



World Health
Organization

REGIONAL OFFICE FOR Europe

EXPERT MEETING ON PROTECTING INVESTMENTS IN HEALTH AND MAXIMIZING NEW OPPORTUNITIES TO ADVANCE HEALTH EQUITY AND WELL-BEING



15 November 2018
Venice, Italy



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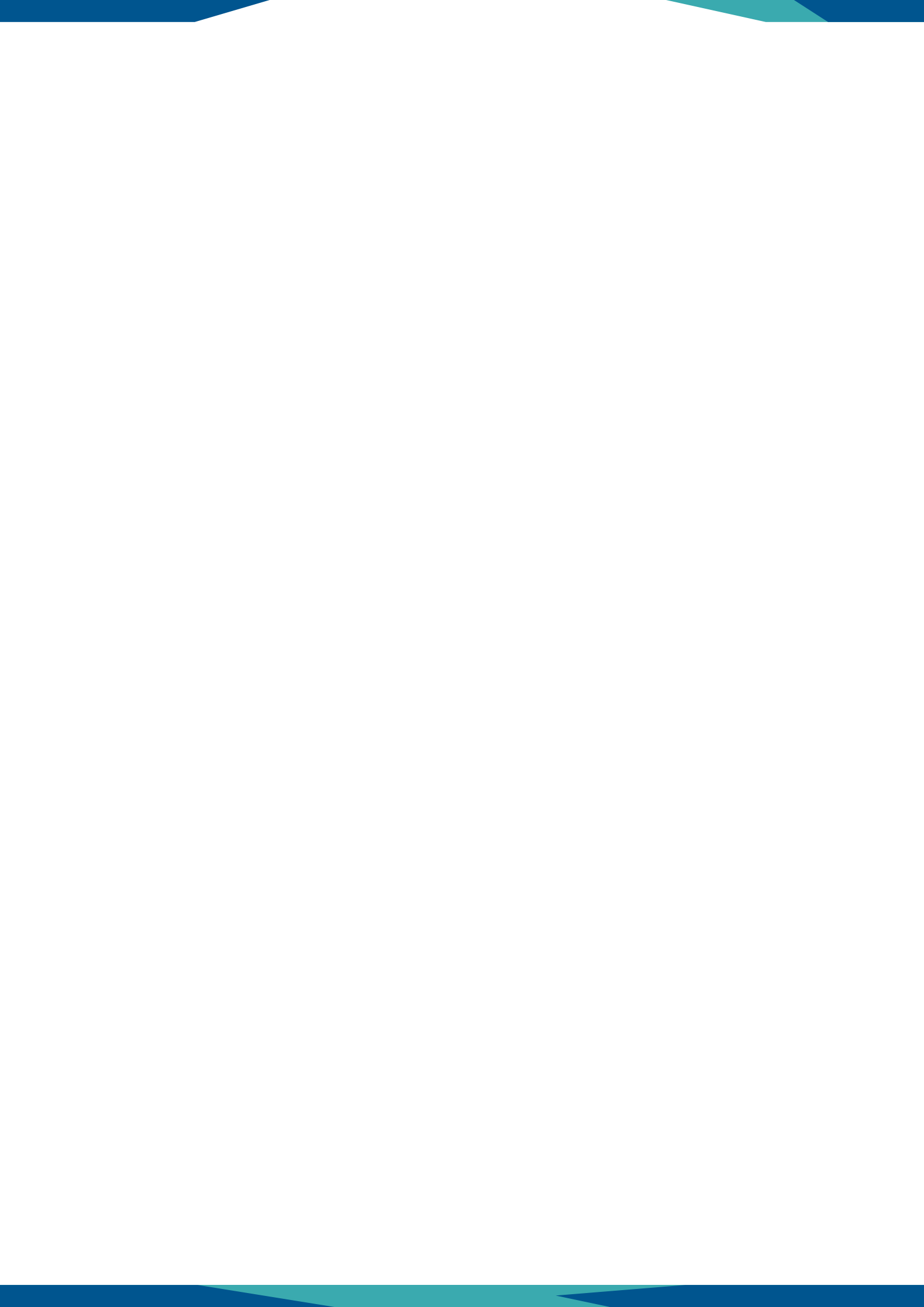
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Contents

Introduction	1
Session 1. Economic and social impacts and benefits of health systems (report).....	2
Discussion	3
Session 2. Examining impact on local systems – evidence from England and Slovenia	5
Discussion	7
Session 3. Anchor institutions: experience and impact in the United States	8
Discussion	8
Session 4. Procurement in health systems	9
Discussion	10
Session 5. Looking forward.....	11
Role of WHO and respective organizations	13
Closing remarks by WHO.....	14
References.....	15
Programme: Economic and Social Impacts and Benefits of Health Systems ...	17
List of participants	19



Introduction

The Expert Meeting on Protecting Investments in Health and Maximizing New Opportunities to Advance Health Equity and Well-being was held in Venice, Italy on 14–15 November 2018. The meeting sought to provide guidance for the continued work on the economic and social impact of health systems within the WHO Regional Office for Europe. It also aimed to strengthen the evidence on the impact of health systems, as well as their relationship with improving equity and sustainability and with national and local development policies.

Leading experts in the area of inequities and health systems came together in order to:

1. consider and advise on the proposed methodology for analysing the economic and social footprint of health systems;
2. make recommendations to the WHO Regional Office for Europe on the future direction of the footprint and anchor analysis.

Expected meeting outcomes included:

1. advice on the information and tools that Member States would need to assess the economic and social impact of health systems, along with how to implement actions based on this information;
2. guidance on how the WHO Regional Office for Europe can continue its work in this area.

Opening statements were given by Dr Piroska Ôstlin, Director of the Division of Policy and Governance for Health and Well-being; Chris Brown, Head of Office of the WHO European Office for Investment for Health and Development (Venice Office); Dr Giuseppe Ruocco, Secretary General and Chief Medical Officer of the Italian Ministry of Health; and Dr Chiara Corti of the Veneto Region's Regional Epidemiology Service and Director of Azienda Zero (Azienda Zero, 2018).

In their introductory statements, all partners confirmed that the work being carried out is in line with local, regional and national priorities and that there is continued need to demonstrate how investing in health can have a concrete impact in other areas. It was confirmed that this work is also in line with the Sustainable Development Goals (SDGs), putting health at the centre, and that the meeting outcomes would provide innovative evidence to convince other sectors to see the value of health systems.

Furthermore, the speakers agreed that the work being carried out on the economic and social impacts of health systems supports a common agenda around investing for health and development, embedding common values of inclusion and solidarity, through new evidence on how investment is developing momentum for the benefit of the whole of society. Partners highlighted the high employment numbers from their health systems (for example, Azienda Zero employs 70 000 people and buys 50% of its goods in the Veneto Region of Italy).

Session 1. Economic and social impacts and benefits of health systems (report)

Tammy Boyce, representing WHO Regional Office for Europe, presented the report on economic and social impacts and benefits of health systems during session 1 of the meeting. Background was provided on the link between the current work and the Tallinn Charter (10 years ago), which stated that health systems needed to think about investments as being essential to improving health and health equity. At the time, these ideas were not filtering down as needed, and it was a challenge to shift the argument to convince people that health was not just a cost but indeed a benefit. As a result, there was a move towards disinvestment in health. The work presented challenges the disinvestment argument, by providing concrete examples of how investing in health generates other outcomes that have an important positive impact on health. For example, health systems are providers of high-quality employment that is inclusive, secure and, often, well remunerated. The health system is also a constant presence in every country, often working with local suppliers. Thus, it can play a role in shifting thinking about purchasing and employment. Another indirect impact of health systems is their ability to create a good sense of community.

Timotej Jagrić, from the University of Maribor in Slovenia, presented the methodology applied to calculate the impact of the health care sector on national economies. The methodology developed was first tested on the Slovenian economy and then applied to 19 European countries. Using input/output tables, estimations and multipliers, he modelled the short-term economic effects of the health system. Results confirmed that the health care sector can contribute to economic growth and increase national output. The main results presented (across various multipliers) are outlined here.

- €1 of spending on health care sector services and products (output) would result in €1.402 of greater national economy output (when accounting for direct and indirect effects, and €2.704 when also accounting for induced effects).
- An increase in health care expenditure of €1 would result in a €0.678 rise in household income (measured as direct, indirect and induced effects).
- €1 spent on health care services (health care sector output) would result in an increase of €0.824 in the value-added of national economies (including direct and indirect effects), or €1.139 when induced effects are also included.
- An increase of €1 million in health care sector services and products would on average result in the creation of 30.96 new jobs (when direct and indirect effects are included), or 40.89 new jobs when induced effects are also included.
- A strong relationship was found between import multipliers and gross domestic product (GDP) per capita. Countries with higher incomes have lower import multipliers because they spend more on health care and have a more developed health sector, which needs fewer imports.
- In countries with lower GDP per capita the impact of the employment multipliers is greater than in countries with higher GDP per capita. Low-income countries will have greater gains by additionally stimulating the health sector than high-income countries would.

In most countries, health care had a greater-than-average impact when compared to other sectors. The health sector was also found to be stable – with various multipliers unaffected despite financial crises – making it a solid investment in both the short and long term. Limitations to the work were noted: the results of this analysis are for the year 2010, with a 6-year upper limit for results validity in a country (in this case, until 2016); and the analysis used data from only 19 of the 28 European Union (EU) countries. Future plans are in place to develop more regionalized calculations of the impact of health systems.

Discussion

Health systems create local jobs; encourage local spending of wages; and reduce travel distance – all factors which contribute to local development. The results presented show that investing in health systems translates into investing in communities. They also provide some key language that can be used by ministers of health, for example when they are speaking with ministers of finance, to ensure a common understanding.

Participants praised the excellent work carried out, noting it as a milestone, and recognized that it provides an argument to incorporate the notion of fiscal multipliers into discussions looking to increase investments in health systems.

Specific observations on the methodology included those listed here.

- The input-output tables make for a solid methodology, since this allows for comparison across countries. This work could be very relevant for other countries, especially seeing the impact in countries with low GDP. While the health workforce in high-income countries is 10%, it is less in low income countries (3–4%).
- While data are sound in Europe, it is worth remembering that this might not be the case in non-European areas.
- It is important to consider the role of the private sector; particularly in the context of the possible expansion of this work beyond Europe.
- The methodology implies mechanical effects that might not hold in the future, when situations change (e.g. artificial intelligence, a changing workforce, and so on). Flexibility is needed in considering projections of what the situation could be in the future.
- It is necessary to understand the sectors that have a greater impact on national economies. The impact of the health sector compared to other public sectors (e.g. education) should also be better understood.
- In the long term it will be necessary to explain to politicians why investment in the health sector is needed (and indeed the value of the sector), as opposed to investing in other sectors.
- It is important to be able to show how health sector investment can stimulate income and reduce poverty, since it can also contribute to poverty (through out-of-pocket payments). It will be necessary to separate health care sectors and to consider the effects of community and primary care separately.

- Indirect effects also need to be considered. For example, investment in health systems generate immediate economic impact through employment opportunities, but also a second subsequent set of impacts by improving the health of the workforce, who can then contribute more positively to the economy.

A key question posed by policy-makers involved the duration of the effects of the analysis; they were particularly interested in results that covered the short term. The methodology assumes linear technology advancement and uses a short-term model. The estimates presented were for one year; as such, this analysis did not delve into long-term effects (or those longer than the life of a government).

In some countries it may be a challenge to obtain the detailed data needed to carry out the input-output analysis across 64 sectors; it will be important to encourage national governments to share the data needed.

The report produced moves beyond the evidence considered in this analysis to propose ways of using procurement and employment practices to generate increased social and economic impacts from the health system. Procurement figures in the EU show that even a small shift in procurement practices could generate a significant change. EU rules were changed in 2014, with new emphasis in 2018 to support strategic social purchasing (Správa, 2018). Instead of placing “value for money” as the main objective, EU regulations state that other criteria, such as qualitative, environmental and/or social aspects, should be considered. For example, NHS Wales has implemented penalties if providers do not deliver on their social targets (NHS Wales, 2018).

A set of important questions should be considered by health systems, such as who is being employed, what employment practices are in place, what future recruitment looks like and how employment processes are monitored. Sharing the impact and benefits of health systems with local communities is critical. Procurement budgets need to be understood, as well as what is being purchased and where it comes from. Selectively shifting parts of procurement to local suppliers would have a substantial impact. There is a need to act intersectorally, but not as we traditionally know it.

This work contributes to the priorities of the WHO “triple billion” goal (WHO Regional Office for Europe, 2018b), as well as to SDGs 3, 8, 10 and 12 (Sustainable Development Knowledge Platform, 2018) and the circular economy (WHO Regional Office for Europe, 2018a). The work and its associated methodologies were strongly appreciated and encouraged by the participants, and they recommended engaging with economic theorists for further support for it. Participants acknowledged that it would take time and political will for such measures to be implemented. Possible barriers were also highlighted, particularly around opposing needs in procurement, such as quality and locality.

Session 2. Examining impact on local systems – evidence from England and Slovenia

Dominic Harrison, Director of Public Health at Blackburn with Darwen (United Kingdom), presented evidence on examining the impact of health systems and employment. Since 2010 in England and Wales, life expectancy has been declining, with the worst effects for older people. The two main hypotheses are that people are dying of the same conditions but younger, and that the health system cannot manage increases in demand during surges. Alongside this, there has been increasing social exclusion from economic opportunities (Blackburn with Darwen Borough Council, 2015).

Lancashire and South Cumbria conducted a Joint Strategic Needs Assessment of social mobility, analysing employment and work data, with a focus on mental health. Worsening social mobility and mental health were revealed, with a high burden of poor mental health in young people, and low school readiness.

Three primary groups of people were highlighted as being unemployed (Blackburn with Darwen Borough Council, 2015):

1. those who do not work for cultural reasons;
2. those who are looking for work and claiming benefits;
3. those with a health-related barrier to work.

The latter group was quoted as being the largest, highlighting that investments addressing mental health issues do actually constitute economic development.

The health sector is the largest employer in this region. Work was carried out to estimate the economic impacts of the health system in the area, based on a study in Sacramento (United States) in 2016. The analysis found a spend of £3.2 billion, of which £2.2 billion was used for labour costs and paid direct to service providers (72% spent on staffing costs). The total calculated local business spending reached just under £700 million. It is also common for staff that are paid more to live outside the area in which they work, which results in wages not being spent locally.

Systems and methods are available to understand the economic impact of local procurement. Blackburn with Darwen council uses Spendpro software to analyse and map where local spending is going.

Several conclusions were drawn from the work carried out.

1. The data suggest that for Lancashire and South Cumbria, there is a critical and reciprocal relationship between the **economic well-being** and the **health and well-being** of the population.
2. It is better to predict and prevent than to diagnose and manage. Investing in improving health and well-being for those with long-term conditions (especially mental health) may

now be the most important economic growth investment to effectively improve the local economy – as measured by labour market productivity, economic inclusion, social mobility and (increasing) household and personal earnings.

3. There is an (as yet) unrealized demographic dividend for economic growth, in terms of the number of jobs likely to become vacant in the health and social care system over the next generation (25 years). If directed and managed to offer local employment in low-income areas, there could be a very significant win–win scenario of reduced health and social care system demand paired with economic growth.
4. Continued expansion of local procurement/social value purchasing within the health and social care system and public services more generally will bring about economic growth in low-income areas.
5. New NHS investment needs to be focused on prevention, with high (defined) return on investment levels – not just “more of the same” – in order to improve economic outcomes and translate into health as wealth.

The next steps include:

1. developing an explicit Health and Economy Strategy between the Lancashire Enterprise Partnership (LEP) and the Integrated Care System;
2. developing an explicit Social Value Procurement Strategy in the health and care sector;
3. developing a pilot site (hospital or local authority location) to operationalize opportunities identified and capture benefits realized from this approach;
4. formally including the health and care sector in the LEP partnership as a major partner in the delivery of the United Kingdom’s Industrial Strategy (Gov.UK, 2018);
5. maintaining and developing existing academic, strategic and institutional partnerships to accelerate the delivery of economic, health and social benefits arising from this approach.

Peter Beznec, Director of the Centre for Health and Development Murska Sobota in Slovenia, spoke about the relevance of the previously described methods in their region. In total, 6% of the country’s employed population work in the health sector. Pomurje is the most underdeveloped region in the country, in which 8% of people work in health care. Approximately 3000 people work directly within the health care system, with 33% of these having further or higher education; 30% with secondary-level education and 37% with primary education or an unknown level of education. There are currently 277 medical doctors (50% of whom work in hospitals); 70 dentists; 67 pharmacists; 318 nurses; 912 health care technicians and 8 childbirth nurses (SURS, 2018). Employment is one of the most important health determinants.

In Slovenia, 47.5% of all unemployment is of the long-term kind; this rises to 50% in Pomurje (while the EU average is 44.7%). A higher proportion of Pomurje’s workforce (21%) is made up of the population with a lower level of education than the national average (10%). Planning with local industries is needed in order to see what products and services can be offered for the local health system in Pomurje. An analysis of local employment figures showed that employment in the health system was less likely to lead to long-term unemployment. In fact,

according to data from the Statistical Office of the Republic of Slovenia (SURSTAT), only 3.6% of the long-term unemployed stated that their most recent employer had been the health or social care sector.

Discussion

Participants were asked if such actions could also be taken in their countries and some replied that it is already happening, but not in a structured way. In Sweden, for example, some people who were long-term unemployed had been offered jobs, but half of those suffered from post-traumatic stress disorder, which made it difficult to maintain employment. This is an example of the relationship between poverty and health. Solutions can be found; for example, when a hospital is placed close to a shopping centre, representing a non-health action that brings money to a deprived area and thus indirectly improves well-being.

Participants discussed the fact that putting **more** money into a health system may or may not translate into improved health. The example of the United States was cited, where one third of the country's GDP is invested in health, as opposed to the Veneto Region in Italy where less is invested but more (better) health is produced. Such examples show how investment in social drivers is more important than simply investing money.

Session 3. Anchor institutions: experience and impact in the United States

David Zuckerman of The Democracy Collaborative (TDC) spoke about the role of anchor institutions in the United States, the idea behind which is to create an equitable economy in the country, taking a longitudinal perspective. The TDC definition of anchor institutions is that they are non-profit-making or public organizations, rooted in the places in which they are based (TDC, 20118a). TDC carries out research and field-building, and provides advice to institutions across the United States.

TDC is committed to community wealth-building, which involves intentional planning and asset-based community development to help identify and target available resources. From the perspective of health systems, this involves going beyond the core duty of providing health care to fulfilling a social mission with all available assets.

Drivers of community well-being are seen as: place, ownership, multipliers, collaboration, inclusion, workforce, and the system. By leveraging their anchor power, anchor institutions such as health systems can generate community well-being and wealth. In terms of inclusive hiring, this should include equipping residents for jobs, maximizing internal opportunities, and creating pathways to advance. Inclusive and local sourcing involves connecting local supply and demand and creating capacity to meet demand. Through place-based investment channels, health systems can provide capital for social initiatives (such as grocery stores in so-called food deserts), while generating a financial return.

Two case studies were explored: the “Evergreen” initiative involves a community-based laundry, and consists of mentoring, business incubation and aggregating demand (TDC, 2018b). The second case study was “Bon Secours”, through which taking a community-driven approach has led to the health system investing in affordable housing, revitalizing neighbourhoods, youth employment and workforce development (Zuckerman, 2013), as well as safer streets. These examples highlight the role of trust and engagement as core issues for health systems.

Discussion

Participants were interested in knowing how to engage anchor institutions, which often do not look like their communities, and it was expressed that those institutions should be asked what they need. Questions remained about how to engage anchor institutions that are not interested in these concepts, as well as the required changes to the regulatory environment.

With regard to possible regulatory environments that could enable community asset-building, it is hard for communities without resources to acquire assets in the first place. One solution could be to build a fund to help acquire businesses, which could be eventually transferred to employees, who would then gradually gain the skills needed to run the businesses. This way, employees do not have to find the capital to fund such an endeavour. Another example could be in cases where housing is needed: a non-profit-making entity could own the land but let people own the houses built on that land. This would provide the benefits of ownership but ensure that other generations can benefit from having a home of their own.

Session 4. Procurement in health systems

This session focused on social and equity perspectives in procurement. **Tom Lloyd-Goodwin** of the Centre for Local Economic Strategies (CLES) shared their experience in working with local communities in England to change their procurement processes. The CLES critiques the notion of inclusive growth, arguing that it is not comprehensive enough to deliver social justice. It has a broader view of anchor institutions than TDC, including the private sector.

The CLES has been working with Manchester local government since 2007 and in Preston since 2012, trying to change procurement practices. In Preston, local spending has increased from 5% in 2013 to 18% in 2016/2017 (equating to a £70 million increase). Regional spending in the Preston area also increased from 39% to 80% (£200 million), with an extra 1600 jobs being created. As a result, Preston – previously ranked among the country’s most deprived areas (in the lowest 20%) – rose out to become “the most improved place to live” in the United Kingdom. In Manchester, local spending increased from 51% in 2009 to 74% in 2015/2016, resulting in 6000 jobs being created (GB News, 2018).

The CLES described the challenges of juggling cost and efficiency pressures in procurement, reinforced by media narrative and leading to increased centralization (especially around laundry, food and construction). There had been difficulties maintaining local contracts, a lack of large cooperative suppliers, and a lack of funding.

Marko Harapainen from the City of Helsinki, Finland, shared their experience in public procurement from a city perspective. Public procurement is seen as a way to signal to the market what is required and to demonstrate good governance. The use of employment clauses is intended to specify when providers must employ someone from a target group, and this approach has been used in Sweden, the Netherlands and Finland. As part of a comprehensive approach, the city of Helsinki has:

- put in place two ESF-funded projects in Helsinki during 2016–2019;
- carried out 25 targeted procurement contracts with different kinds of employment clauses, from among different sectors;
- created approximately 250 jobs or apprenticeships for people in vulnerable labour market situations;
- developed an operating model for how to employ people in vulnerable labour market situations through public procurement;
- developed training and information for participants in the apprentice programmes;
- improved cooperation between cities, employment services, and companies;
- improved knowledge about employing people in vulnerable labour market situations, with a focus on long-term unemployed people, people with immigrant backgrounds, people with disabilities, and young people (THL, 2018).

Among the lessons learnt is the fact that such efforts require: lobbying, a demonstration of benefits, proactive market dialogue, guidance for contracting staff and supporting companies,

and a reporting system. Efforts have been well received and feedback from participants shows that people being recruited through such approaches are motivated and grateful for new opportunities.

Discussion

Participants discussed the fact that quality and cost dominate procurement discussions. It was deemed necessary to be clear that the suggestions being made were **not** to compromise either efficiency or quality. Advice would be helpful for health systems as a whole and particularly for primary care hospitals (with separate advice needed for the different levels of the health care system). The question was asked whether there is a possibility to shift to thinking about procuring for outcomes. Other participants shared their experiences with procurement. Some participants suggested procurement practices are hard to change (for example, in Italy). Sweden is implementing some of these requirements but often the lowest price is still a determining factor. The decision often faced was whether to be inclusive and get communities involved, or to opt for the cheapest, so that another person could be employed.

Participants acknowledged that the reality is changing and there is a need to think in a flexible way to accommodate new developments. It will be important to convince policy-makers that a small shift can have a massive impact. A core task is to understand how health care systems commission their services. If there is a shift from interventions to outcomes (that is, from commissioning inputs to outcomes) the result could be a more scientific approach that allows for investment in other areas. It will also be important to understand what is known about the applicability of this methodology in eastern Europe and if it could be put in place in countries such as Uzbekistan, Turkmenistan and the Russian Federation, for example. It is important to remember that effects in transitional countries are more powerful (as discussed by Timotej Jagrić).

The WHO Regional Office for Europe would like to see this methodology applied across the Region and it should be incorporated into WHO health systems governance support and advice.

Session 5. Looking forward

Session 5 focused on looking forward to identify actions to support health systems in creating and sustaining equitable and prosperous communities. Participants were asked to reflect on how to take evidence and create support for countries from it; the tools and resources that would be needed; and how to embed this into practice. They were also asked about the role of WHO and the Venice Office in moving this forward.

The discussion is summarized by key themes.

1. Policy lab / future work

- Specific examples should be gathered of challenges faced in countries (at national or regional levels) that could be discussed in such a forum.
- Countries need to define key and core policy directions in order to implement policies in line with them.
- Value-based policy and policy directions need to be brought in line with calculations in order to move beyond rhetoric.
- Short and long-term returns should be shown.
- It should be discussed what data are required / need to be improved.
- It should be defined how to create asset-based communities.
- The case studies discussed at the meeting are useful to highlight examples of good practice.
- Tools should be created for health systems to be able to advocate. Countries need to be given tools and arguments to enable discussion of different ways to consider health as an investment. For example, the King's Fund estimated that for every £1 spent, gains can be obtained in mental health resilience, traffic control, and unintended pregnancy, to name just a few areas (The King's Fund, 2018). This shows the returns different investments in health will bring.
- The issue of framing should be clarified; health systems can be more efficient as well as being key to inclusive development (i.e. it is not one or the other).
- The **intention** health systems can have to improve local and national health and well-being and economies should be borne in mind (and referred to).

2. The importance of expanding to other parts of the WHO European Region

- This work is in line with the core values of the Tallinn Charter.
- There is the need and interest to expand and apply this methodology to countries in the south-eastern part of the WHO European Region, as well as countries with populations of under one million.

- More possibilities for discussion on this topic can be gained from including the sister agencies of the United Nations.
- The South-eastern Europe Health Network (SEEHN) recently signed a subregional cooperation strategy defining collaboration up to 2020; one of topics will be investment in health.

3. This methodology provides evidence that health systems are an integral part of an economic system

- There is still a need to work towards a more integrated narrative. The tools required for this are available but the idea needs to be “switched on” in people’s minds.
- A better definition is needed of what it means to invest in health.
- The methodology can provide evidence to ministers of finance not to disinvest in health systems and to regard them as part of an inclusive economic development plan.
- Working with the media (including social media) to share relevant stories could be beneficial.

4. Moving away from the idea of a health care system to that of a health system

- New models are needed as health care systems can no longer deliver the pace of improvements achieved over past 50 years. The hospital model no longer works as it traditionally has, for many reasons.
- There is a need to change the concept of what the health system is and does. Investing in more of the same will not be the answer.

5. Data requirements and the importance of their availability

- WHO will provide guidance and leadership on the need to ensure timely and accessible data are available for these methodologies.
- WHO will advocate making data available from Eurostat.
- WHO will create the minimum datasets required for the analysis.
- Data can be used to engage and encourage the public into action, as well as adding political pressure.

6. Health systems’ core function is still the top priority; to improve population health and well-being

- It should be made clear that the health systems’ core function (improving health and well-being) is not to be compromised in the pursuit of these goals.
- It is important not to overemphasize the impact of health systems.

7. Developing new case studies

- Emilia Romagna (Italy) and Friuli Venezia-Giulia (Italy) expressed interest in sharing data and carrying out such exercises in their particular settings.
- The former Yugoslav Republic of Macedonia is already in the process of carrying out an analysis using this methodology. Romania is also keen to carry out an analysis; the country is hosting the Presidency of the EU Council in 2019 and could thus explore putting this methodology/project into its work.
- It could be interesting to explore whether the methodology could be used to minimize and/or exclude fraud.

Role of WHO and respective organizations

Participant observations

Methods are now available to begin to shift how resources are used in the health system. Other sectors should now get involved, from a public administration perspective; WHO can help with this by engaging and encouraging other sectors on this issue. Further sharing of experiences would be welcome.

WHO can support countries by:

- refining methodologies and research based on comments and feedback from this expert meeting;
- providing guidance on interpretation of EU procurement law;
- reframing the role of health care to view health as an asset;
- being bold and producing evidence-based guidance while continuing to think, do and mobilize within its capacity;
- providing the best generalizable evidence and clarifying what is meant by investment and prevention;
- helping countries to bring attention to the benefits of health spending, including gathering of evidence about transition countries;
- extending this work to low- and middle-income countries, including discussion of efficiency and equity issues;
- involving Member States with a population of under one million (specifically, those of the WHO Small Counties Initiative);
- advising countries to consider corporate social responsibility in public procurement versus efficiency.

Closing remarks by WHO

The expert meeting ended with a sense of enthusiasm for the work undertaken so far, as well as that to be continued. It is clear that every country wants concrete tools and would like to be able to carry out these analytical exercises in practice. This initiative now has a communications plan which will help disseminate progress and experiences as they develop. There is now also a good balance between the strategic and the practical. The meeting succeeded as a dialogue, with WHO's commitment reaffirmed and strengthened. Participants were assured that all comments would be taken into consideration. They were also reminded that the 2019 High-level Regional Conference on Health Equity is approaching and there are plans to bring this work into that context.

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Programme: Economic and Social Impacts and Benefits of Health Systems

The power of health systems to create and sustain equitable and prosperous communities

Thursday, 15 November

9:00–9:25	Registration and coffee
9:25–9:45	<p>Welcome / Introduction Ms Chris Brown, Head, WHO European Office for Investment for Health and Development, Italy Dr Maria Chiara Corti, Director, Azienda Zero – Regional Epidemiology Service, Veneto Region, Italy Dr Giuseppe Ruocco, Secretary General – CMO, Ministry of Health, Italy</p>
9:45–10:45	<p>Session 1. WHO Regional Office for Europe report launch – Economic and Social Impact of Health Systems Dr Tammy Boyce, Consultant, WHO European Office for Investment for Health and Development, Italy Professor Timotej Jagrič, Professor of Applied Economics and Econometrics, University of Maribor, Slovenia</p>
10:45–11:30	<p>Session 2. Examining impact in local systems – evidence from England and Slovenia Dr Dominic Harrison, Director Public Health, Blackburn with Darwen Borough Council, United Kingdom Mr Peter Beznec, Director, Centre for Health and Development Murska Sobota, Slovenia Moderator: Dr Tammy Boyce</p>
11:30–12:00	COFFEE
12:00–12:45	<p>Session 3. Anchor institutions: experience and impact in the United States Mr David Zuckerman, Director, Healthcare Engagement, The Democracy Collaborative, United States</p>
12:45–13:45	LUNCH
13:45–14:45	<p>Session 4. Procurement in health systems Mr Marko Harapainen, Planning Officer, City of Helsinki, Finland Dr Tom Lloyd-Goodwin, Associate Director, Centre for Local Economic Strategies, United Kingdom Moderator: Ms Tatjana Buzeti, Policy Officer, Multisectoral policies for health equity, WHO European Office for Investment for Health and Development, Italy</p>

14:45–15:45	Session 5. Looking forward Identifying actions to support health systems to create and sustain equitable and prosperous communities Panel discussion Dr Dominic Harrison Ms Chris Brown Ms Boriana Goranova , Policy Analyst, DG Economic and Financial Affairs (ECFIN), European Commission
15:45–16:00	Call to action / Policy recommendations Closing remarks by WHO Chris Brown Tammy Boyce

The **policy recommendation** following the dialogue will inform Venice Office actions, examples, strategies and policies.

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The WHO Regional
Office for Europe

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

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