, Ireland, Latvia, Norway and Serbia are examples of countries where intersectoral collaboration on priority-setting and resource allocation is shared between these sectors. In Armenia the national child and adolescent health strategy was developed by an intersectoral working group involving the ministries of health, education and finance, the police and other local and international stakeholders, with continual technical support provided by WHO. In Latvia intersectoral collaboration takes place around long-term care services. Norway's directorate of health has reported annually since 2009 on all ministries' and sectors' contributions to public health. Norway also engages in a variety of other measures such as HIA; at the municipal level, social and land-use planning have been introduced with an action plan to reduce inequalities. In Serbia intersectoral collaboration takes place around palliative care.

Laws and regulations are powerful levers for integration. In Finland all ministries are legally required to provide the information necessary for evaluation of performance against national and interdepartmental public health objectives.

Countries have also taken the lead in providing guidance to other sectors on improving health through HIAs and health equity impact assessments. These are important tools to support decision-makers in choosing between different options and predicting their consequences. So far the techniques have most often been used at the regional and local levels, but the approach has been used at the national level. In Slovenia an HIA was conducted of the agricultural and food policies proposed as a result of the country's accession to the EU. This appears to be the first time that any government has attempted to assess the health effects of agricultural policy at the national level. The HIA followed a six-stage process: policy analysis; rapid appraisal workshops with stakeholders from a range of backgrounds; a review of the research evidence relevant to the agricultural policy; analysis of Slovenian data for key health-related indicators; a report on the findings to a key cross-government group; and evaluation. The experience in Slovenia shows that the HIA process has been a useful mechanism for raising broader public health issues onto the agricultural agenda, with positive results for policy formulation. Reducing health inequalities is one of the priorities of the Welsh National Assembly, whose HIAs have focused on the health equity impact of specific measures. For example, an HIA initiated by a local residents' association was conducted to analyse the impact of a road construction project, to document the health impacts on the already poor and vulnerable population. The HIA took account of the health impacts of pollution, noise and physical activity levels, and the evidence collected led to the conclusion that the road construction would have negative health impacts on the local population. The EC has included health in its impact assessment procedure, reflecting the requirement in Article 152 of the Treaty of Amsterdam that "a high level of human health protection shall be ensured in the definition and implantation of all Community policies and activities".

COMMITMENT 3

The third Tallinn commitment is to promote transparency and be accountable for health system performance to achieve measurable results.

Main messages

- To improve the overall transparency of health care systems many countries reported increasing use of public reporting to hold both providers and institutions accountable. Development and publication of annual reports by health insurance funds and purchasing agencies is also helping to increase transparency and accountability.
- The new System of Health Accounts, 2011 edition (SHA 2011), developed jointly by the Organisation for Economic Co-operation and Development (OECD), Eurostat and WHO, allows more policy-relevant tracking of revenue sources and expenditures on health (54).
- Information on entitlement to benefits and obligation to pay user charges has been made public to increase transparency and accountability in several countries.
- Reporting by designated national authorities on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel (45) has demonstrated countries' commitment to transparency. Questionnaire responses covered the subjects of health migrants' rights, international recruitment and mobility.
- Several countries are focusing on authorization to practise of the health workforce, referred to as regulation, licensing, certification or accreditation. When properly designed and administered, authorization to practise can protect the public's health and safety by increasing the quality of professionals' services.
- Countries are turning to evidence-informed decision-making to select medical products and guideline development to justify the selection of medicines used and reimbursed.
- Prioritization exercises like HTAs have been useful mechanisms to guide countries in the process of introducing and using new products to guide reimbursement.
- E-health technologies to track health system performance and strengthen accountability have been reported across the Region.
- Health system stewards have an important role to play in harnessing the full potential of health system performance measurement.
- The development of indicators has been reported with particular frequency when it comes to the commitment to transparency and accountability, but countries have been less successful at identifying and monitoring poverty indicators. Across the European Region, the focus on reference indicators that hold providers and hospitals accountable for their services by way of quality monitoring, patient safety indicators, health services utilization and benchmarking has increased. Considerably less activity has been observed for applying indicators to public health and population health services compared to clinical settings, but the public health community is increasingly considering whether quality development mechanisms (such as accreditation) can be introduced for public health services (beyond laboratory services).
- Some countries have taken various ex-ante approaches (such as evaluating their NHSPs using predefined indicators and monitoring and evaluation frameworks) while others have adopted ex-post approaches (such as HSPAs) to assessing health system performance.
- The extent to which health systems have been centralized or decentralized in monitoring health system performance varies across the Region.

Measures to keep providers and institutions accountable

Without question, attention has increased across the European Region to reference indicators that hold providers and hospitals accountable for their services by way of quality monitoring, patient safety indicators, health services utilization and benchmarking. Several countries have also created dedicated institutions or bodies at the national level, tasked with development of the field of health care quality. In Malta the Superintendence of Public Health ensures that all health facilities are up to the standards defined by Maltese and European legislation and guidelines, in both the public and private sectors and across all levels of institutional care. Montenegro has set up quality control committees for health centres. The Republic of Moldova has established institutional quality management systems and created bodies responsible for care quality in all health care facilities. The institutional quality management systems are primarily responsible for ensuring the safety and security of patients; these measures are supported by the creation of a system of external medical audits, continuing education and similar. The ministry of health has defined a set of quality indicators for monitoring service quality and health outcomes in the country while also enabling a disaggregated assessment of service institutions. A national expert committee for monitoring the quality of care and safety of patients has been formed in Serbia.

Many countries have focused on patient safety to improve service delivery. Austria's patient safety strategy is accompanied by a detailed set of indicators that enable continual monitoring of patient safety and outcomes, providing a platform for informed interventions for further care improvement. The indicator results are validated against predefined target values. If an indicator for a hospital is significantly above the target value, a second analysis step (peer review) is initiated. These reviews take the form of structured dialogues between external experts and the responsible staff at the department: they analyse and discuss patient cases according to predefined criteria, trying to identify the main weaknesses of the department and measures to improve the situation. Ireland's comprehensive "Patient Safety First" campaign is an awareness-raising initiative through which health care organizations declare their ongoing commitment to patient safety, supported by uniform branding and the launch of a dedicated website. A national patient safety advisory group has been formed and three national patient safety conferences have been held in conjunction with this campaign. In parallel, a national clinical effectiveness committee has been established and has launched several guidelines, while the national clinical programme provides strategic leadership to develop and roll out models of best practice in clinical care nationally in collaboration with physician associations and service providers. A code of conduct for health service employees and managers clearly sets out employees' and managers' responsibilities in relation to achieving an optimal safety culture, as well as the governance and performance of the organization. Moreover, national standards for safer, better health care have been adopted and implemented, while data on individual service providers (acute care) are published as part of the "Open Disclosure: National Policy" initiative. Norway also launched a patient safety campaign in 2011 and renewed it in 2014. The overall aim of "In Safe Hands" is to reduce patient harm and improve safety. To accomplish this, three objectives have been defined: reduce preventable patient harm; establish lasting structures for patient safety; and improve the patient safety culture in health and care services. A group of health care experts have identified several target areas where the potential for clinical improvements is significant and possible interventions have been proven effective. These expert groups suggest packages or bundles of interventions in each target area that the

campaign will pilot. The pilot projects are evaluated prior to national implementation. The campaign provides assistance to enterprises and community health care services in implementing and monitoring the interventions. All treatment units in each hospital carried out a patient safety culture survey in 2012 using a safety attitudes questionnaire. Other initiatives and bodies (often intersectoral) have been created to ensure that all aspects of care quality improvement are covered, including the establishment of WHO's Patient Safety Champions Network.

Accreditation systems for institutions have been an important mechanism for ensuring quality and patient safety. Bulgaria has established an accreditation system for medical institutions. The Czech Republic has developed a system for reporting adverse events, with the objective of improving the quality and safety of provided health services. Slovenia has established a model to develop a system of accreditation, and more than two thirds of all Slovenian hospitals now have an internationally recognized certificate of accreditation. In the United Kingdom the institutions providing the poorest levels of care are placed in special measures. These measures include partnership with a highly performing institution, development of a rapid action plan with detailed public review of the progress made, appointment of a director with sole responsibility for care improvement and clear accountability for the results achieved, and a review of the institution's leadership to ensure that it is capable of turning the provider around.

Reference indicators are used to monitor not only institutions but also providers. The Republic of Moldova has established a comprehensive system of provider accreditation and regular evaluation (every five years) to promote continual improvement of care quality. The professional quality of Slovenian health services is ensured by the Medical Chamber of Slovenia, which carries out regular and ad hoc professional controls of physicians and dentists as part of the licensing requirements for work in the country. In July 2014 the government of the former Yugoslav Republic of Macedonia created an independent agency for accreditation of health care providers, whose mandate is to establish standards and criteria for the quality of care, as well as criteria for assessment of compliance and adherence to the standards.

Many countries reported increasing use of public reporting to improve the overall transparency of health care systems. Austria, Belgium, the Czech Republic, Hungary, Ireland, Serbia, Switzerland and the United Kingdom publish quality-of-care indicators annually so that both patients and care providers can get a better understanding of provider performance in respect of care quality and outcomes. In Lithuania an enormous amount of information on the activities of health care institutions is calculated from administrative data sources in the compulsory health insurance information system. Data on the resources and activities of health care institutions are made available to the public on the Institute of Hygiene's website, and the Institute also produces an annual public health report. In 2012 Norway established a national quality indicator system with the aim of monitoring the quality and improving the stewardship of health care services. It consists of 60 indicators (as of 2014) that measure aspects of quality in the secondary, primary, long-term and dental care settings. The system is revised on a yearly basis and new indicators will be developed.

The Tallinn Charter has been instrumental in applying transparency and accountability mechanisms to the area of public health. Accreditation and quality control mechanisms are increasingly being introduced for public health services beyond the laboratory. In France

a new national cancer plan was launched in 2009 to cover the period 2009–2013, with regular interim reporting. This plan has five main vertical areas – research, monitoring, prevention and screening, care, and living during and after cancer – and three horizontal or transverse areas – inequalities, individual and environmental factors, and increasing the role of all treating physicians involved in the whole course of the disease. These two dimensions are combined through 30 indicators at the most important intersections, where they are used for monitoring progress and show a clearly multisectoral and multidisciplinary approach. The current priority is mobilizing the population to undergo colorectal cancer screening. A number of other public health problems have received attention at the health policy level, including reducing alcohol consumption, the role of adults in preventing drug abuse in children and adolescents, and a campaign for physical activity. Israel's national programme for quality indicators in community health care, which has a particular focus on primary prevention, has been struggling for years to develop positive health indicators to better understand the quality of health as a differentiation from the “negative” indicators around mortality and morbidity. The programme is now a well functioning monitoring system, which has allowed Israel to show continuing improvements in health care (both to domestic audiences and in comparison with other countries), with increasing rates of quality over time. In addition, through this monitoring system the overall quality of community health care has improved over recent years, and Israel has been able to maintain high levels for the majority of indicators. These results are largely due to the concentrated efforts of Israel's health plans and their active role in community medicine. In Sweden health targets are grouped under 11 main objectives, formulated to reflect the way public administration is organized. These targets support the country's public health policy, with its overarching goal to create the conditions to ensure good health, on equal terms for the whole population. The Swedish National Institute of Public Health is responsible for monitoring implementation of the policy and attainment of its objectives, and has developed new indicators appropriate to its cross-cutting objectives. The policy requires an evaluation report to be presented to parliament every four years, although evaluation is complex and difficult in view of the highly decentralized nature of the Swedish governance system, with many actors involved at different levels.

Guidelines to inform the work of providers are also a useful accountability mechanism at the service delivery level, as they can be referred to by managers but also by providers themselves to account for procedures undertaken. Clinical guidelines help decision-makers to move away from opinion-based medicine; they can also serve as litmus test to reflect the responsiveness of a system, in that they do or do not incorporate patient-focused considerations. For example, while all countries have included reproductive cycle medications on their essential medicines lists, the appropriate use of such medicines (such as magnesium sulfate) is of critical importance for patient safety. The approach in the Republic of Moldova targets standardization of medical services as a means to move towards evidence-based medicine, for which practice guidelines, clinical protocols, treatment algorithms and medical standards are important requirements. Mental health is one area where clinical guidelines are less common and require more attention. In general, the use of guidelines has been identified during various Regional Office activities (such as NCD assessments) as an important entry point by which to improve service delivery, but little was reported by countries in questionnaire responses on the enforcement or use of clinical guidelines.

Improving transparency in health system financing

Countries have data collection tools in place to monitor and report on levels of health spending – especially public spending on health as a share of total government spending and out-of-pocket payments as a share of total spending on health (increasing, remaining stable, decreasing). Countries that demonstrate improved transparency and accountability for health system financing have information about revenue collection, pooling and purchasing processes publically available. Development and publication of annual reports by health insurance funds and purchasing agencies in particular have helped increase transparency and accountability in Estonia and the Republic of Moldova. These reports illustrate how internal performance targets and their links to overall policy objectives may enhance system performance and accountability in particular. Regular patient satisfaction surveys may also contribute to informing this process and enhance transparency and responsiveness. Transparency also improves when entitlements to benefits and obligations to pay user charges are easy to understand for the population. The Czech Republic, Kyrgyzstan and the Republic of Moldova have made significant progress in assembling better information on entitlement to benefits and devising simple user charges policies to increase transparency.

It is clear from countries' questionnaire responses that tracking of health expenditure has been a widespread activity across the Region. SHA 2011, developed jointly by OECD, Eurostat and WHO, has allowed for more accurate tracking of resources generated and spent on health (54). All EU and OECD countries adopted this new system of reporting and a growing number of non-EU and non-OECD countries in the European Region have developed their own reporting systems according to the new guidelines. As a result, data collection has improved significantly across the Region since Tallinn.

Promoting health workforce accountability

Austria reported that the framework conditions and practical implementation of regulations on access to health professions (occupational licensing) are more regularly evaluated and adapted. Licensing of medical specialists has increased in importance in Estonia and Slovenia. In both cases further mandatory certification systems are in place, and in Slovenia a medical specialist must be recertified every seven years to be eligible for work. In Turkmenistan and Uzbekistan certification is compulsory when moving into a higher salary category where the requirements for professional preparation are correspondingly higher. When properly designed and administered, authorization to practise can protect the public's health and safety by increasing the quality of professionals' service. It is important, however, that these measures also do not promote near-exclusive scopes of practice to only a few professions, which can create unreasonable barriers to high-quality and affordable care. The need for accessible health care calls for flexible scopes of practice that recognize the demonstrated competence of various practitioners to provide the same health services. Some countries reported revising authorization practices to this end.

This focus on authorization has also translated for some countries into increased attention to the authorization of initial training institutions, continuing education opportunities, continuing professional development (CPD) and professional discipline. Several Member States are working to improve accountability through increased public representation and disclosure of practitioner information so that consumers can make informed choices

about their care. The public's perception of professionalism and its need for information about practitioners has led to an increase in public reporting across the Region. It is also increasingly expected that professional regulatory bodies will become more accountable to the public they serve.

Reporting by designated national authorities on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel (45) has also demonstrated countries' commitment to transparency and accountability. Questionnaire responses covered the subjects of health migrants' rights, international recruitment and mobility. Increased attention has been paid to the process of regulation of health care practice (registration, licensing, certification and accreditation). The first report to the World Health Assembly in May 2013 on progress with implementation of the Code showed that the European Region has the widest coverage of countries with designated national authorities monitoring the Code's implementation (42 of the 85 countries globally). Moreover, 40 countries in the Region have reported actions of engagement with the Code. A number of good practices exist in the Region, including in Belgium, Finland, Germany, Ireland, Italy, Norway, the Republic of Moldova, Switzerland and the United Kingdom.

Promoting rational and evidence-driven use of HTP

Countries are turning to evidence-informed decision-making to select medical products and guideline development to justify the selection of medicines used and reimbursed. Prioritization exercises like horizon scanning and HTAs have been useful mechanisms to guide countries in the processes of introducing and using new products and reimbursement. The Regional Office recently produced a report on access to new medicines in Europe (47), which summarizes European countries' efforts on horizon scanning and forecasting for the introduction of medical products, and lists HTA initiatives across the Region. HTA is rising in popularity as a tool to guide reimbursement, as reported by Austria, Estonia, France, Hungary, Italy, Latvia, Lithuania, Malta, Norway, Poland, Serbia, Slovenia, Spain, Sweden and the United Kingdom. The two most developed models in the Region are widely recognized as being France's HAS and the United Kingdom's NICE. These are independent bodies that provide guidance on the clinical and cost-effectiveness of drugs and treatments. NICE has twice updated its guide to the methods of technology appraisal, in consultation with stakeholders (55). In addition, NICE has also established a new work programme to evaluate medical technologies and diagnostics, which supports the rapid and consistent adoption of clinically and cost-effective technologies in the national health service. Several countries including Estonia, Hungary, Lithuania, Serbia, Slovenia, Spain and Poland have followed suit and set up national HTA agencies or committees. Austria and Lithuania have developed national HTA strategies, while in Switzerland a government proposal for a law to set up an HTA has been submitted for stakeholder consultation followed by discussions in parliament. Estonia, Hungary, Latvia, Lithuania, Malta, Poland and Sweden have taken steps to strengthen the role of HTA in calculating the costs of health care services and making decisions on public health care financing. EUnetHTA, an HTA network, has been created to foster collaboration between countries in the EU. Expansion of collaboration on HTA methodology to include eastern European countries has been carried out in collaboration with ADVANCE_HTA, a research project funded by the EC's Research Framework Programme (FP7) (56). HTAs are also increasingly being made available in the public domain by countries like Austria, Italy

and Norway; they can then be used by other countries, provided measures are taken to conduct secondary reviews to ensure that their conclusions are culturally appropriate.

Clinical programme guidelines are important information tools to enhance appropriate treatment of patients. Methods for developing these have evolved and now include the grading of recommendations assessment, development and evaluation (GRADE) methodology. Several countries have strengthened their clinical programme guidelines. In 2010 Estonia started revising its national clinical guideline development process as part of an overall programme of quality improvement in health care, and developed a national handbook for guideline development that brings together experience and internationally accepted methods. This process supports a consistent approach to guideline development, and was tested through a pilot project to develop a new guideline on the management of hypertension in primary care during 2010–2011. In April 2015 the new process was fully implemented and 15 guidelines are currently in different stages of development – three have been approved to date. In addition, in most countries of the Region CPD among physicians to enhance rational use of medicines can be strengthened and will play a role in appropriate use of medical products.

Several countries are in the process of or have already introduced value-based pricing of medicines. Although pricing for new medicines remains free from controls in Sweden, companies marketing new patented medicines must prove superior cost–effectiveness in comparison to existing medicines to get a listing under the national pharmaceutical benefits system. This value is defined in terms of patient or clinical outcomes divided by the cost of the product. Manufacturers can improve the likelihood of a listing by lowering the cost of a product. Similar systems exist in several EU countries, combined with price-control systems. As affordability and financing of new medicines pose challenges to governments in many countries, these pressures mean that decision-makers, including payers, must choose which new medicines to fund and in which patient populations, while still fostering a climate for innovation. For many countries, however, this is a new or emerging area, in which policies are not yet fully developed and decision-makers remain unsure of how to act.

E-health technologies to help strengthen accountability have been developed across the European Region. Bulgaria has made particularly large investments in the area of information systems. In 2008 the ministries of health and state launched the “Information Technology in Health Care” project, in which a key partner is the international company InterComponentWare and the supplier of software to GPs is Kontrax. The project’s scope includes 40 000 state administration employees. It gathers information in three key areas: basic information on adverse events, allergies, current treatments and diagnoses; details of patients’ choices about utilization of services, encounters with health professionals and documentation from these visits; and details of patients’ choices of treatment and provider. Poland reported developing several e-health projects to improve health system efficiency. The goal of its most prominent project – an electronic platform for collection, analysis and sharing of digital medical records – is to enable public authorities, companies (including health care facilities, pharmacies and medical practice centres) and citizens to collect, analyse and share digital resources on performance. Its implementation will also contribute to improvement in the quality of public administration responsible for the health care sector, increasing the capacity of public institutions through computerization of services and of the business environment using the e-health services. At the beginning of 2013 a platform for medical records was established and launched in Poland; this is a

universal information technology tool to keep registers and provide electronic services that ensure an optimal level of safety. During integration with this platform, registers are rebuilt to be consistent with the reference architecture, which allows them to communicate with the platform by means of web services or to be entirely embedded on the platform. Turkey has made major investments in new information systems, including e-prescriptions and a medicines track-and-trace system that facilitates monitoring of the supply chain.

Pharmacovigilance system strengthening has been carried out in many countries but many settings still face major challenges and gaps in implementation of pharmacovigilance systems, improved data recording and reporting on adverse drug events. WHO has made specific efforts to strengthen expert capacity in drug regulation and tuberculosis (TB) control in eight countries in eastern Europe (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, the Republic of Moldova, the Russian Federation and Ukraine) to improve the proactive monitoring of new TB medicines use and adverse events in this regard.

Establishing the role of stewards in measuring and evaluating health systems

Developing operational and effective accountability arrangements that can monitor and evaluate performance is particularly challenging, given that health systems are characterized by dispersal of responsibility and activities across the public, private and not-for-profit sectors, as well as along national, regional and local divisions. Health system stewards therefore have an important role to play in harnessing the full potential of health system performance measurement and evaluation, given the motivations and behaviours of multiple actors and diverse agendas, finances and organizational structures.

Use of indicators for measuring health system performance

At least 31 countries in the European Region have national repositories or platforms of health system performance information with packages of indicators that are regularly measured over time. The number of indicators varies from about 26 in Austria to more than 1000 in Finland.

Many countries have performance measurement strategies that are linked to the goals set out in an NHSP or to general health system goals in the absence of an NHSP. Belgium has no overarching NHSP but instead works with “indicator domains”. The country has developed a total of 74 health system performance monitoring indicators along five domains – health promotion, preventive care, curative care, long-term care and end-of-life care. Furthermore, each of the five domains can be evaluated on the dimensions of accessibility, quality, efficiency and sustainability. Croatia measures health system performance through a set of indicators related to health financing, quality and management of care; these are set out in its NHSP. In Germany the health information system reports indicators associated with national health goals derived from around 100 data sources. The indicators cover all relevant sectors of the health care system and public health, including public health monitoring, demographic and socioeconomic conditions, environmental and lifestyle-related health risks, diseases/conditions, the health care system, and expenditure, costs and financing. In Ireland health system performance is measured through a package of indicators linked to the national health policy “Healthy Ireland”. These are disaggregated along the following categories: disability, older people,

acute services, mental health, social inclusion, children and families, palliative care and primary care (including health promotion). Measurements are submitted to the department of health on a monthly basis. In Kyrgyzstan about 80 indicators (progressively reduced from over 100) are in place to measure implementation of the country's health system transformation strategy. Several departments within the ministry of health are responsible for their measurement. In the Netherlands the three broad stated goals for the health system (access, quality and costs) have 13 indicator domains associated with them for monitoring purposes. Serbia reports health indicators related to eight broad areas (demography and other socioeconomic indicators, mortality, morbidity, lifestyles, environment, health resources, use of health services, and maternal and child health) which are associated with its public health strategy. Sweden has not specified an NHSP as such. Instead, performance measurement is conducted using indicators associated with the guidelines for certain conditions, while other indicators are identified in collaboration with the county council organization. Overall, Sweden produces information on more than 800 distinct indicators. In January 2013 the Federal Council in Switzerland approved a comprehensive strategy entitled "Gesundheit2020" (Health 2020). A total of 36 measures across all areas of the health system aim to maintain quality of life, increase equal opportunities, raise the quality of care and improve transparency in the country. These measures will be implemented in the course of the next few years with the involvement of all key stakeholders, to make the Swiss health system fit to face the challenges ahead and yet keeping costs affordable. The department of reforms at the ministry of health in Tajikistan is responsible for regular measurement of the implementation of its national health strategy for 2010–2020, to inform policy-makers precisely about achievement of targets and progress.

Emphasizing systematic and rolling reviews of health system performance

Reviews of health system performance should occur systematically and continually inform priority-setting. Two general formulations commonly used to review health system performance are the ex-ante evaluation of NHSPs and the standalone/ex-post HSPAs. Findings from these can lead to the identification of new priorities for further action. Even where health is not high on the government agenda, continual systematic reviews of health system performance can identify policy options. The WHO Regional Office for Europe has recently started to look at the ways in which tools can be used to assess performance beyond the health system.

Countries conducting evaluations of NHSPs based on ex-ante pre-specified goals and objectives include Kazakhstan, Kyrgyzstan, Malta, Poland, Portugal, the Republic of Moldova and Tajikistan. In Kazakhstan the most comprehensive sector review is the annual report of the ministry of health, which is based on a review of all health system components and their measurement against indicators of achievement, as defined in the national programme. The last such report set out the results of the work of the ministry in 2013 and its tasks for 2014. This assessment was undertaken by a wide group of stakeholders including the prime minister, parliament and nongovernmental organizations. A similar process of health sector review has been followed in many countries of the former Soviet Union. In Malta a working group has been set up to determine an action plan based on the list of stakeholders identified in the NHSP. Similarly designated authorities have been identified for all disease-specific strategies and will also be established to oversee the HSPA, which will be completed once the overarching framework is finalized. Other examples of countries where annual reviews are linked to NHSPs are Poland, where a yearly report on implementation of the national health programme is produced and

delivered to the Ministers' Council, and Spain, where data on the indicators compiled through the monitoring mechanism provide input to the interterritorial council of the national health system.

An ex-post assessment methodology – the HSPA – focuses on key health system goals and core functions, with an emphasis on evaluating system-wide performance and achievements rather than focusing on specific programmes. For that reason it can be used to inform policy decisions. Many attribute the increasing use of this tool to the Tallinn Charter's focus on increasing transparency and accountability in managing the health system (57). The body of experience with HSPAs in the European Region is growing, and the EC has created a platform for EU countries to exchange this experience (58). Most importantly, health system performance measurement tools such as HSPAs must be ongoing and inform future priority-setting. Countries that reported having adopted the HSPA process (at national or subnational levels) include Armenia, Azerbaijan, Belgium, Estonia, Georgia, Italy, Kyrgyzstan, Portugal, the Republic of Moldova, Sweden, Turkey and the United Kingdom. Countries still developing the HSPA process include Hungary, Kazakhstan and Malta.

The HSPA is linked to financial commitments and to an institution responsible for performance assessment and reporting. The Armenian HSPA is now an integral part of an evidence-based policy and management cycle, and is used as one method of holding stakeholders to account. Another country that has institutionalized the HSPA is Georgia, which approved a ministerial decree to that effect and produced its last review in 2012. The HSPA can be applied and tailored to track progress with recently implemented programmes or interventions. For instance, implementation of the Georgian universal health coverage programme started in February 2013. The country is currently undertaking a first assessment of the programme.

Belgium has published two HSPAs in 2010 and 2012 on the basis of a regular review of the set of health system indicators, which will henceforth continue to take place every three years. More recently, Hungary has also institutionalized a multistakeholder process for implementation of the HSPA, with several specialized agencies taking part in assessment and validation of the findings, including a standing working group of the ministry of health dedicated only to the HSPA. The ministry is expected to publish HSPA reports biannually, with a standard version including only indicators to be updated every year. Portugal undertook an HSPA in which targets set by the national health plan for 2004–2010 were reviewed and measured regularly several times a year through an intersectoral review committee in collaboration with the national government and the Portuguese regions. The HSPA helped the Portuguese health authorities to prepare the national health policy for 2011–2016 by motivating engagement of key stakeholders and clarifying system goals (59).

Decentralizing health system performance measurement and evaluation

Another dimension of health system performance measurement is the extent to which health system performance monitoring is centralized or decentralized; this varies between countries in the European Region. This factor often relates to the administrative level at which decisions on the types of indicators compiled are made, which in turn may affect national coverage and the extent to which such sets of indicators are homogeneous across regions. In Denmark the ministry of health alone defines some health system performance indicators, while others are set in cooperation with the regions. Finland is an example

of a highly decentralized health system: monitoring is driven by the regions and 320 municipalities; as a result, the number of indicators compiled is very high (over 1000). Coverage across regions is not necessarily uniform, however, and the frequency and depth of monitoring activities vary significantly from one municipality to another, depending largely on local capacities and commitment. Spain measures a set of 110 indicators that are published every three years, reporting data on areas such as population health, health determinants, health resources and expenditures. These indicators are selected by consensus among the administrative levels represented in the interterritorial council of the national health system. The development of such indicators is also the result of collaborative work with the autonomous communities. Tajikistan regularly measures implementation of its national health strategy for 2010–2020; this is the responsibility of the department of reforms at the ministry of health at the national level.

COMMITMENT 4

The fourth Tallinn commitment is to make health systems more responsive to people's needs, preferences and expectations, while recognizing their rights and responsibilities with regard to their own health.

Main messages

- Emphasis on meeting citizens' expectations and increasing both population and patient satisfaction with special attention to confidentiality and dignity has increased. Regular surveys are being conducted by health care institutions on patient experiences with access and use of health services.
- Several countries have reported efforts to strengthen their primary care services. These efforts have also capitalized on the reorganization of services and new operational partnerships and networks between health providers and services.
- The reorganization of services has also included reorganization of hospitals and increasing referrals to optimize the use of resources.
- Countries are increasingly demonstrating a focus on the needs of people by tailoring their services to the diversity of individual needs as they vary by gender, culture, language and political and economic status.
- Countries have increased the responsiveness of their health systems by extending the universal benefit package to include primary care and public health, reducing financial barriers, increasing transparency around their health benefits and directing funds to improve performance, while maintaining sustainability.
- Task shifting and attention to changing roles have helped health professionals to be more responsive to people's needs, preferences and expectations.
- Alignment of the education and training of health professionals with health system reforms, population needs and patient safety is a growing requirement. To achieve this, an increasing trend of interprofessional education and increased attention to CPD and lifelong learning can be seen. Particular focuses have been training of the primary care health workforce and harmonization of education structures so that health professionals are able to secure employability across the Region.
- Innovative e-health and e-prescription technologies and tools are being used across the Region to improve responsiveness and utilization of services. Technologies are also being engaged to deliver care to hard-to-reach populations. Security of patient information has subsequently become of increased importance.
- Several efforts to institutionalize patient rights and entitlements have been made across the European Region; these are increasingly being enforced with the use of patient ombudsmen.

The 2000 world health report (7), dedicated to the performance of health systems, originally proposed that responsiveness to citizens' expectations should be a fundamental goal of all health systems. This moved forward a debate that framed responsiveness as a valued and desirable outcome of health system interventions, regardless of the extent to which those interventions lead to health improvement (5). Countries have reported on making systems more responsive in various ways, illustrating confusion over the definition of responsiveness. In many cases questionnaire responses gave examples of increased choice and options of services and providers, while in others the focus was

on improvement of technologies and services and reorganization of services to make more opportunities for care available at the primary care level and to a wider group of people, including vulnerable groups.

Reorganizing services to improve access to quality services

Several countries reported efforts to strengthen their primary and outpatient care services, including Belarus, Greece, Ireland and Lithuania. Proactive primary care can help with illness management before and after events. Examples of this are performance of routine physical examinations that include blood testing, blood pressure readings, head-to-toe assessments, eye and hearing exams for defined populations; vaccination programmes; child health screening; and screening programmes for the early detection of diseases. Several countries (including Andorra, England, Ireland, Kazakhstan, Luxembourg, Norway, the Republic of Moldova and Sweden) reported developing specific health counselling services at the primary care level. Topics covered smoking cessation, alcohol reduction, substance addiction, nutrition and diet, oral health, reproductive health, cardiovascular health (including multidrug therapy for people with a high risk of developing heart attacks and strokes, such as those with established cardiovascular disease), hygiene and sanitation and indoor air quality. As more health problems are effectively managed and resolved in primary care settings, several countries have expanded their services to include community pharmacies, accident and emergency units and out-of-hours care enabled by mobile health and information technology.

These primary care initiatives have also capitalized on the reorganization of services across the European Region through operational partnerships and networks between health providers and services (in Armenia, France, Hungary, Iceland, Lithuania, the Netherlands and the Republic of Moldova). This reorganization is reported as a measure to promote the continuum of effective and high-quality care. This reorientation of care from reactive management of illness to proactive management of health, well-being and social determinants of health with citizen engagement that empowers and engages individuals and communities as partners, not as passive recipients. Denmark's public health services provided at local community centres are using health promotion plans based on individual and cultural needs. In 2014 municipal health promotion packages were adopted to assist municipal decision-makers in organizing local health-promotion and disease-prevention initiatives, taking advantage of their proximity to citizens. These are targeted at addressing significant risk factor areas, with a focus on tobacco, alcohol, physical activity, mental health, sexual health, sun protection, indoor climate in schools, hygiene, healthy food and meals, obesity and preventing drug abuse. In France, which has a tradition of singlehanded practice, a national plan has successfully increased the number of group practices and multidisciplinary "maisons de santé" in primary care. The plan has also counteracted threatened shortages in underserved areas (33). Hungary has established multidisciplinary teams of health professionals, including public health professionals, community nurses, physiotherapists, dietitians and health psychologists. Four group practices consisting of 24 primary care practices have been established in the North Hungary and North Great Plain regions. These teams are employed to deliver a wide range of services that were not previously provided and to plan and implement public health services. Ireland's Health Service Executive launched a community health care organizations report on reorganizing health services outside the acute hospital system; this focuses primarily on providing

the maximum proportion of care to people in the communities where they live and to achieving joined-up, integrated services. Existing resources are being reorganized into 90 primary care networks, each serving about 50 000 people. Each network is headed by an identified, accountable person responsible for care delivery by professionals such as nurses, therapists and social workers to meet a wide range of people's needs in an integrated way. GP involvement is strong and the focus is on decision-making at the local level. The new structures also have a strong focus on building good links with the acute hospital system so that people's care pathways are appropriately planned and their needs met in the right setting. As part of this reorganization, integrated chronic disease management programmes are being developed to improve patient access and to manage patient care in an integrated manner across service settings, resulting in better health outcomes, enhanced clinical decision-making and the most effective use of resources. The Netherlands offers an innovative model for home care: the Buurtzorg model or "care in the community". By 2010, Buurtzorg teams nationally were serving about 30 000 clients annually. The model aims to integrate home care with social services, GPs and other formal and informal care providers to deliver high-quality health care services to all people in need of home care.

Giving GPs the role of gatekeeper is an established way of coordinating care (39). The family medicine model has been introduced in several countries of the former Soviet Union (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan). Another means of engaging providers to coordinate care includes nurse-led strategies (France, the Netherlands, Sweden and the United Kingdom). In a similar vein, countries have started to improve referral systems to optimize all services and particularly to strengthen the role of primary care services. These systems also help to strengthen lines of communication, and they are an effective means of reducing unnecessary expenditure of hospital resources. For example, primary care reform in Bulgaria has focused among other things on strengthening primary care and improving patient referral systems between medical institutions.

Accompanying this strengthening of primary care and reorganization of services has been an increased focus on waiting lists, emergency services, travel time to services and the network of providers (in Armenia, Belarus, Romania, Slovenia, Spain, the former Yugoslav Republic of Macedonia and the United Kingdom, among others). Many of these service improvements have involved mergers and reductions of hospital services. The number of hospital beds in Belarus has been reduced in an attempt to steer health service delivery towards more effective resource use. In addition, some of the hospital beds for acute care have been re-profiled for provision of rehabilitation and nursing care; as in other parts of the Region, this has been accompanied by an increase in availability of day surgery and outpatient care. Management of the hospital sector has also been strengthened and some hospitals brought under the remit of the ministry of health as part of a wider push to reduce the average length of stay in hospitals and resource waste in inpatient care. In the Czech Republic the ministry of health has established centres for highly specialized health care (such as oncology, traumatology and cardiology) on a regional basis and defined maximum travel times and waiting times for the use of individual health services. During the global economic crisis, in 2009–2010 Latvia introduced significant changes within a short period of time. Reforms included a substantial reduction by 63% in the number of hospitals over four years, with parallel development of outpatient health care services, strengthening of primary care and optimization of the number of

services provided at different levels of care. In Lithuania hospital mergers have been accompanied by centralization of highly specialized care and diagnostic equipment. This process has also involved the assignment of minimum volume criteria for inpatient care services, setting service requirements by catchment area, a reallocation of funding from inpatient to outpatient and primary care and the development of outpatient and nursing services. The main aims of the reform were to improve the quality and availability of services and to optimize the scope and structure of services for residents' health care needs. This has resulted in more efficient use of existing resources, improved patient safety, streamlined patient flows, abandonment of service duplication, improved access to services and bringing services closer to people.

Countries are increasingly tailoring their services to the diversity of individual needs as they vary by gender, culture, language and political and economic status. Both Estonia and Lithuania have successfully moved towards organizing drug and addiction services, alongside services for TB, hepatitis C, and mother and child health, to improve health promotion for marginal groups. One important area was changes to make services more "migrant-friendly", which has involved a combination of outreach and health promotion services targeted at migrants, as well as training and continuing education for health professionals so that facility-based services can be better adapted to the needs and cultural contexts of specific migrant populations. Austria reported piloting several tools for improving communication with migrant populations as part of its patient safety strategy. Under this strategy a central unit was built to employ interpreters in Turkish, Bosnian, Croatian, Serbian and sign language, all specially trained in the health field, who are available 16 hours a day to offer audiovisual interpretation. In Bulgaria mobile offices and teams provided by the ministry of health perform prevention check-ups for uninsured people of Roma origin and people with little access to medical facilities. Offices are located in areas of Roma population to cover the maximum number of people who have difficulty in accessing health services. Activities are implemented with the support of health mediators, regional health inspectors, obstetricians, GPs and paediatricians from local medical establishments. Campaigns are organized in cooperation with the national network of health mediators and the National Council for Cooperation on Ethnic and Integration Issues to the Council of Ministers. To enable culturally sensitive and tailored services, many regions in Germany provide provider information and services in various languages to be able to reach out to the migrant non-German speaking population. Hungary has launched a primary health care model in the most vulnerable areas of the country. The public health-focused model programme for organizing primary care services, which is backed by a virtual care service centre, aims to improve the health status of the entire Hungarian population and reduce health inequalities, with a specific focus on the most disadvantaged regions of the country. Preventive programmes have also been introduced in Montenegro. In 2010, as part of its collaboration with the EC, WHO provided guidance on how health systems can best address health inequities linked to migration and ethnicity (60).

The emergence and success of these few initiatives suggests that more can and should be done in understanding how to incorporate people better in their care. This requires a clearer understanding of what people-centred care means and how to achieve the balance between what people want and need, and what can be provided.

Improving responsiveness through financial mechanisms

Country responses to questions about responsiveness focused on five areas:

- extending the universal benefit package to include primary care and public health;
- reducing financial barriers and increasing financial protection, specifically for vulnerable populations;
- increasing the transparency of financial benefits for informed choice and decreasing misuse of funds;
- directing funds to improve quality of services, decrease wastage, improve performance and increase sustainability;
- putting in place financial incentives to improve the responsiveness of providers.

As the previous section showed, reorganization of services towards primary care has been one method countries have used to ensure the responsiveness of health systems. Ensuring that these are adequately financed and included in universal benefit packages is the next step. For example, all public health services in Malta are provided to the population without additional fees. The only exception is part-payment arrangements for long-term care, where residents forfeit 60% or 80% of their pension, depending on the facility, as partial funding for the stay. The Republic of Moldova reported that access to primary care and emergency services are covered regardless of insurance status, as are certain public health services such as immunization and services for patients with HIV or TB. Romania's new benefit package as of 2014 includes several prevention and primary care services based on a risk assessment tool. The country has also recently increased access to TB treatments and drugs. Countries including Serbia have guaranteed several screening programmes under the universal health coverage scheme.

Some countries also reported extending coverage by imposing compulsory requirements on health insurance schemes. In 2010, the Republic of Moldova extended the package of medical services that must be covered by health insurance schemes to include approximately 300 new medical investigations, diagnostic services and surgical interventions; in total this has benefited over 2.8 million people. Switzerland and Lithuania both reported that access to a broad range of services is guaranteed to all citizens through a mandatory private insurance system. In the former Yugoslav Republic of Macedonia the insurance scheme includes a wide range of services from primary, secondary and tertiary levels of care.

Several countries reported on decreasing out-of-pocket payments to reduce financial barriers, focusing on these as an indicator of access and responsiveness. Bulgaria reported opening discussions at the national level on how to decrease the percentage of out-of-pocket payments, which still occupy a high proportion of total health expenditure. Estonia has also used rates of out-of-pocket payments to assess equity and responsiveness to patients' needs. In Lithuania, Serbia, Slovenia and the former Yugoslav Republic of Macedonia health care services are covered at the primary, secondary and tertiary levels, with differential levels of co-payments and their waivers defined by either service or population group. In Montenegro all services from the health service package are funded from compulsory health insurance; while symbolic co-payments exist, these are waived for vulnerable population groups. The Republic of Moldova reported that by merely extending coverage of services by the state and health insurance companies, out-of-pocket payments have decreased.

Several countries reported increasing transparency by publishing service entitlements to accelerate the reduction of informal payments and increase informed decision-making around the use of health services. Bulgaria reported investigating corruption and decreasing informal payments by making fees publically available. Hungary has imposed mandatory publishing of health insurance entitlements. Poland has used its map of health care needs to identify where increased financing and investment is needed. Slovakia uses an application called “Ask the doctor” to inform patients of cheaper generics or therapeutic substitutions and to provide important health information.

Several countries highlighted how a redirection of funds was an important tool for improving quality of services and responsiveness. This is the case for Croatia and the Czech Republic, which have both centralized highly specialized and costly care in the interest of increasing coordination and efficient use of the services, thereby decreasing waste and increasing proper use and efficiency. The Czech Republic has directed funds at reducing nosocomial infections. In 2009 Sweden set aside 2 billion kroner to strengthen the county councils’ incentives to reduce waiting times.

Incentives are a targeted way of improving performance and one reported by several countries, despite the evidence not being entirely decided on how this is best done (61). For those countries incentivizing primary care physicians and specialists, most have given bonuses for reaching performance targets such as preventive care, efficiency of care, patient satisfaction and management of chronic diseases. For hospitals, programmes include bonuses or penalties – mostly for processes of care, but some also for clinical outcomes and patient satisfaction. Bulgaria uses incentives to persuade GPs to work in underserved settings and emergency care, and reports using incentives to improve the treatment of patients in outpatient settings. In 2010 Montenegro introduced a new acute hospital treatment payment scheme, which focuses on outcomes and performance. Belgium, Turkey and the United Kingdom reported using incentives in primary, specialist and hospital care. Other countries where incentives have targeted a range of services including primary care and inpatient care include Hungary and the former Yugoslav Republic of Macedonia, where this was introduced in combination with implementation of a diagnostic-related group-based payment component. In addition, Estonia and Serbia have introduced diagnostic-related groups in inpatient payment mechanisms.

Aligning health workforce capacities with patient needs

The general consensus is that the health workforce is not large enough to accommodate population needs, and those that are actively working are not being used optimally. As a result, task shifting and attention to health professionals’ changing roles are increasingly offering countries opportunities to be more responsive to people’s needs, preferences and expectations. Austria has adopted new regulations for the dental assistant and medical assistant professions. Belarus has introduced ancillary staff into its health sector workforce. These “helpers of the doctor” are intended to reduce physicians’ workloads, especially in primary care. Belgium organized a session on skill-mix issues at the Sixty-fourth World Health Assembly in 2011 to challenge Member States on how they think about the health workforce. During that discussion participants clearly agreed that they need to stop thinking about health professionals in boxes (nurses, physicians and so on), and while physicians may be reticent to give up their monopoly on treatment, there is evidence that in some areas nurse outcomes are as good as doctor outcomes. Opportunities exist in all

areas for task shifting but have been called for in the areas of maternal and child health and sexual health. In the Czech Republic the ministry of health is reforming education and regulatory mechanisms to create more flexibility in the volume and skill mix of the health workforce as a means of ensuring necessary numbers and a more efficient use of human resources. As part of the push towards more efficient use of resources for training, the duration of the specialist education of paramedic professions has been shortened; these specialists can now also enter into higher levels of medical education more easily. In France a transfer of jurisdiction was approved in 2009 to allow health care professionals to enable the transfer of care between professionals. One focus of an upcoming bill on health will be the adoption of new health professional training models to better meet the needs of NCDs. Ireland has approved the use of pharmacists to provide a variety of services including giving vaccinations during immunization campaigns and monitoring blood pressure and glycaemic index. Slovenia has been expanding the roles of nurses and introducing them into primary care teams to add quality in health promotion and prevention programmes. The United Kingdom allows pharmacists to administer methadone treatments – an important measure for making services more accessible to those patients.

The changing patterns of disease and the need for more efficient delivery of services are increasing the need to align the education of health professionals with patient needs – both initial education and CPD. A global independent commission on the education of health professionals led by Julio Frenk (62) called for an overhaul of professional education, attributing persistent and glaring gaps and inequities in health to outdated and inflexible education strategies. To achieve the necessary health reform, according to Frenk, “all health professionals in all countries should be educated to mobilize knowledge and to engage in critical reasoning and ethical conduct so they are competent to participate in patient- and population-centred health systems as members of locally responsive and globally connected teams”. In almost all countries the commission looked at, it found that “the education of health professionals has failed to overcome dysfunctional and inequitable health systems because of curriculum rigidities, professional silos, static pedagogy (the science of teaching), insufficient adaptation to local contexts, and commercialism in the professions”. As a result, today’s health workforce is hard pressed to master the knowledge, judgement and attitudes (competencies) for productive multidisciplinary collaboration; nor is it exercising the adaptability, leadership and positive attitudes towards change that are necessary to transform health systems and health services delivery.

To rectify this situation various responses have emerged across the European Region. Austria reported that education and training for the health professions is undergoing reform, with the primary aim of increasing the quality of training of doctors, as well as including aspects of GP training in medical practices (especially in underserved areas). Kyrgyzstan is prioritizing staffing of medical universities, availability of up-to-date literature for medical education, availability of well equipped facilities for practical training and a system of postgraduate and continuing education. Poland has shortened the initial training of doctors from seven to six years and is making this process more practice-oriented. The duration required for specialization has also been reduced (from 6–9 years to 5–6 years, depending on the specialization), and the ministry of health is working on changing basic training for nurses. Curriculum changes in Slovakia have increased the focus on primary care, with increased volumes of general medicine subjects during the last year of medical education for doctors. Spain and Hungary have reduced training durations for nurses and made this training more practice-oriented. Sweden has increased overall training volumes for both doctors and nurses. Tajikistan

and Ukraine also report an increased focus on training of family doctors: the number of these specialists in training has increased by about 20% annually in Ukraine in recent years. Turkmenistan has initiated training in new specialities (such as sports, military, rehabilitation and alternative medicine).

A trend has been seen in the Region towards making initial training more interprofessional as a means to improving medical professionals' ability to be more responsive to patients. Finland, Germany, Kazakhstan, Spain and Switzerland are examples of countries where more interprofessional training is being pursued. While the education of health professionals has been recognized by several countries as important and a priority, however, far too few are engaging in the transformative models of education proposed by Frenk et al. (62). Countries that are developing more transformative models include Austria, Belgium, England, Lithuania and Scotland. These programmes are taking health professional education beyond the hospital and into community-based primary health care and public health settings. Such modes of training better reflect the realities of life and promote learning in the continuity of care, teamwork, mentoring and professional development.

Increased attention has also been devoted to CPD and lifelong learning, which clearly contributes to increased patient safety, provided these interventions are primarily intended to keep the knowledge and skills of the health workforce up to date and are relevant for patient needs. In some countries these have been imposed as mandatory, whereas in others they have been introduced as ethical obligations. E-learning and distance learning approaches for CPD are also available in Belarus, where additional priorities in the renewal of the CPD system include increased practice orientation, raising qualification of trainers providing continuing education courses and implementation of new technologies in practice. Cyprus has developed and implemented a programme of continual worker training to improve the efficiency, effectiveness and productivity of health care personnel and the delivery of health care services. Continuing education is now mandatory for all nurses and midwives in the country and renewal of a practice licence is dependent on participation in the programme. The Czech Republic has amended legislation on lifelong education for practising nurses and has initiated reform of a continuing education credit system. The main amendment to the existing system involves not limiting the number of eligible credits from e-learning courses and seminars organized by health facilities. This has enabled more flexible organization of training according to the needs of health workforce. Other changes include adaptation of postgraduate and lifelong professional education in the interest of improving motivational, working, educational and social conditions for workers in paramedic professions. A national training programme has been initiated in collaboration with several other countries to train specialists from Turkmenistan several months at a time. Uzbekistan has developed a regional network of CPD centres for medical specialists and an extended network of CPD cabinets for primary care nurses in 159 locations. Overall, the volume of professionals enrolled in these programmes has increased significantly, particularly among doctors working in rural areas. The CPD system has now been linked to mandatory accreditation (at least every five years).

Finally, the RN4CAST study (63) has shown that while appropriate training and skills are important, well-being of health professionals must also be taken into account if progress is to be made with retaining and optimizing the use of the health workforce. Some countries like the Czech Republic, Hungary and the Republic of Moldova are working to increase the prestige and status of the health workforce, especially of family doctors and nurses. The ministry of health in the Czech Republic has introduced International

Nurses Day, National Nursing Day and the Nurse of the Year awards. In Hungary the birthday of the famous Hungarian doctor Ignac Semmelweis has been a legal holiday for health professionals since 2011, and 19 February was declared the Day of the Hungarian Nurses in 2014 in an effort to increase social appreciation of health professionals. The Czech Republic has primarily targeted the working conditions of nurses. A position of head nurse has been created in the country to ensure simplification of nursing and medical documentation. This means of alleviating the workload of nurses also aims to improve teamwork and management of health services. The country's labour code is being used to ensure that nurses are not overloaded owing to lack of numbers. Over the past three years Hungary has been focusing on improving working conditions, pay and other incentives to motivate people to return to the profession and the country. Turkey has recognized the importance of supporting health care professionals through legislation that supports more flexible working hours and has redesigned the training of health professionals including physicians and nurses (11). In the United Kingdom an independent report was commissioned to assess staff engagement and empowerment in the national health service. This review found compelling evidence that health service organizations with high levels of staff engagement – where staff are strongly committed to their work and involved in decision-making – deliver better-quality care. Building on ongoing initiatives such as the “Mutual Support” programme, a government fund of £1 million was announced to support more research into the potential advantages of the mutual model in the acute sector.

Prioritizing innovation and fair pricing

Financial incentives are being put in place across the European Region to promote responsiveness to people's needs and preferences. These have included the implementation of incentives for generic prescribing and (higher) user charges for less cost-effective pharmaceuticals and services. Hungary reported that during the last few years use of generics has been promoted and that one of the tools for this is a partial prescription of drugs based on active agents (compulsory only for cholesterol-lowering drugs). At the same time, incentives are provided to pharmacies to increase offering of generics. Further, the competitiveness of generic substitute products is actively incentivized by the health insurer. Lithuania has developed a national generics programme. Prices for the first generic produced must be 50% lower than the price of the original product, and prices of the second and third generics have to be 15% lower than the price of the cheapest in that group. Slovenia reported the introduction of a system of interchangeable medications: where the cheapest medication of the same molecule is available under statutory health insurance, any medications exceeding this price are available at a charge of the difference. This system also includes clustering of all pharmaceuticals into therapeutic groups based on the active agents; these measures have enabled price reductions ranging from 20% to 30% in Slovenia.

Innovative e-health and e-prescription technologies and tools are also being used across the Region as a means of improving responsiveness and utilization of services. While the use of health technologies has so far been concentrated in hospitals and pharmacies, it seems likely that its role in primary care settings will increase (33) and this is already the case in some countries (Croatia, Latvia and the former Yugoslav Republic of Macedonia). E-health has become a valuable tool for countries to reduce service provision resource needs and improve service efficiency. Overall, countries like Austria, Azerbaijan, Belarus, Bulgaria,

Cyprus, Estonia, Kyrgyzstan, Lithuania, Montenegro, Poland, the Republic of Moldova, Slovenia, Switzerland and the former Yugoslav Republic of Macedonia explicitly indicated development of e-health services in their responses to the consultation questionnaire. Poland is using e-health solutions to enhance the capability of rapid, coordinated responses to health threats and to enable effective action to promote health and prevent disease. Moreover, its information systems are enabling improved information and knowledge for the development of public health. Reliability and quality of data (including completeness, timeliness and consistency) are also expected to increase through wider use of e-health services, which in turn will ensure consistency of health care processes, systems and governance. Denmark has successfully scaled up home monitoring of patients with chronic respiratory illness and introduced countrywide electronic health records. Poland and Estonia have introduced e-referral systems.

Croatia has introduced patient management tools in primary care settings to prompt and support family physicians managing NCDs with “NCD panels”. These are gradually being expanded to allow a range of other health professionals (specialists and primary care and public health nurses) to access this information for better patient management.

Technologies are also being engaged to deliver care to hard-to-reach populations. Telemedicine has been widely used throughout the Region, especially to manage chronic illness. While telemedicine usage varies significantly across western and central Europe, it is widely used in Denmark, the Netherlands, Norway and Sweden and is increasingly used in Poland. The security of electronic health records has, as a result, become very important: countries like Cyprus, Estonia and the Republic of Moldova have implemented measures to ensure that patient information is protected.

Strengthening patient rights and entitlements

Many countries reported having introduced policies and legal/regulatory instruments to define and promote awareness of patients’ rights. In the EU Directive 2011/24/EU on the application of patients’ rights in cross-border health care has been instrumental in securing this awareness. Latvia’s law on patients’ rights, which was developed with technical support from WHO, came into force in March 2010. The law enumerates rights along a number of dimensions, such as people’s rights to information about their medical documents, medical treatment (consent or refusal), choice of physician and health facility, personal data protection and others. Norway’s national health plan makes explicit key aspects of such rights, such as appropriate waiting times for accessing services. Regulatory instruments are also used in Portugal, where the ministry of health has established charters on the rights and duties of users of the national health system and for hospitalized citizens. In Romania sophisticated e-platforms have been developed to assist patients in monitoring their access to services. Slovenia, which adopted an act on patients’ rights in 2008, has since applied it to managing waiting lists and introduced a patient advocate service, which provides patients with information and guidance on how to exercise those rights, while either receiving care or negotiating services with providers and insurance companies. Other countries are still in the drafting phase of preparing their legal instruments to protect patients’ rights.

In addition to this, Croatia, Cyprus, Denmark, Estonia, Finland, Hungary, Slovenia, Sweden, the Republic of Moldova and the United Kingdom reported having taken steps to provide

patients with the right to choose their primary care provider. While the evidence varies on whether allowing patients to choose providers is indeed what should be defined as “patient-centred care” (9), it has been reported to enhance patient satisfaction and competition between providers, which can improve the quality and efficiency of health care provided (64). Based on the laws on health care and compulsory health insurance in the Republic of Moldova, patients may freely choose their family doctor and primary care provider. In practice, however, registration is usually made with a doctor in the closest primary care facility and all family members in the household register with the same doctor.

To help enforce patient rights several countries have also introduced patient ombudsmen since the signing of the Tallinn Charter to protect patient interests and rights in the health system, including Croatia, Cyprus, Latvia and Montenegro. Other countries have taken a less legal route by creating an environment that makes healthy choices easy for everyone and that empowers people with regard to their health. In Estonia recommendations are provided on how individuals can take action to preserve and improve their own health, and a commitment to protect patients’ rights is matched by the intent to make citizens more aware of these rights in the health system. Health knowledge and healthy behaviours will be taught in schools. The effects of these changes, including changes in population health behaviour, will be measured with an annual survey.

Assessing patient satisfaction has been another mechanism used by ministries of health to inform improvements in responsive health systems. Many countries now use “hotlines” or web-based mechanisms to assess patient satisfaction. These tend to serve two functions: they provide feedback on citizens’ health- or health system-related questions and offer a means for citizens to register complaints. The website of the ministry of health in Azerbaijan includes the phone number for the ministry’s hotline, which citizens can call with any questions. In Portugal all facilities are set up with a formal complaint processing unit, which is obliged to respond upon receipt of a formal complaint. Turkey’s assessment of its “Health Transformation” programme, using call centre data, found the population’s rate of satisfaction with health services to have risen from 30% in 2003 to 75% in 2011. The call centre was set up to handle 1 million queries per year, with the benchmark that 90% needed to be resolved within 24 hours. A separate online forum was established for health staff to report directly to the minister of health.

COMMITMENT 5

The fifth Tallinn commitment is to engage stakeholders in policy development and implementation.

Main messages

- Political and administrative decentralization, including responsibilities for health, have been observed throughout the European Region as a measure to improve responsiveness.
- Improved dialogue and engagement with ministries of finance have been reported in some countries, particularly through the efforts of OECD and WHO in organizing joint meetings of health and finance officials.
- Engagement with other stakeholders has been a critical tool for strengthening human resources for health in the Region and is increasingly in place to improve employment of health professionals (recruitment, deployment, retention, incentives and migration). Silos between professionals, however, remain pervasive and are barriers to comprehensive and effective engagement.
- Countries have engaged a range of stakeholders including patients, providers and industry to improve efficiency in HTAs.
- All countries have initiated dialogue with other relevant stakeholders to some extent for the purposes of policy development and implementation. Mechanisms to sustain stakeholder engagement are less apparent.

Decentralizing the planning and implementation of health services

Political and administrative decentralization were reported throughout the European Region in the interest of improving stakeholder engagement. In Denmark, Finland, Norway and Sweden control of primary care services has been decentralized to municipal governments, enabling integration of primary care with other local services (such as social care), increased coordination of services with secondary care and strengthened preventive activities. The shift in decision-making power to municipal governments has also reportedly enabled better alignment of interventions with the health and social needs of local communities. Integration between organizations and administrations has enabled effective coordination of health care, public health and social services. The introduction of integrated care pathways with the use of a single payment-providing organization that incentivizes the most cost-effective care pathway has successfully shifted services from expensive hospital setting to home-based care, especially when managing older patients.

Following structural reform, Denmark introduced a new health law in 2008 to empower the Danish Health and Medicines Authority to define specialized functions and decide who should carry them out. Through a “bottom-up” process involving medical specialists and regional health representatives, 1200 specialized functions were defined on the basis of criteria such as complexity, rarity and resources. The plan was fully implemented in 2010; a recent evaluation showed broad commitment from all stakeholders and a transformation of the hospital sector towards fewer hospitals and more specialized

care. For cancer, 26 care pathways have been defined and more are being developed, but it has become evident that patients with uncharacteristic symptoms have quite long and unsatisfactory pathways. Based on the experiences of one region, therefore, diagnostic patient pathways have been created in all regions, managed by staff working in multidisciplinary clinics. Lithuania, in its efforts to improve quality coordination of services, reported that the infrastructure for public health services has been developed in municipalities, with the objective of improving accessibility. In Sweden central agencies, county councils and municipalities are all tasked with influencing public health and identifying future directions for action. A national public health survey shows the latest state of the population's health and follows up over time. Collaboration between the Swedish National Institute for Public Health and county councils and regions is ongoing. In the United Kingdom service provider management reforms have focused on strengthening governance structures in the form of foundation trusts. Legislation outlines the duties of boards of directors of national health service foundation trusts, stipulating that they must act to maximize the benefits of the trust for its members, including staff, patients and the public. In these efforts, the powers of a hospital's board of governors have also been strengthened: it has been assigned the statutory duty to hold non-executive directors of the hospital accountable and to oversee all significant hospital transactions. Limited evidence suggests that decentralization has led to improved policy innovation, contained health expenditure without widening health care inequalities and led to improved health outcomes.

Improving dialogue and engagement with ministries of finance

Ministries of health need to improve dialogue and engagement with ministries of finance as one of the most important measures by which to secure financing for health systems. This has been a recognized priority in several countries and has increasingly involved reframing health priorities to align with the language and priorities of ministries of finance. The economic crisis led to a change in outlook regarding the financial sustainability of health systems. From a purely fiscal perspective the question of sustainability is limited to maintaining a balance between a government's income and expenditure. A performance perspective, however, gives a more nuanced approach to the concept of sustainability, focusing on what level of achievement of public policy objectives countries can or are willing to sustain. While it may not be possible to increase or maintain absolute levels of health expenditure during an economic downturn, governments can choose how to implement budget cuts; this in turn reflects their priorities.

Many countries reported improved dialogue and engagement with ministries of finance, particularly through the efforts of OECD and WHO in organizing joint meetings of health and finance officials. Participants from countries such as Austria, Belgium, the Czech Republic, Denmark, Estonia, France, Germany, Greece, the Netherlands, Norway, Poland, Slovakia, Slovenia, Sweden, Switzerland, Turkey and the United Kingdom have been involved in such exercises.

Involving the health workforce in policy-setting

Engagement with other stakeholders has been a critical tool for strengthening stewardship of the health workforce in the European Region. Promoting cooperation with all relevant

stakeholders and sectors beyond health – including education, finance, labour, civil service and home affairs – in health workforce coordination and planning is particularly important and was explored in the chapter on the second Tallinn commitment. The United Kingdom's "Connecting" programme is exemplary for requiring that senior civil servants and policy-makers spend twenty and five days per year, respectively, in one or more health and care organizations to shadow staff and observe their day-to-day work to learn about their needs, as well as the needs of patients. The programme has connected 130 care providers with policy-makers and civil servants in a range of services including acute and mental health trusts, care homes and homeless outreach teams. Staff in service settings also benefit, and so far the department of health has held several days introducing the policy-making and parliamentary processes to health and care staff. It is also important to build a shared vision for planning, training, retaining and supporting human resources for health with the health workforce in the private and public sectors, academia, professional associations and patient representatives. This is an area that has also experienced significant engagement of patient organizations. Belgium, Finland, Germany, Israel, Italy and the Netherlands have made significant progress in engaging patient organizations in the development of health workforce policies.

Professional associations have emerged across the Region; while not always fully participating in the process of improving delivery of health services, they offer an important opportunity for more expert input to policy-making. During the Soviet period various professional associations existed in the countries of the former Soviet Union but with little or no real independence: the medical profession was unable to lobby for professional standards or the interests of its members (65), but this has started to change. In Kyrgyzstan, for example, professional organizations such as the Association of Family Group Practices and the Hospital Association work closely with the ministry of health on health sector reform. The Republic of Moldova also has strong local networks of nongovernmental organizations, which are playing an increasing role in health policy development in areas such as HIV/AIDS, TB and tobacco and alcohol control. In Slovakia working groups have been established to address a variety of issues, such as the definition of standards for the network of health facilities and emergency health service and drug policies. Stakeholders involved include health insurance companies, hospital associations, national experts and professional bodies.

Silos between health professionals, however, remain a great challenge. To address this, interprofessional planning teams, education and practice are being promoted in countries including Austria, Finland, Ireland, Spain and the United Kingdom. Nevertheless, because the health workforce is a domain of so many conflicting interests, policy-making cannot be exclusively consensual. Without strong leadership, national policies tend to flounder in a combination of ad hoc solutions, many of which focus on defending the interests of particular professional categories. National leadership is therefore necessary to initiate the process, push for breakthroughs, engage key stakeholders (workers, government and civil society), promote the synergistic roles of each and encourage them to adopt a partnership approach.

Engaging stakeholders to improve efficiency in HTAs

A wide range of stakeholders is involved in the HTA process in European countries, including patients and clinicians; this enhances transparency and trust in decision-

making and fosters mutual respect between patients, industry and regulators (66). One example is the Scottish Medicines Consortium (SMC) – a consortium of stakeholders including policy-makers, clinicians, pharmacists, patient representatives and industry representatives. The deliberative process employed by SMC has led to good engagement and a strong relationship with the area drug and therapeutics committees, which implement SMC's decisions in NHS Scotland (67). In Sweden patient representatives sit on the Dental and Pharmaceutical Benefits Agency's reimbursement board and as members of the Swedish Council on HTA; they are expected to give input on ethical matters and interpretation of study outcomes (68).

Communication between HTA agencies and manufacturers has also been pursued to improve efficiency in HTAs and avoid delays in the appraisal process (69). Efforts such as early and informal dialogue between the Norwegian Medicines Agency and manufacturers to identify relevant comparators (70) aim to avoid resubmissions and save resources for both health authorities and the company. In the United Kingdom in 2009 NICE established a fee-for-service scientific advice consultation service to pharmaceutical companies; this includes the supply of written advice; formal written advice projects were completed in the first three years of the service (69, 71, 72).

At the European level two initiatives to facilitate early dialogue between regulatory bodies and manufacturers deserve attention. First, the European Medicines Agency (EMA) issued a press release in 2013 stating that “a strong interaction between regulators and HTA bodies is critical to enable innovation to reach patients, and ultimately for the benefit of public health” (73). Since 2010 EMA has run a pilot project of parallel scientific advice. The programme allows developers to receive simultaneous feedback from regulators and HTA bodies on their development plans for new drugs. Second, the Shaping European Early Dialogues Consortium, led by France's HAS and financed by the EC, aims to explore ways of increasing early dialogue between HTA assessors and manufacturers during the development phase of their products (74).

Participatory governance

The importance of more participatory processes was highlighted in the Ljubljana Charter on Reforming Health Care in 1996 (2), in which ministries of health are directed to “row less and steer more”. In this vein, almost all questionnaire responses reported fostering of dialogue between civil society and policy-makers. All countries reported that directives and mechanisms are in place to promote stakeholder engagement, including consultations on individual strategies or reforms and standing feedback platforms (whether digital or by way of committees or advisory boards). Austria has set up an advisory board to implement its 10 framework health goals for 2012 to 2032: it undertakes regular and intensive discussions with the various stakeholders on primary care reform. Development of the framework, which was adopted in June 2014, took into account the important contributions of the advisory board and input from more than 30 institutions and more than 4000 citizens. The ministry of health in Belgium has invited external partners and experts to participate in the development process of its integrated health services strategy, on the assumption that planned changes should take advantage of the existing system and improve its strengths by harmonizing practices. In the Czech Republic the ministry of health seeks consultations on all laws, decrees and other materials under preparation with experts, professional societies and other ministries. The materials are sent out to

all entities involved – including health insurers, professional chambers, associations of hospitals, patient organizations and regional authorities – as part of the development process. In Estonia all relevant stakeholders – including nongovernmental organizations such as the Estonian Patient Advocacy Association and labour unions representing the health workforce and hospitals – are included in decisions that affect them or could benefit from their input. Germany has worked with a collaboration of more than 120 institutions to adopt and update seven national health targets. Evaluation of the targets between 2013 and 2015 is expected to feed into a new national health target programme. Numerous target-setting projects are also under way at the regional, district and municipal levels. In Hungary a decree regulates that patient organizations should be consulted regularly in the preparation of health policies and should be involved in consultations. The national patient's forum, which represents more than 200 patient organizations, participates in the development of health programmes, draft legislation and helping to develop professional standards. In late 2009 Kyrgyzstan began developing its new health sector strategy for 2012–2016, led by a working group of the ministry of health, which meets regularly with civil society representatives to discuss key elements of the strategy. WHO has provided technical assistance to the process throughout. To support the drafting of a federal law on disease prevention and health promotion in Switzerland, a working group was established with representatives from the cantons, public and private agencies and the federal state. It formulated the specification of national disease-prevention goals, which was then integrated into the provisional version of the act.

Patient input has been specifically targeted across the European Region, which has led to the development of both ombudsmen and patient representative bodies at the ministries themselves. The Czech Republic, for example, reported on establishment of a patient council at the ministry of health to harness input from patients on the delivery of health services.

Countries are increasingly engaging professional groups and vulnerable groups in decision-making around priority-setting. HIV services are one example, where the “greater involvement of people living with HIV/AIDS” principle dominates. Countries including Estonia, Tajikistan, Turkey and Ukraine have been working very closely with civil society groups to better reflect the needs of drug injectors, men who have sex with men, prisoners, migrants and sex workers in HIV policies; this has changed health outcomes dramatically. Azerbaijan reported extensive engagement with civil society in developing its 2008–2015 strategic plan on reproductive health. This approach was also taken during its 2013–2014 public health reform, which included not only reproductive health priorities but also child health, tobacco control, healthy behaviours and tackling domestic violence. It is not always clear, however, to what degree these groups also participate in evaluation of the implementation of these priorities.

The most common form of mobilization of stakeholder involvement is setting up web platforms that enable delivery of feedback on legislation, decisions, strategies and policies. These feedback mechanisms are important to foster a dialogue between civil society and policy-makers, but it should be ensured that the communication is two-directional and that the ministry is also addressing feedback. Estonia has implemented annual patient satisfaction surveys that feed directly into two indicators on quality and accessibility in the national health plan. Spain uses a tool known as the “health care barometer” to explore public opinion on services annually. The United Kingdom introduced the “friends and family test” in 2012: a single simple question that asks patients whether they would

recommend the care they have just received to their friends and family if they needed similar care or treatment. The feedback is virtually real-time, which means that services can look at their feedback and take steps quickly to address issues. The initiative was implemented for acute inpatient services, maternity settings and emergency services in April 2013, and for general practice, community health and mental health services in December 2014. It was implemented for all remaining services in March 2015, and since April 2014 the health service has heard from over 4 million patients.

COMMITMENT 6

The sixth Tallinn commitment is to foster cross-country learning and cooperation on the design and implementation of health system reforms at national and subnational levels.

Main messages

- Strengthening coordination/integration in the delivery of services is recognized as playing a pivotal role in responding to both health needs and the shortcomings of existing models of care. This has become a priority for countries in the Region and has occupied the focus of cross-country collaboration.
- Countries have actively participated in multicountry policy dialogue events and attended WHO training courses on health financing for universal health coverage and the flagship courses on health system strengthening.
- Significant initiatives in cross-country collaboration have taken place in joint data collection by WHO, Eurostat and OECD. More recently, the EU joint action on workforce forecasting has been an important source of experience sharing in information systems and statistics, good practices, capacity-building and the WHO Global Code of Practice on the International Recruitment of Health Personnel (45).
- To gain access to HTA reports from other parts of the Region, several countries are actively participating in the EUnetHTA (EU countries) and ADVANCE_HTA (central European and Balkan countries) networks, which aim to standardize methodology for assessing medical products and medicines.
- Several countries have engaged in intercountry and regional communication and information sharing to develop health plans, visions and strategies for their health systems.

Developing a vision for coordinated/integrated care

Moving towards health services that strive to provide high-quality services for all – particularly the most vulnerable – and that are more responsive to people's needs is both a cornerstone of the Tallinn Charter and central to Health 2020's vision of strengthening health system performance. Strengthening coordination and integration in health service delivery is increasingly recognized as pivotal in responding to both health needs and the shortcomings of existing models of care. In this context, and in response to countries' calls for contextualized, evidence-based policy options to enable system-wide changes, a framework for action towards coordinated/integrated health services delivery (CIHSD) is being developed for the European Region. The development process is consultative and inclusive, using a participatory approach to include input from countries, an expert advisory team and representatives of stakeholders, providers, patients and civil society.

In line with the wide engagement of stakeholders, the CIHSD stakeholder consultations have provided a range of actors including policy-makers, providers and patients with a unique opportunity to engage in the framework development process and a role in transforming health services to become more people-centred. Representatives from European patient, provider and professional associations had the opportunity to present their perspectives on how to transition towards a CIHSD system and the roles these

stakeholders may play in facilitating this process. This international consultation provided stakeholders with a forum to exchange ideas and experiences and to discuss important topics with international experts and country representatives. It will be used to develop and refine the framework, ensuring the highest possible relevance and practicability for countries and stakeholders alike.

Learning from experience in implementing health financing reforms

Countries identified information sharing and problem solving as important areas for development to better understand and make more informed decisions on the spending balance between health care, disease prevention and health promotion. Sharing experience on implementing health financing reforms in countries of the former Soviet Union has been facilitated by regional and country-specific training and policy dialogue events. The economic crisis further increased interest in cross-country learning and cooperation on different policy responses. Countries' questionnaire responses reported that the high-level meetings on the crisis in Europe organized in Oslo in 2009 and 2013 were particularly helpful (16, 75).

Evidence on policy responses to the economic downturn was collected, documented and used in training courses on financing. Participation in these training events has been the most common exercise for cross-country learning reported by countries. Altogether, 42 countries reported sending attendees to WHO training courses on health financing for universal health coverage and flagship courses on health system strengthening organized in Barcelona.

Learning about the health workforce

Better evidence and good statistical data have been recognized as critical enablers of enhanced governance at the national, regional and global levels. Experts identified these as areas of much needed attention, and they have experienced heightened activity. Many countries have consolidated their efforts to improve data and evidence on health workforce dynamics, labour market trends and policy responses for sound planning and decision-making. The findings of the EC project on health professional mobility in the EU (Health PROMeTHEUS) provide evidence from 17 European countries (76). The EC project on mobility of health professionals (MoHPRof) has generated evidence on international migration of health workers in 25 countries, with a focus on migration within, to and from the EU (77). Among the more active participants are Austria, Belgium, Denmark, Finland, France, Germany, Hungary, Ireland, Italy, the Netherlands, Portugal, the Republic of Moldova, Spain, Sweden and the United Kingdom. A project in the Republic of Moldova on better management of health professional mobility has dramatically improved the availability and use of data and evidence on human resources for health for policy-making and planning among countries who benefit from the migration of Moldovan health professionals.

Countries have pursued various measures to combat both external and internal migration to ensure uninterrupted service provision. All countries reporting action on the mobility of human resources for health seem to employ financial incentives, often combined with in-kind or social incentives. These mechanisms are further supported by increased

volumes of training in some cases and a focus on improving work conditions, as well as increasing the overall flexibility of the labour market in health sector. The Republic of Moldova, Switzerland and the United Kingdom reported on their use of the WHO Global Code of Practice on the International Recruitment of Health Personnel (45).

Significant progress in ongoing cross-country collaboration has been achieved, improving and harmonizing the definitions for data collection on health workforce employment and education for a joint database created by OECD, Eurostat and the WHO Regional Office for Europe (78). Countries including Hungary, Kazakhstan and the Republic of Moldova have since initiated the development of national and subregional human resources for health observatories.

The Joint Action on Health Workforce Planning and Forecasting, a 36-month project started in April 2013, aims to provide a platform for collaboration and exchange between countries to support them in preparing the future of the health workforce in Europe (79). The project seeks to collect essential data for health workforce planning, empower exchange of good practices in planning methodologies, support the use of horizon scanning and ensure that the results are delivered to relevant target groups. The Joint Action has been an important source of experience sharing in information systems and statistics, good practices, capacity-building and the relevance of the WHO Global Code of Practice on the International Recruitment of Health Personnel and ethical recruitment. Countries taking leadership roles in this initiative include Belgium, Bulgaria, Finland, France, Germany, Hungary, Iceland, Italy, Malta, the Netherlands, Portugal, Slovenia, Spain and the United Kingdom. In addition, 30 associate partners and 44 collaborating partners are involved.

The Bologna Process – which focuses on strengthening quality assurance in health professional training institutions and standardizing qualifications and periods of study for easier recognition across the EU – has helped to harmonize education structures so that health professionals are able to secure the employability of personnel across the European Region (80). In addition to the great efforts taking place in workforce forecasting in the EU, countries outside the EU are also collaborating across borders on these issues. Azerbaijan, Belarus, the Russian Federation and Turkey are collaborating to develop health professional education. Bulgaria has conducted an evaluation of its health workforce education and training system to identify the needs of public health and health care and to address prioritized public health problems effectively. As a result, changes in the regulation for a health care degree acquisition have been adopted.

Standardizing HTA methodology

To ensure more cost-effective and responsive use of HTP, continual learning opportunities are needed in the Region to increase the capacity of the health system to implement research on changes concerning medicines and medical products in systems. Joint forecasting and procurement activities for strategic products are also valuable exercises that can provide major benefits to health systems. Finally, platforms for exchanging ideas on best practices concerning medicines and technologies have also proved useful.

Several countries are actively participating in the EUnetHTA and ADVANCE_HTA networks, which aim to standardize methodology for assessing medical products and

medicines. Bulgaria, the Czech Republic, Cyprus, Estonia and Slovakia have harmonized their national legislation on pharmaceuticals with the EU regulations on the matter, while national medicines agencies have been created in Malta, Montenegro and the Republic of Moldova. This collaboration facilitates sharing of HTA reports between countries.

Improving knowledge in the stewardship function

Questionnaire responses deemed important activities such as policy dialogues to share experiences of the roles and functions of ministries of health. Several countries have engaged in intercountry and regional communication and information sharing to develop health plans, visions and strategies for health systems. The European Observatory on Health Systems and Policies, in collaboration with the DSP, has been particularly active in knowledge brokering and carrying out policy dialogues jointly in and with Member States at the national and subnational levels.

COMMITMENT 7

The seventh Tallinn commitment is to ensure that health systems are prepared and able to respond to crises, and that countries collaborate with each other and enforce the IHR.

Main messages

- Some attention and investment has been reported in the establishment of effective triage services as a means of responding to surges in demand.
- The availability of financial resources within the ministry of health's budget but also across sectors is essential for preparedness and management of emergencies; however, no countries reported on this in questionnaire responses.
- Simulation exercises and training of the health workforce on an institutional basis are in place across the European Region. Without reports on indicators or formal audits of the skills and capabilities to deal with health crises of health staff, however, it is difficult to identify gaps in knowledge, skills and capacities.
- Countries are increasingly recognizing the need for a larger public health workforce and competencies among health and non-health professionals to be able to respond to crises. Some countries reported on work in this area.
- The ability to respond effectively to emergencies relies on early preparedness of medical products, vaccines and technologies to facilitate their effective use for admitting and treating casualties and patients. Very few countries, however, reported having achieved sophistication in this area.
- Strengthened, well prepared and well managed health systems can effectively contribute to preventing health events from triggering a security crisis. An effective response requires the close collaboration of governments, international organizations, civil society, the private sector and other partners.
- Effective crisis preparedness and response is governed by a number of cross-cutting (strategic) principles that WHO encourages Member States to adopt. These relate to the all-hazard, the whole-health and the multidisciplinary (intrasectoral) approaches, as well as multisectoral and comprehensive approaches.
- In addition, WHO has a unique international mandate from its Member States to promote and support the IHR.
- Prepared and resilient health systems start primarily with the strong guidance of good stewardship. Countries in the Region have reported an increase in capacity and focus particularly in the area of accountability for emergency preparedness. Questionnaire responses demonstrated that health security is increasingly being approached as an intersectoral issue.
- Information systems and established lines of communications have been crucial in implementation of emergency plans for several countries in the Region. Many have invested in information systems to help in the surveillance, prevention and coordination of emergencies.

It is clear that much is at stake when it comes to crisis preparedness. Health crises and the human suffering they cause could jeopardize the progress made in strengthening health systems towards sustainable development and the achievement of progress made in improving health outcomes. This is why preparedness planning is critical. High-performing health systems that are more efficient are better prepared and more

resilient during times of crisis. This commitment received the second-highest level of actions reported.

As part of strengthening capacities, countries have established health sector-wide programmes to build the capacity to anticipate, prevent, prepare for, respond to, mitigate the effects of and recover from health crises. This includes a variety of activities across all health system functions, such as continually refining and updating a health sector emergency response plan based on endorsed policies, ensuring the health workforce is prepared, establishing crisis management structures and triage systems, stockpiling medication and introducing technologies to facilitate fast and responsive risk-reduction measures involving communities.

Ensuring availability and quick access to essential services

Key features of services that are prepared to respond to emergencies include mechanisms that help workers cope with surges of demand on health services (such as effective triage systems) and subnational or service-based emergency response plans. Considerable attention and investment have been devoted to increasing access to emergency services across the European Region and the establishment of effective triage services as a means of responding to surges in demand. During the floods in May 2014 the ministries of health in Serbia and Croatia reported prioritizing assistance to the injured and most vulnerable groups, pregnant women, children and those with chronic disease needing acute care such as haemodialysis patients. All patients in acute need were safely transported for provision of services. Poland has invested a number of resources in its medical air rescue programme. Its revision of the law on national medical emergency services includes improving emergency notification systems, establishing a minimum number of specialist medical rescue units and optimizing the number of medical dispatch centres in order to avoid confusion of communication lines. It has also introduced modern technology for more efficient management of emergency medical teams. Romania has set up an excellent emergency medical service system, which is being used as an example by several other countries. Turkey, in its experience with earthquake victims and Syrian refugees, has prioritized the maintenance of uninterrupted, high-quality health services to refugees – particularly those registered with the Turkish authorities.

Securing finances for times of crises

Despite the importance of being financially prepared for crises, no countries reported on the mechanisms by which they have ensured the availability of financial resources within the ministry of health's budget for preventing, planning for and managing emergencies. Nor did any report on mechanisms by which to source funds for multisectoral preparedness and management of emergencies. This reflects a worrying lack of emphasis on the importance of financial preparedness during crises. Nevertheless, the responses may reflect the original framing of the questionnaire, which did not explicitly request reporting in terms of the core health system functions. Work to explore responses to the economic crisis as a follow-up to the Charter did, however, emphasize the need case for countercyclical financing, thus enabling more spending during hard times and a building up of reserves (or the potential to move into deficit spending) during good times (16, 44, 75, 81).

Preparing human resources for health

To have a workforce capable of mitigating the effects of an emergency, ministries of health – in collaboration with other ministries – must take responsibility for defining the human resources needs of the health care system during emergencies and for implementing planning mechanisms to overcome gaps. Standards for the various personnel employed need to be defined, including required knowledge and competencies, preferably based on recommendations made by expert committees created for this purpose; this could be part of a health workforce strategy document. Plans for recruitment of both individuals and organizations are also important. Ideally, a central computerized database of staff should detail the current status of available personnel in relation to updated needs assessments. Finally, countries should ensure that the basic health workforce curriculum includes emergency preparedness and should also offer specialized training to help health systems strengthen their preparedness for emergencies.

In addition to efforts at improving stewardship for health during emergencies, the second area most frequently reported on in questionnaire responses was strengthening the health workforce for implementation of emergency programmes. Several countries reported the use of simulation exercises and training of the health workforce on an institutional basis. These are helpful in ensuring that the health workforce is knowledgeable, competent and skilled in emergency-specific services. The Regional Office is working with Azerbaijan, Georgia and Turkey on the mandatory inclusion of training on public health in emergencies in the initial training curriculum of medical students and the postgraduate curriculum for doctors. In response to the Ebola outbreak, Azerbaijan has provided special guidance to physicians who might be in contact with infected patients. The Czech Republic reported investment in the training of quality crisis managers, experts in emergency and relief medicine, logistics and quality management. Finland reported having simulation training in place at all institutions. Israel's ministry of health defines annual and perennial training policies, including drills, which are disseminated as a compulsory programme to all medical institutions and are implemented in hospitals. The annual programme is coordinated with all stakeholders, including the police and ministry of defence, and several joint drills are carried out each year. The scenarios for each drill are determined jointly, according to current risk assessments. Lithuania has recently implemented an Ebola preparedness, prevention and management plan, which includes measures on how to ensure public communication, case detection, case management (transportation, isolation and treatment). It also provides training and exercises on how to don protective equipment and improve communication and intersectoral collaboration. To be better prepared for handling the influx of migrants, Malta has conducted several training seminars on public health preparedness and response core capacities. It has also conducted simulation exercises within the country and in collaboration with other countries in the Mediterranean region. Poland's revision of the law on national medical emergency services includes reforms to education and training of the health workforce, increased staffing of emergency medical teams and new procedures for handling bodies. Spain is also strengthening training programmes for health professionals working in hospitals to ensure proper management of Ebola patients. The training takes place at the National School for Public Health in Madrid. The former Yugoslav Republic of Macedonia conducts annual simulations of mass accidents with all emergency health services, hospitals, police, fire brigades and the Red Cross.

Countries are also increasingly recognizing the need for a larger public health workforce and competencies among health and non-health professionals to be able to respond to

crises. Public health competencies to prepare for, plan and prevent emergencies are being developed by Denmark, Israel, Kazakhstan, the Russian Federation, Turkey and the United Kingdom. The Association of Schools of Public Health in the European Region has been instrumental in defining these public health competencies. It is less clear, however, how these skills are monitored and tracked. Very few countries have indicators or perform formal audits of the available skills and capabilities for health crises of health staff, which could help in identification of gaps in knowledge, skills and capacities.

Ensuring availability of essential technologies and medicines

The ability to respond effectively to emergencies relies on early preparedness of medical products, vaccines and technologies to facilitate their effective use for admitting and treating casualties and patients. Ministries of health must determine the standards and scope of essential medical supplies and equipment for emergency operations, based on risk assessment and analysis. They must also ensure availability of the types and extent of stockpiles deemed necessary to create and maintain an immediate response to potential risks. Storage planning and guidelines are important to minimize the need to dispose of items that have expired or are no longer suitable for medical use. Stocks of supplies and equipment required in pandemics including antiviral drugs, personal protective equipment, vaccines, imaging and laboratory equipment are also important. A distribution system for vaccines, including a cold chain, is vital to ensure rapid delivery of supplies and equipment in the event of an emergency. Israel's ministry of health has all these items in place and also operates a national centre for unique drugs that are not frequently used during routine times; these are made available to medical facilities round the clock as the need materializes. A mechanism for rapid procurement enables purchases in cases when necessary supplies are not accessible in the country. The medical equipment, supplies and pharmaceuticals are purchased by the ministry and stored across a wide geographical area to enable rapid transport to admitting hospitals in an emergency. A proportion of the equipment is allocated to hospitals in routine times; it is stored within emergency departments to facilitate an immediate response during an emergency and to expand surge capacity. In addition, the ministry operates several warehouses for buffer and emergency stocks. The stockpiles are monitored on an ongoing basis to ensure appropriateness for immediate use. Medical supplies are checked and rotated periodically to ensure their use before expiry date, so the inventory is continually resupplied.

Experts have expressed concern that security of laboratory services is often one of the important bottlenecks in responding to biological or medical emergencies, but only a handful of countries mentioned this in the questionnaire responses. A chain of laboratories must be available at the national, regional and local levels, including referral laboratories for various potential risks. Where this is not possible due to a lack of resources and knowledge agreements must be in place to obtain these services and skills as needed. Protocols for the safe transport of biological and environmental specimens for testing and/or confirmation by national and international reference laboratories are especially important. All existing laboratory supplies and equipment should be tested periodically.

Countries have made significant investments in information systems to help in the surveillance, prevention and coordination of emergencies. Israel has established three computerized information systems, operated by the ministry of health to ensure an online

and accurate view of hospitals' potential surge capacity. These include an online system interfacing with admission transfer and discharge that reports on all general hospitals to assess bed utilization; a web-based system through which hospitals report on ventilated patients in and outside intensive care units and on the severity of injuries of all casualties admitted to emergency departments, including acute stress reactions; and a computerized system for identification of casualties to facilitate transfer of information to the public. Serbia has adjusted the ministry of health website to update the information needed by professionals and citizens in times of emergency. This includes lists of recommendations, guidelines, leaflets and posters for citizens and methodological guidelines for institutions. Spain's Agency for Consumer Food Safety and Nutrition has a strategy in place on risk evaluation (providing scientific advice and data analysis), risk management (regulation and control) and risk communication. To facilitate early detection of risks a network for alerts related to food is articulated through a coordinated system of rapid exchange of information. Preliminary conclusions show that a high level of organization and competence at the national and subnational levels has resulted from such information systems across the health service.

Preparing stewards to lead and coordinate during times of crisis

Prepared and resilient health systems start with the strong guidance of good stewardship. Key recommendations include establishing clear national crisis plans that provide direction for well functioning health information systems designed to facilitate and support health, as well as multisectoral coordination, strategic and operational decision-making and risk communication strategies to reduce public fear and uncertainty. Improved stewardship has experienced the most progress of all four core health system functions over the past seven years.

The European Region has witnessed an increase in capacity for emergency preparedness, particularly in the area of accountability. In addition to implementing the IHR, several countries have put emergency preparedness plans in place, either as overarching national plans or with other instruments that legislate for the implementation of preparedness plans at a regional, local or institutional level. In Georgia, according to a response plan for natural and man-made disasters approved by presidential decree, every medical facility must have an emergency response plan. To date, 184 health care facilities have developed, agreed and submitted their emergency preparedness and readiness plans to the ministry of health. Similarly, Lithuania reports that all medical care institutions and public health care centres have emergency management plans. Norway has comprehensive national and local plans for preparedness, both within the health and social sector (for all service providers) and outside it (created by the Norwegian Directorate for Civil Protection). Health sector plans for preparedness cover roles and responsibilities in crises and measures to be implemented. Local authorities are obliged to develop preparedness plans and perform exercises. In the Republic of Moldova the government-approved national plan for emergency preparedness and response contains chapters on public health aspects at the national level. In Serbia the national plan for maintaining readiness for emergencies, natural disasters, epidemics and disasters and man-made disasters obliges all institutes and departments of public health and health care institutions to have contingency plans, which are reviewed annually. Slovenia has nine national emergency response plans that include both guidance for individual health services and a comprehensive national plan that directs the coordination of all levels of health services. The former Yugoslav

Republic of Macedonia's plan for crisis emergency and response was endorsed in 2009 by the ministry of health, and a pandemic plan was endorsed in 2013 by the ministry's pandemic influence committee. These have been piloted and updated. Also in place are action plans for prevention of the harmful effects of heat waves and cold snaps, which have been prepared and tested in cooperation with stakeholders from other sectors.

Ministries of health also reported their readiness to be in charge of health system preparedness planning and managing health crises so that they can be ready to take a leading and coordinating role and guide other sectors during a health emergency. This was made clear by the frequency with which countries reported having designated authorities and committees in place to oversee the response to health emergencies. For example, all 53 countries in the European Region have designated round-the-clock national IHR focal points. Georgia, Israel and Latvia have established emergency disaster units within the ministry of health. Cyprus has established a department of medical and public health services, which is responsible for the surveillance of all infectious and communicable diseases, early detection and control of epidemics and monitoring and evaluation of control programmes. In Hungary a rapid response department was established in 2010 and the crisis management centre of the office of the chief medical officer in 2011. In Lithuania a health emergency operations centre has been established at the ministry of health, with a health emergency situations centre as its implementing unit. In the case of large-scale emergencies or if municipalities seek assistance, this centre coordinates national health system personal and public health care institutions, regardless of their subordination and forms of ownership. All private and public health services must be prepared to organize their activities in compliance with the institution's emergency management plan, drawn up according to recommendations approved by the ministry of health. In the Republic of Moldova the emergency commission of the ministry of health has been designated to make specific decisions on public health in the event of an emergency public health situation. Romania's national health emergency preparedness plan has led to the creation of a medical emergency system integrated into the national system for management of emergency situations. Its goal is the efficient prevention and management of emergency situations through coordination of the necessary human, material and financial resources. This system was created prior to Romania's accession to the EU; it has undergone significant development in last few years, aimed at integrating all activity sectors and ministries among which emergency medical assistance is an important part. Some countries have also introduced task forces on an event-by-event basis, including Montenegro and Switzerland to address the Ebola crisis.

A health sector crisis management programme should include links to other sectors involved in crisis management and standardize a management system. Countries' questionnaire responses demonstrated that health security is increasingly being approached as an intersectoral issue, with some examples of well established coordination mechanisms involving not only a range of government sectors but also nongovernmental institutions. Georgia has designated the ministry of internal affairs as the government agency responsible for emergency management. It provides coordination to all other ministries and government structures in times of emergency. The ministry of health operates a department of emergency coordination and regime – a special structural unit responsible for development and coordination of the emergency readiness of the national health system. In Israel the ministry of health undertakes activities according to a national plan that mandates an all-hazard, multidisciplinary approach to risk reduction and crisis management. The director-general of the ministry or his/her representative

is a member of the national multisectoral emergency management body. For handling massive influxes of migrants, Italy has implemented an intersectoral response whereby the health authorities of the Sicily region have established a coordination plan involving various sectors, with the participation of all directors of health services in the region. The goal is to develop a modular emergency contingency plan for the provision of effective health services and to coordinate response operations in the event of a health emergency on Lampedusa (82). In Spain the Centre for Coordination of Alerts and Emergencies based at the ministry of health is the focal point for the national system for early warning and rapid response, formalized in 2012; it coordinates a network that includes all the regional structures. In addition, the Centre fulfils epidemic intelligence activities, management and monitoring of health threats, and performs risk assessment, situation analysis and activities related to preparedness and response in public health.

Countries also reported a particular emphasis on information systems and establishing lines of communication, particularly where the IHR have been implemented. Azerbaijan introduced a national focal point along with an alternative and has translated, published and distributed the IHR in Azerbaijani to ensure that these are understood at all points of care. The country has also prioritized ongoing exchange of information using the network of IHR focal points. In response to the Ebola outbreak, Azerbaijan's Public Health and Reforms Centre developed and disseminated information on the Ebola virus to all ports of entry to Azerbaijan. Israel's ministry of health is designated to lead the health sector in management of a national disaster. As such, it develops and disseminates policies and guidelines to all medical institutions and agencies, both public and private. In Lithuania the Health Emergency Operations Centre coordinates preparedness and response of the national health system for emergencies, with the primary function of coordinating the exchange of information with other ministries, health care institutions and the general public. The Republic of Moldova's National Centre of Public Health was designated a national focal point for the IHR. Its basic functions include round-the-clock communication, collection of information from the surveillance and reporting system (health systems, points of entry into the country, informal sources) and dissemination of information and updates to relevant government administration sectors (including those responsible for surveillance and reporting, public health services and clinics). In Slovenia a coordination group is responsible for early detection, assessment, communication and interdisciplinary coordination of responses to risks from communicable diseases and environmental factors; collection and review of information (from regional, national or international reporting); and, if necessary, activation, communication and coordination of an interdisciplinary team to manage risks that may represent a direct threat to the population.

CONCLUSIONS

Acknowledging the difficulty of attributing specific policies or outcomes directly to the Tallinn Charter, this report demonstrates that countries have undertaken numerous actions across the four core health system functions within the spirit and text of the Charter's seven commitments. Of the 53 countries in the WHO European Region, 40 responded to the consultation questionnaire. Specific activities, policies or interventions were correlated or cross-referenced to the coding matrix (see Fig. 1 in the introductory section on the coding matrix) to show the number that fall within the scope of the Charter. The coding results suggest that progress across the Region varies considerably and that no single model fits all.

In addition, the Charter has been "tested" by the global economic crisis. Both the literature review and the questionnaire responses reveal that the crisis played an important role in determining which policies and health system strengthening initiatives countries chose to pursue. Some countries have been conservative in their pursuit of new policies; others very active, introducing many initiatives. Some health systems were better prepared than others to respond to the crisis due to fiscal reserves secured beforehand. Countries' responses to the crisis provide insight into the strength of the Charter commitments in practice, particularly in key areas such as promoting solidarity, fostering cross-sectoral partnerships and investment, and making health systems more responsive. The WHO Regional Office for Europe has been crucial in providing support to these actions and advocating the commitments. The emergence of Health 2020, the new European health policy framework, as the overarching policy for the Region can only strengthen future activities and directions for ensuring more sustainable and resilient health systems.

Economic crisis

The economic crisis has affected many health systems in the Region – some severely. Fiscal measures taken before the crisis (such as accumulating financial reserves, establishing countercyclical formulas for government budget transfers and ensuring the health system was adequately funded), as well as pre-crisis efforts to minimize gaps in health coverage and reduce out-of-pocket payments, meant that some countries were better prepared to cope with an economic downturn than others. Nevertheless, all countries affected by the crisis have faced similar challenges.

- Health systems require stable, predictable sources of revenue. Sudden interruptions to public revenue streams can make it difficult to maintain necessary levels of health care.
- Cuts to public spending on health made in response to an economic shock typically come at a time when health systems require more, not fewer, resources – for example, to address the adverse health effects of unemployment and to deal with increased reliance on access to publicly financed health services.
- Arbitrary cuts to essential services may further destabilize the health system if they erode financial protection, equitable access to care and the quality of care provided, increasing costs in the longer term. In addition to introducing new inefficiencies, cuts across the board are unlikely to address existing inefficiencies, potentially exacerbating the fiscal constraint.

In responding to the crisis, most countries reported having introduced positive changes (44). Several countries have mobilized public revenue for the health sector, sometimes in ways that have brought additional benefits – introducing taxes with public health benefits, for example, or measures to make health financing fairer. The crisis has prompted action to enhance financial protection, including extending health coverage to new groups of people and reducing or abolishing user charges. Faced with growing fiscal pressure, countries have also taken steps to get more out of available resources, and efforts to strengthen pharmaceutical policies have been especially common. Nevertheless, countries have not always taken necessary action or been able to achieve desired results and have sometimes introduced changes likely to damage performance. As a result, a handful of countries have experienced a sharp and sustained reduction in public spending on health and there is some limited evidence of increases in mental health disorders, the incidence of catastrophic out-of-pocket spending and unmet need. Evidence of these negative effects may grow as the crisis persists (particularly in countries where unemployment is still high) and as the longer-term consequences of blanket spending cuts and coverage restrictions begin to be seen.

Tackling inefficiency has been an important priority for most European countries in recent years, and not just because of the crisis. Where the short-term situation compels governments to cut public spending on health, the emphasis in the Tallinn Charter clearly points to cutting wisely to minimize adverse effects on health system performance, enhancing value and facilitating efficiency-enhancing reforms in the longer term. Health systems with strong leadership and well functioning governance arrangements have proved to perform better in general, and during a crisis in particular. Given the labour-intensive nature of the health sector, implementation of supportive health workforce policies is a critical part of this process. Since the cost of medical products (in particular of many new medicines) is often high, countries have increasingly turned to better use of evidence and guideline development to inform and justify the selection of medicines made available and reimbursed. Use of HTAs and investment in e-health technologies have been reported across the Region as useful mechanisms to guide countries in the process of introducing and using new products to guide reimbursement, while also contributing to health system performance and strengthened accountability.

Countries that have made strategic, transparent, intersectoral and far-reaching decisions, and where commitment to equity, solidarity and financial protection is strong, have been better able to avoid undermining performance. The Tallinn Charter has thus effectively made the case for the virtuous cycle of health–health systems–wealth. The commitments of the Charter, when cross-referenced with the core health system functions, provide a valuable framework with which to prioritize and develop the intelligence and capacity for health system strengthening needed to defend health budgets and improve the contributions of health and health systems to promoting wealth and societal well-being.

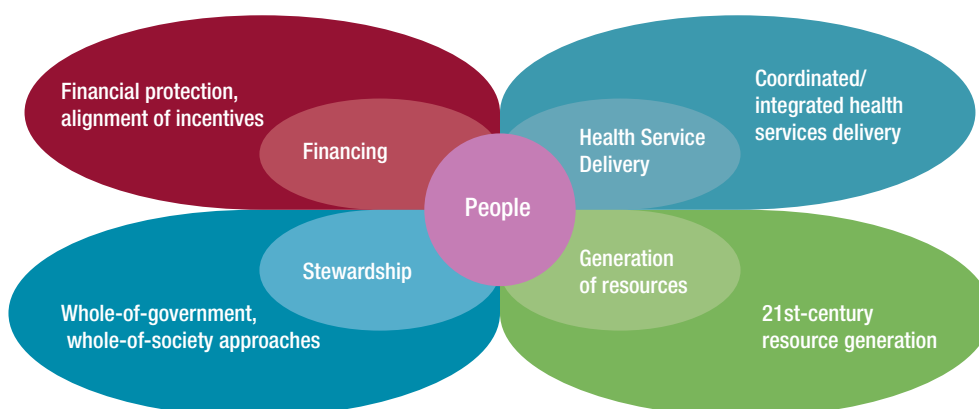
Health systems for health and wealth, Health 2020 and future directions

To mark five years after the signing of the Tallinn Charter and to examine both the progress made and the potential way forward, a high-level meeting was held in Tallinn in October 2013 (11). The meeting confirmed considerable enthusiasm for implementing the commitments of the Charter and related them to the third priority area of Health 2020

(strengthening people-centred health systems, public health capacity and emergency preparedness, surveillance and response) to help identify priorities and directions for health system strengthening in the Region (10).

It was agreed that while the Tallinn Charter has provided the systems thinking, Health 2020 provides a coherent policy framework for strategic objectives and priorities that brings the right policies and the systems thinking together. This context allows for a more targeted and strategic approach to our understanding of health systems strengthening. Fig. 2 shows the strategic directions in which the four health systems functions are being strengthened towards becoming more people-centred. Discussions around health system financing are now more precisely focusing efforts to ensure universal risk protection with the aim of reducing inequities. Service delivery prioritizes transformations towards more coordinated/integrated models of care as this approach is necessary to address fragmented public health and health care services and enable a continuum of high-quality, people-centred services. Stewardship aims to engage a whole-of-government and whole-of-society approach to improve outreach to other sectors. Resource generation more specifically refers to the many new and exciting developments in both medicine and information technology, as well as ensuring that human resources keep pace with innovation in these areas.

Fig. 2. Health systems in the context of Health 2020



In keeping with this context, and based on reported country experiences, Member States identified and proposed several strategic priority areas of work to direct health system strengthening activities in the coming years.

- Further assistance is needed in implementing Health 2020 and strengthening public health services, as well as in reinforcing the capacities of local public health authorities to implement the 10 essential public health operations set out in the European Action Plan for Strengthening Public Health Capacities and Services (83).
- The integration and coordination of primary care services with hospital and public health services is one of the greatest challenges faced by the Region. Reorientation towards primary care and public health, it was agreed, can only be accelerated to achieve improved health outcomes in tandem with development of a better understanding of patient needs.

- Given that millions of people continue to experience financial hardship when accessing the health services they need, action is still needed to reduce out-of-pocket payments and increase financial protection for vulnerable populations.
- Guidance is required on strengthening accountability arrangements and their management, and improving the training and deployment of the health workforce (especially nurses and other primary health care personnel) so that it is equipped with the skills to promote these care delivery models.
- More needs to be done to develop targeted health workforce strategies that better align with patient and population needs.
- Persistent silos challenge the organization of providers and remain an important area for improvement.
- HTP need to continue to keep pace with people's needs and innovations.
- Further support is needed to develop HTA; this continues to be required across the Region.
- The availability of disaggregated information – crucial to targeting the social determinants of health and health inequalities – also needs improving.

Member States identified several strengths of WHO, including its credibility and neutrality, its convening power, its ability to organize peer reviews and the visionary Health 2020 policy and Tallinn Charter. Four key ways of working were seen to be particularly effective for the Regional Office: generating and disseminating evidence; holding countries to account to their populations; building capacity at the regional and country levels; and providing country-specific technical support.

The way forward

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 European Region-wide set of commitments focused on accountability for the performance of health systems, the Charter represents an important exercise, and valuable lessons have been learned from the experience of Member States and the Regional Office in implementing it.

Health 2020 has since positioned people at the centre of health systems (see Fig. 2). This marks a paradigm shift that emphasizes patients as front-line workers in the health system. Pursuing the transformative change required for more systems-thinking approaches towards more people-centred health systems is challenging; it calls for more attention to the vital role of management and leadership among stewards of the health system.

Taking all this into consideration, the Regional Office has developed a high-level strategic paper on priorities for health system strengthening in the European Region 2015–2020, which will be presented to the 65th session of the WHO Regional Committee for Europe. Through consultation with Member States, two key strategic directions for future Secretariat work in strengthening people-centred health systems have been identified: transforming health services to meet the challenges of the 21st century; and moving towards universal health coverage for a Europe free of impoverishing out-of-pocket health expenditures.

To transform health services the Regional Office will support Members States in:

- building capacity to restructure public health services;
- ensuring a comprehensive continuum of services;
- moving away from traditional modalities of service delivery;
- breaking down boundaries across care levels and settings;
- managing processes for better outcomes.

To move towards universal health coverage the Regional Office will support Member States in:

- promoting policies to reduce out-of-pocket payments;
- ensuring adequate public financing for health systems;
- reducing fragmentation in health system funding channels;
- adopting strategic purchasing mechanisms;
- ensuring effective and equitable coverage decisions.

The mission of the Regional Office, therefore, continues to be to support Member States in strengthening their health systems to accelerate health gain, reduce health inequalities, guarantee financial protection and ensure efficient use of societal resources, including through intersectoral actions consistent with whole-of-society and whole-of-government approaches. This involves responding to the diverse needs of all people, paying particular attention to the values of solidarity and equity. It means that people should not face financial hardship when accessing needed health services. It requires a focus on efficiency, so that valuable resources are not wasted, and requires greater transparency and a renewed commitment to performance assessment for accountability. These are all reflected in the spirit and text of the 2008 Tallinn Charter.

The Charter continues to inspire and act as a banner for strengthening health systems in the Region and beyond – this was the strong message from countries in their responses to the consultation questionnaire. As such, the Tallinn Charter represents a strong focal point in the third priority area of Health 2020, which will take forward commitments within a wider, more comprehensive health agenda for Europe.

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World Health Organization
Regional Office for Europe
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 30 70 00. Fax: +45 45 30 70 01
E-mail: contact@euro.who.int.
Web site: www.euro.who.int