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Final report on implementation of the Tallinn Charter – summary

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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 adopted the Tallinn Charter, which was subsequently endorsed by the WHO Regional Committee for Europe in resolution EUR/RC58/R4. The Tallinn Charter marked an important development since the Ljubljana Charter on Reforming Health Care in Europe, adopted in 1996. It was followed up with a series of meetings in Oslo, Norway, during which Member States could strategize their responses to the financial crisis that began shortly after the signing of the Tallinn Charter.

In the resolution endorsing the Tallinn Charter, the WHO Regional Director for Europe was requested to submit a final report to the Regional Committee in 2015 on support provided by the Regional Office and progress accomplished by Member States in the framework of the follow-up to the Conference. The report process was overseen by a core group of Member States, working closely with the Division of Health Systems and Public Health. The report is based on interviews, a desk review, and answers submitted to a questionnaire circulated to all Member States.

The responses to the questionnaire served to inform document EUR/RC65/13, Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people-centredness. Health systems strengthening and public health are at the core of Health 2020, the European health policy framework adopted by the Regional Committee in 2012. Health 2020 reinforces the values, principles and goals of the Tallinn Charter and provides political impetus for putting health higher on the agenda of governments, with a particular emphasis on equity, sustainability, universal health coverage, transparency, better health outcomes, people-centred coordinated/integrated care based on primary health care, and health capacities. Health 2020 promotes whole-of-government and whole-of-society approaches to health and well-being, focusing on policy coherence and accountability for health at all levels.

This document is a summary of the final report on implementation of the Tallinn Charter. The full version of the final report, currently in press and soon to be available on the Regional Office's website, contains a rich source of country examples.

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Key messages

1. In the WHO European Region, the Tallinn Charter: Health Systems for Health and Wealth *(1)* has helped stewards of health systems – ministries of health – 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 in health and 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. This has been supported by Health 2020, which promotes whole-of-government and whole-of-society approaches to ensure the contribution of health systems in improving health outcomes.

2. The Tallinn Charter, which signalled a significant development after the adoption of the Ljubljana Charter on Reforming Health Care *(2)* in 1996, emphasized the importance of transparent and accountable health systems 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. The Division of Health Systems and Public Health of the Regional Office continues to support this work under the Health 2020 agenda.

3. A reorientation towards primary care and public health services has been observed in some parts of the Region. However, 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, and Health 2020 has further put them at the centre.

4. The Tallinn Charter emphasizes the importance of reference indicators for promoting health systems 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 inform the people-centred health systems approach under Health 2020.

5. Since the Tallinn Charter was signed, there has been a greater focus on health financing, largely due to the financial and economic crisis. Although some Member States have taken important measures to ensure adequate health systems funding and to promote financial protection for households, millions of people continue to experience financial hardship when accessing the health services they need. This calls for action to reduce out-of-pocket payments. Health 2020's goal of accelerating the health gain and of lowering inequalities offers a platform for pursuing universal health coverage (UHC) in the Region.

6. Many countries have made good progress in implementing health workforce policies. However, further effort is required in some Member States 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 of the health workforce, research and the organization of providers with patient needs. These are areas that feature strongly in Health 2020.

7. Member States 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 (HTA) 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.

8. 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. Member States continue to make strides in that 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.

9. An important call under the Charter was for improved cross-national learning. The Regional Office has facilitated that call by leveraging its convening power to provide opportunities, engage key partners, foster networks and develop collaborative processes and tools. The Regional Office 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 to support the values of the Charter in order to achieve the Health 2020 goals has been cited as crucial to health systems strengthening activities in the Region.

10. Despite the progress made in many areas of health systems strengthening since the endorsement of the Charter, more work needs to be done with respect to broader systems thinking and approaches for 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.

11. 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 for enabling two key strategic directions for future work of the Regional Office: (i) transforming health services to meet the challenges of the 21st century; and (ii) moving towards universal health coverage for a European Region free of impoverishing out-of-pocket health expenditures.

Introduction

12. The WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth", held in Tallinn, Estonia, from 25 to 27 June 2008, marked a milestone in strengthening health systems in the WHO European Region. The Ministerial Conference, the adoption of the Tallinn Charter and the endorsement of the Charter (resolution EUR/RC58/R4) by the WHO Regional Committee for Europe in

September 2008 were a direct response to increasing evidence that investing in health systems not only has an intrinsic value but also contributes directly to population health and economic wealth, which in turn contribute to social well-being and stability *(1)*. The Tallinn Charter was 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 regularly assess the performance of health systems 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.

The Tallinn Charter

13. The Tallinn Charter 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 in mind: 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 systems development in the European Region and expresses the key commitment of Member States to move from values to action. The 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.

14. The seven commitments for action set out in the Tallinn Charter are to:

- promote shared values of solidarity, equity and participation through health policies, resources allocation and other actions, ensuring due attention is paid to the needs of the poor and other vulnerable groups;
- invest in health systems and foster investment across sectors that influence health, using evidence on the links between socioeconomic development and health;
- promote transparency and be accountable for health system performance to achieve measurable results;
- make health systems more responsive to people’s needs, preferences and expectations, while recognizing their rights and responsibilities with regard to their own health;
- engage stakeholders in policy development and implementation;
- foster cross-country learning and cooperation on the design and implementation of health systems reforms at national and subnational levels; and
- 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.

Objectives, structure and methodology

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

- to assemble relevant knowledge and experience from around the Region of integrating the commitments of the Tallinn Charter into policy development;
- to analyse this knowledge and experience in terms of how Member States' commitments to the Tallinn Charter have strengthened health system performance; and
- to provide a reference point for actions and initiatives taken by European Member States in line with the Charter, thereby helping to lay the foundation for planning future directions for health systems strengthening in the European Region.

16. In order to gather the requisite knowledge and experience from around the Region, a number of key information sources were used: responses to a web-based consultation/questionnaire with Member States between August and October 2014; a targeted literature review; and semi-structured interviews with programme managers from all divisions at the Regional Office.

17. 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 several times, namely, at the Sixty-seventh World Health Assembly in Geneva, Switzerland, in May 2014; during the 64th session of the WHO Regional Committee for Europe (RC) in Copenhagen, Denmark, in September 2014; and at two separate events during the fourth session of the Twenty-second Standing Committee of the WHO Regional Committee for Europe (SCRC), held prior to the opening of the Sixty-eighth World Health Assembly in Geneva in May 2015, to approve the final report to be presented at RC65 in Vilnius, Lithuania, in September 2015.

18. In addition to the four meetings between the Division of Health Systems and Public Health and the core group, the SCRC was also engaged in the planning and approval of the final report. During the second session of the Twenty-second Standing Committee, held in Helsinki, Finland, in December 2014, a team from Health Systems and Public Health presented the approach and reported on the progress made in compiling the report. At its fourth session, held prior to the Sixty-eighth World Health Assembly in Geneva in May 2015, the SCRC reviewed the final report before it was submitted to RC65.The information collected for the final report was shared with the team preparing the strategic paper "Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people-centredness" (document EUR/RC65/13), to be presented at RC65.

19. The information gathered for the final report is organized and presented in terms of the four core functions of health systems initially identified in *The world health report 2000 (3)*.

20. The Tallinn Charter clearly defines these functions in line with the values endorsed by Member States (see Box 1). The decision to approach this report by cross-referencing the seven Tallinn commitments with the four functions of health systems is also in line with the two consultative and the four preparatory meetings[1] leading up to the Tallinn Conference in 2008. While these activities are presented separately by function, effective reform requires acknowledgement of their linkages and interdependence *(4)*.

21. The establishment of the four functions provides a robust framework for assessing health systems, diagnosing weaknesses and informing future directions for health systems strengthening. The terminology throughout the final report is therefore consistent with that of the Tallinn Charter, with one slight modification. In order to facilitate discussion and understanding of the very diverse area of "resources for health" (which, under the Tallinn Charter, includes pharmaceuticals, health technologies, information systems and human resources for health), this function is divided into two subsections: human resources for health, and health technologies and pharmaceuticals.[2] Furthermore, since the Tallinn Conference in 2008, programmatic priorities and Member State activities have highlighted the fact that the function of creating resources needs to be balanced with guidance on how to use or manage these resources. Thus, this report focuses its analysis not only on the ways in which human resources for health, health technologies and pharmaceuticals are being created, but also on how their application is being guided and managed.

22. A coding matrix, developed to translate the seven commitments of the Tallinn Charter into activities that represent optimally functioning health systems, is depicted in Fig. 1. This matrix may also serve as a guide and platform for future activities of the Regional Office and in Member States. The focus on how the activities reported by Member States under each commitment in the Tallinn Charter have or have not strengthened the four functions of health systems marks a fundamental difference between the final report and the interim report *(5)*. This approach was approved by the core group of Member State representatives 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 pillar of Health 2020 *(6)*, the new European health policy framework that was developed four years after the Tallinn Charter.

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[1] Two consultative (24–25 August 2006, Vienna, Austria; 30–31 October 2006, Barcelona, Spain) and four preparatory (29–30 March 2007, Brussels, Belgium; 19–20 November 2007, Bled, Slovenia; 3–4 April 2008, Rome, Italy; 6 June 2008, Brussels, Belgium) meetings were held in preparation for the WHO European Ministerial Conference on Health Systems in 2008.

[2] In line with the approach taken in WHO's framework for action for strengthening health systems – Everybody's business: strengthening health systems to improve health outcomes – WHO's framework for action. Geneva: World Health Organization; 2007 (http://www.who.int/healthsystems/strategy/en/, accessed 8 June 2015).

Box 1. Aims and actions of the Tallinn Charter

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 inter-professional 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.[a]
- Fostering health policy and systems research and making ethical and effective use of innovations in medical technology and pharmaceuticals are relevant for all countries; health technology assessment should be used to support more informed decision-making.

Stewardship

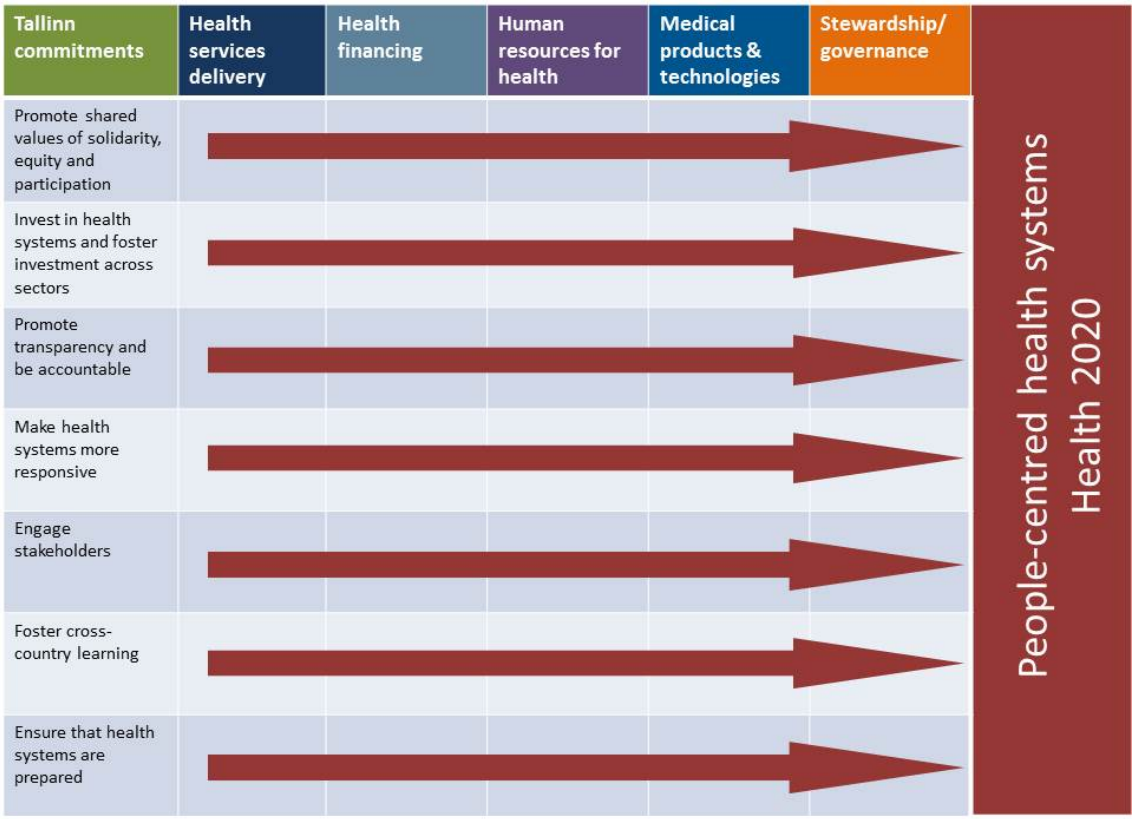
- While each Member State has its own way of governing its health system, ministries of health set the vision for health system development and have the mandate and responsibility for legislation, regulation and enforcement of health policies, as well as for gathering intelligence on health and its social, 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.

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

Source: reproduced from paragraph 13 of the Tallinn Charter *(1)*.

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



Context for implementation of the Tallinn Charter

23. Not long after the Tallinn Conference, the global financial and economic crisis struck the Region, and it was clear that in many countries the commitments made in the Tallinn Charter would be put to the test. The onset of the global financial 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 *(7)*, with a peak of 10.9% in 2013. Some countries experienced much larger increases in unemployment, especially unemployment among younger people. Heavily affected European countries have now been navigating the crisis for more than six years, indicating its prolonged nature. The tight fiscal context and high unemployment rate are expected to continue in the medium term.

24. The evidence from previous economic shocks and the current economic crisis points clearly to two broad observations *(8)*. First, the crisis has adversely affected many social determinants of health – notably, income, employment and the levels of public spending on health and other social sectors. In several countries, the crisis has had far-reaching social and political consequences and has contributed to an increase in health inequalities between population groups and across the Region *(9)*. Secondly, given that health needs increase when unemployment rises and household incomes fall, fiscal and health policy responses to the crisis may also have affected population health if they were not able to maintain effective social safety nets or protect access to good-quality services, especially for more vulnerable groups of people.

25. The Regional Office has engaged intensively with Member States to make effective policy decisions that improve health and reduce inequalities during the crisis period. Health 2020 has become the foundation for this engagement. The new European health policy seeks to significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure sustainable people-centred health systems. Health 2020 is aimed at the whole of government and the whole of society. It envisages actions and outcomes far beyond the boundaries of the health sector and outside the remit of the Ministry of Health. Health 2020 proposes that health ministries should reach out to and work with other ministries, departments, sectors, organizations, stakeholders and civil society organizations. It also proposes that governments should reach out to and work 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.

26. In identifying health systems as one of the four action areas, Health 2020 reaffirms the central tenet of the Tallinn Charter to invest in health systems and their improved performance as a way of improving the health of all members of society. However, the Health 2020 policy framework goes further by challenging such health systems to be more people-centred, part of a whole-of-government approach to improving health, aligned towards strengthening public health and contributors to reducing social inequities over the life-course.

27. At the time of the signing of the Tallinn Charter, Member States shared the understanding that public health was located both within and outside the health system. Health 2020 has reached out to decision-makers beyond the health sector 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 clear during the high-level follow-up meeting in Tallinn in 2013 *(10)*, at which participants expressed frustration at the lack of advocates for public health as a single community to accept responsibility and accountability. Indeed, there was a call for more dedicated public health training and a greater recognition of the importance of the discipline as a career choice.

28. Another important development since the signing of the Tallinn Charter is the increased importance that Member States have attached to the use of evidence in informing 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, although there are signs that this is changing. With rising costs and financial pressures, an affordable and cost-effective health system has to make difficult decisions about which interventions and services to provide. Data that has been disaggregated according to income level, geographical location and sex, to name a few, can help decision-makers target policy decisions. Robust, evidence-informed and transparent processes also help to prevent decisions on the basis of special interests and foster public acceptability.

29. Countries that have achieved a shift in culture towards a more evidence-informed approach have pursued three key pillars over time. These are: (i) a regular demand for health evidence by policy-makers; (ii) building capacity to produce high-quality health evidence, and (iii) sustainable institutional solutions linking demand and supply. WHO has been generating demand for evidence-informed health policy through an ongoing dialogue with Member States on various aspects of health systems strengthening. By organizing international and country-level courses, as well as engaging in joint analytical work and facilitating peer-to-peer exchanges of experience, it has been building the capacity of countries to carry out high-quality research, performance assessments, policy analysis and sectoral monitoring. With regard to institutional development, several Member States have established or are in the process of establishing policy analysis or sectoral monitoring units within the Health Ministry. Engagement in strengthening capacities and institutions for evidence-informed policy development has delivered synergies with other areas of health systems strengthening.

Commitment 1 – Promote shared values of solidarity, equity and participation

30. This first commitment in the Tallinn Charter stands apart from the subsequent commitments in that it binds Member States to a set of values rather than activities. The values promoted in this first commitment underpin all other commitments. Since these values are cross-cutting, this commitment is reviewed only in terms of how Member States have articulated them through national health plans and policy instruments.

31. Many countries in the Region have developed national and subnational health strategies, plans or equivalent documents to give direction and coherence to their efforts to improve the health of their populations *(11)*. To the extent that they apply health systems principles and values in 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, a set of national health priorities or focus areas, and reform 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 a national health strategy or plan. 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. Health objectives are sometimes defined through health system reform programmes. Other mechanisms by which national health goals and objectives are set include legislation and regulation. Several countries that have recently developed health strategies have explicitly reinforced the importance of whole-of-government approaches emanating from Health 2020.

32. The Tallinn Charter has proved to be a powerful instrument for guiding policy responses to the economic crisis through its explicit commitment to solidarity. Several countries have used their national 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 inequalities. Most countries in Europe have gender equality policies that define priorities across sectors. There has been widespread support for actions that limit the financial vulnerability of disadvantaged population groups. Key activities in this regard have been to prioritize the movement towards universal health coverage by ensuring that the whole population can access a wide range of necessary health services of good quality without financial hardship and to focus on primary care and public health services.

33. Public health services and infrastructure, however, still remain weak and outdated in many parts of the European Region. Policy tools have therefore included reorienting services towards outpatient primary care and public health, as these are deemed more cost–effective and appropriate for reaching larger proportions of the population. By increasingly reorienting services to primary care, Member States have started to recognize the importance of strengthening this level by improving the continuity of care, optimizing the organization of providers and raising the quality of services.

34. Most Member States reported a commitment to responding to the needs of vulnerable groups, including taking measures to extend coverage and to create and sustain universality in entitlements. Several countries have avoided indiscriminate cuts in public spending on health care and social welfare, as these increase poverty and reduce the health of the population; instead, they have increased efforts to promote redistributive revenue collection to improve solidarity. Some Member States have been successful in reducing user charges and out-of-pocket payments, while others have given higher priority to the health sector in government budget allocations, including funding social health insurance.

35. Many European countries have reviewed their health workforce needs and made good progress in developing and implementing health workforce policies, strategies and plans. An important component of such policies has involved a commitment to improving research, data consolidation and planning in order to develop targeted national health workforce strategies. These areas have been identified as particularly underdeveloped in several Member States. There has also been a reorientation towards primary care in the recruitment and training of the health workforce, and growing recognition of the need for effective policies on workforce distribution to improve population access and on workforce retention to improve system efficiency and effectiveness. The Regional Office and European Member States have played a leading role in developing and supporting the adoption, in 2010, of the WHO Global Code of Practice on the International Recruitment of Health Personnel, which provides a framework for Member States to develop effective policies for workforce planning, retention and migration in order to support health workforce sustainability.

36. Most of the reporting countries also indicated efforts to guarantee equal access to quality medicines and health technologies. Although some European countries have not traditionally engaged in active priority-setting for access to pharmaceuticals and health technologies, such policies are increasingly seen as critical for improving efficiency in spending while maintaining an appropriate balance between access and cost–effectiveness. Those countries with policies on health technologies and pharmaceuticals are clearly working to prioritize affordability, access and equity, as well as quality and innovation. Pharmaceutical reforms across the Region have been particularly widespread. They have included price reductions, the use of discounts, rebates, claw-backs, the renegotiation of distribution remuneration, changes in value added tax rates, and reimbursement procedures.

Commitment 2 – Invest in health systems and foster investment across sectors

37. There was a high level of reporting on this commitment. As noted above, most countries reported that they had engaged different sectors (most commonly, the social sector) in setting goals for the health sector, and that cross-sectoral health promotion policies (for the control of tobacco and alcohol consumption, violence and injury prevention, road safety, etc.) were being implemented. International frameworks such as the WHO Framework Convention on Tobacco Control have been particularly useful in this regard. Such intersectoral collaboration has benefited the role of stewardship, most notably because it has maximized health gains and minimized the disease burden.

38. Countries are refining the mechanisms by which ministries of health can communicate and collaborate with other sectors. Ministerial panels have been set up, staff to ensure liaison between ministries have been appointed, and special protocols are in place. Some countries reported that the health sector provides technical support and guidance to other sectors in addressing the social determinants of health within other government programmes. Technical support has often taken the form of health or health equity impact assessments. Several countries indicated the existence of mechanisms to optimize the sharing of information between ministries of health and other sectors.

39. The reality is that an individual’s state of health is primarily sustained in homes and communities, while clinical settings and clinicians tackle and manage health needs only for certain stages of the lifespan or for a minority of the population. Member States across the Region are increasingly reporting that they are delivering health services in non-traditional settings, such as schools, workplaces, housing initiatives and community services. The health sector has been particularly active in collaborating with other sectors to address child health and services for older people in non-traditional settings. In several cases, ministries of health have significantly increased access to and the appropriateness and effectiveness of such services.

40. Intersectoral collaboration has served as a means of aligning financial flows in the context of investment planning with flows linked to statutory objectives. The areas of mental health and long-term care have seen a particularly high level of financial alignment between those responsible for health care and those responsible for social care. Joint financing strengthens commitment by partners, thereby providing more certainty around funding. Public service agreements linked with spending reviews

constitute a framework within which departments, local authorities and other local organizations can agree on targets for steering and coordinating public action.

41. There is growing intersectoral collaboration to address health workforce challenges at the global, regional, subregional and country level, particularly since health workforce supply and demand is heavily influenced by a range of factors outside the health system. A majority of these intersectoral efforts have involved close cooperation among ministries of health, finance, employment and education on aligning the education of the health workforce with rapidly changing needs. In some countries, intersectoral collaboration has also led to the improvement of the workplace for the health workforce.

42. Most Member States have increased collaboration between the Ministry of Health and the trade sector in order to optimize the accessibility, availability, acceptability and quality of health technologies and pharmaceuticals, although this has been less true for some newer medical products. Nevertheless, several countries actively support the transfer of knowledge between research institutions and industry. There is a great variation among the 53 Member States in the European Region in terms of investing in intersectoral efforts to increase access to essential medical products. Some countries took steps to provide incentives for public research and development in order to meet the health sector's needs or to promote public–private collaboration on public health priorities.

Commitment 3 – Promote transparency and be accountable for health system performance

43. Health system accountability is increasingly being strengthened across the Region by the systematic setting of national goals and objectives, for example, national health strategies, policies and plans, measuring performance and assessing performance. Strengthened accountability has also been recognized as critical for defending health budgets. Health system stewards have an important role to play in seeking ways to influence the motivations and behaviours of multiple actors and their diverse agendas, finances and organizational structures, forming coherent arrangements for health system accountability *(12)*.

44. Developing mechanisms for measuring health system performance involves defining which indicators and targets are to be compiled and ensuring that the appropriate information is collected and aggregated. At least 31 countries in the European Region have national repositories or platforms for health system performance information, with packages of indicators that are regularly measured over time. Another dimension concerns the extent to which the degree of centralization of the health system shapes the package of indicators used for monitoring in each country. In this regard, experience in the European Region is varied.

45. Reviewing health system performance should occur systematically and should continuously inform priority-setting. Several Member States have pursued this by engaging in ex-ante evaluations of their national health strategies, policies and plans,

while others conduct ex-post health system performance assessments (HSPAs) *(13,14)*.[3] The latter are a tool that many attribute to the Tallinn Charter as a way to increase transparency in managing the health system *(13)*.

46. Health services delivery, in particular, has seen the most substantive development of indicators that hold providers and health-care institutions accountable. These have focused particularly on the quality of care, patient safety, health service access, utilization of and waiting lists for services, and hospital benchmarking. The majority of countries reported the existence of continuous performance monitoring and improvement mechanisms at the provider level. This monitoring has been used to assess not only service utilization but also, in some cases, user satisfaction. Countries use regulations and policies to ensure care quality standards (for example, accreditation of institutions and providers, safety, etc.) in institutions, as well as a competent health workforce. Practice guidelines, clinical protocols, treatment algorithms and medical standards are seen as important requirements of evidence-based medicine. An increasing number of countries are establishing systems for reporting and monitoring adverse events.

47. The Tallinn Charter has also been instrumental in applying transparency and accountability mechanisms to public health. Countries increasingly indicate that they are reporting publicly on health outcomes at the population level, and that these are being regularly published using web portals. Public reporting is increasingly being used across the Region to hold both institutions and providers accountable. The development and publication of annual reports by health insurance funds and purchasing agencies also help to increase transparency and accountability.

48. Noting the impact of the financial and economic crisis on levels of health spending, particularly public spending on health as a share of total government expenditure and out-of-pocket payments as a percentage of total spending on health, Member States that demonstrate improved transparency and accountability for health systems financing are increasingly implementing the means to assess such financing. Information about revenue collection, pooling and purchasing processes is being made publicly available. *A System of Health Accounts, 2011 Edition*, jointly developed by Eurostat, the Organisation for Economic Co-operation and Development (OECD) and WHO, allows for a more accurate tracking of the resources generated and spent on health. All EU and OECD countries have adopted this new system of reporting, and a growing number of non-EU and non-OECD countries in the European Region are developing their reporting systems in accordance with the new guidelines. Countries are also making information on entitlement to benefits and user charges publicly available.

49. Reporting by designated national authorities in Member States in the Region on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel has demonstrated the commitment of countries to transparency and accountability. National reports covered the issues of migrant health worker rights, international recruitment and mobility. More attention is being paid to the

[3] The WHO Regional Office has worked directly with several Member States to develop HSPAs. These countries include: Armenia, Azerbaijan, Belgium, Estonia, Georgia, Hungary, Italy, Kazakhstan, Kyrgyzstan, Malta, Moldova, Portugal and Turkey.

process of regulation of health-care practice, namely, registration, licensing, certification and accreditation. For some countries, this focus on authorization has also translated into the disclosure of practitioner information so that consumers can make informed choices about their care.

50. Countries are also demonstrating a commitment to transparency and accountability by turning to evidence-informed decision-making for the selection of medical products. Health technology assessment is also being more widely used across the Region as a tool to guide reimbursement. Pricing and reimbursement policies, as well as mechanisms to ensure cost-effective spending on pharmaceuticals, are increasingly in use. Several Member States have also started to develop curricula for the health workforce that emphasize pharmacovigilance and accountability for the appropriate use of medical products, and to disseminate prescribing policies and guidelines to health professionals. E-health technologies are being implemented across the Region to track health system performance, strengthen accountability and provide better patient care.

Commitment 4 – Make health systems more responsive to people

51. *The world health report 2000* instigated the idea that responsiveness to citizens' expectations should be a fundamental goal of all health systems. Several Member States have demonstrated a commitment to making their health systems more responsive by investing in feedback loops (electronic or otherwise) for capturing people's needs. Some countries also reported the existence of mechanisms for assessing people's expectations and patients' experiences and/or satisfaction with services. Policies and legal or regulatory instruments have been introduced to define and promote awareness of patients' rights, which are increasingly being enforced through patient ombudsmen. Other countries have taken a less legalistic route, creating an environment that helps people to make healthy choices and which empowers people with regard to their health.

52. With respect to this commitment, the most significant trend in the Region in terms of delivery of health services has been the reorganization of hospital services to improve access for citizens to quality services. Particular attention has been paid to waiting lists, emergency services, travel time to services and networks of providers. Many of these service improvements involved addressing excess hospital capacity and efforts to ensure an appropriate balance between inpatient and outpatient services. Member States have also focused on improving referral systems in order to strengthen the role of primary-care services. Health systems have started to promote the proactive management of health. As more health problems are being effectively managed and resolved in personal care settings, several Member States 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 models are most successful when they are underpinned by an expanded diagnostic capability and emphasize continuity and the long-term multidisciplinary management of chronic illness, multiple morbidity and end-of-life care in a primary health care setting, in the community and in patients' homes. Successful initiatives capitalize on improved flows of information through operational partnerships and networks of health providers. They have often involved new delivery models to improve the organization of services and promote the continuum of effective

and high-quality care, new multidisciplinary team working and additional training of the workforce to develop new competencies. Member States are increasingly tailoring their services to the diversity of the population and individual needs as they vary across gender, culture, language and political and economic status.

53. Member States are aligning resource allocation more closely with people's needs. Financial incentives targeting providers are being used by several Member States to reduce waiting times and transparent systems of waiting time management across providers are being introduced. Regular surveys of patients' experience of access to and use of health services have also been important ways for health systems to steer and assess responsiveness to people's needs. Finally, various e-health services were reported; in most cases, these are not specifically designed to address health system responsiveness, but rather as tools to reduce the financial and other resources required for service provision, thereby improving patients' access to services.

54. Trends in task-shifting and the changing patterns of disease are increasing the importance of aligning the training (both initial education and continuing professional development) of health professionals with patient needs. The Region is experiencing a growing need to align the education and training of health professionals with health system reforms and population needs. This has involved not only a reorientation towards primary care. There has also been a tendency in the European Region to make initial training more inter-professional as a way to improve the health workforce's ability to be more responsive to patients. Member States are paying more attention to continuing professional development and lifelong learning as a means of guaranteeing patient safety. While several Member States have recognized the education of health professionals as an important priority, there needs to be greater engagement and investment in transformational models of education. Several countries are intervening to improve the well-being of health professionals in order to improve retention and to enable the health workforce to be responsive.

55. In order to strengthen their pharmaceutical services, Member States have been re-examining the role of the pharmacist and the pharmacy so as to make them more responsive to people's needs. Innovation has not been limited to the health workforce but is particularly relevant to health technologies and pharmaceuticals. 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. The security of electronic records has become increasingly important with the rise of e-health.

Commitment 5 – Engage stakeholders in policy development and implementation

56. While the second commitment concentrated on collaboration with other sectors, the focus here extends to stakeholders, both within the wider health system and outside government.

57. Almost all countries reported that feedback mechanisms are in place to foster dialogue between multiple stakeholders and policy-makers. A majority of countries reported the existence of clear mechanisms to support civil society involvement in the

formulation of health policies in order to help health system stewards “row less and steer more”, as discussed during the WHO Conference on European Health Care Reforms in 1996 *(15)*. Ministries have often mobilized stakeholder engagement using web platforms to garner feedback on legislation, decisions, strategies and policies. Patient input has been specifically targeted and has led to the appointment of ombudsmen and the establishment of patient representative bodies, even in health ministries.

58. Member States are increasingly engaging professional groups and vulnerable population groups in decision-making around priority-setting for national health strategies.

59. Political and administrative decentralization is an important tool for mobilizing more stakeholder involvement in the planning and implementation of health services delivery. Some countries also reported supporting the establishment of operational partnerships and networks between care providers. Several countries reported that directives are in place to promote the engagement of the population in its health and health care plans.

60. In the area of financing health systems, improved dialogue and engagement with ministries of finance have been observed in some countries, particularly as a result of joint efforts by OECD and WHO to organize meetings of health and finance officials.

61. Engagement with other stakeholders has been another critical tool for strengthening stewardship of the health workforce in the Region. This is an area that has also experienced significant engagement of civil society organizations. Effective health professional associations are becoming increasingly prominent across the Region and provide a major opportunity for more expert input into policy-making. The greater challenge, however, still remains the silos between professions.

62. Creating a broad framework of medicines policies is an incremental process that should be incorporated in overall reforms of health policy-making. To this end, several Member States have been engaging stakeholders in developing overarching national medicines policies and sector-specific strategies. The Region has experienced an increase in delegation of responsibilities from central to regional authorities with regard to decisions concerning technologies.

Commitment 6 – Foster cross-country learning and cooperation

63. There is widespread sharing of information on developing plans and strategies for strengthening health systems, as well as on increasing learning and problem-solving with regard to health services delivery. Almost all countries reported actions in this area. Sharing of information and cross-country learning seem to be less common, however, in the area of the balance of spending among health care, disease prevention, health promotion and future needs.

64. Participation in multicountry policy dialogue events has been of great interest to Member States across the Region. The Regional Office has been instrumental in convening Member States around various networks to share experience and practices in health systems strengthening. Some examples include: the Regions for Health

Network *(16)*, the South-eastern Europe Health Network *(17)*, Evidence-informed Policy Network *(18)*, and the WHO European Healthy Cities Network *(19)*.

65. A number of countries, in particular those that are members of the EU, are also involved in joint research programmes and activities on health services delivery. A total of 42 Member States reported attending WHO training courses on health financing for universal health coverage and health systems strengthening.

66. The Region has seen significant progress and ongoing cross-country collaboration in improving and harmonizing definitions for the collection of data on health workforce employment and education for the joint OECD/Eurostat/WHO Regional Office for Europe database. The findings of the PROMeTHEUS project, on health professional mobility in, and into, the EU, provide evidence for policy-makers on the impact of mobility within the EU, on motivations of mobile health workers and on the effectiveness of policies to manage migration. The MoHProf project, on the mobility of health professionals, has generated evidence on the international migration of health workers in 25 countries, with a focus on migration within, to and from the EU. The EU Joint Action on Health Workforce Planning and Forecasting is providing a valuable platform for collaboration and exchange among Member States. The Bologna Process, which established a European higher education area among 47 countries, has also helped to harmonize education structures so that health professionals can ensure employability across the Region.

67. An important sphere of collaboration in the area of health technologies and pharmaceuticals are the efforts to synergize HTA across countries. EU member countries participate actively in this area within the European network for health technology assessment EUnet HTA, while central European and Balkan countries are members of Advancing and strengthening the methodological tools and policies relating to the application and implementation of Health Technology Assessment, a partnership of 13 consortium members that aims to standardize methodology for assessing medical products and medicines. In the area of health technologies and pharmaceuticals, Member States actively coordinate the surveillance, containment and prevention of the emergence and spread of antibiotic resistance in the European Region. Examples include the Central Asian and Eastern European Surveillance of Antimicrobial Resistance (CAESAR) network, which has brought together the European Society of Clinical Microbiology and Infectious Diseases, the Dutch National Institute for Public Health and the Environment and the WHO Regional Office for Europe. The aim of CAESAR is to set up a network of national antimicrobial resistance (AMR) surveillance systems in all countries of the Region that are not part of the European Commission AMR surveillance network, the European Antimicrobial Resistance Surveillance Network. This would enable joint reports of antibiotic resistance for all 53 countries in the future, based on the same standards and methodologies.

Commitment 7 – Ensure that health systems are prepared and able to respond to crises

68. Between 1990 and 2015, approximately 50 million people in the WHO European Region were directly affected by natural disasters. Strengthened, well-prepared and well-managed health systems can effectively contribute to preventing health events

from triggering a security crisis. The strong guidance of good stewardship is the basis for prepared and resilient health systems. Health system stewards are increasingly prepared and supported to lead health system preparedness planning and the management of health crises so that the health sector can be ready to take a primary and coordinating role and to technically guide other sectors facing a health crisis. Owing to the growing complexity of health security challenges, however, an effective response requires the close collaboration of governments, international organizations, civil society, the private sector and other partners. Effective crisis preparedness and response are governed by a number of cross-cutting (strategic) principles that WHO encourages Member States to adopt.

69. WHO is currently reforming its emergency response operations through the updated *Emergency response framework*, a policy document that governs WHO actions in emergencies with public health consequences. In addition, WHO has a unique international mandate from its Member States to promote and support the International Health Regulations (2005) (IHR). States parties to the IHR are obliged to assess and notify WHO of any event that may constitute a public health emergency of international concern, irrespective of its cause (whether biological, chemical or radionuclear) and origin (whether accidental or deliberate). For effective implementation, States parties, with WHO support, were required to develop a national IHR implementation plan by June 2009 and to meet national core capacity requirements by June 2012. In the WHO European Region, almost all countries have these minimum requirements in place; only very few requested an extension until June 2016. Now the focus is on applying the IHR on a day-to-day basis in an operational way with available capacities, on training and on measuring the performance of national IHR national focal points. The majority of Member States where the IHR have been implemented have also reported the existence of information systems and established lines of communication.

70. The second highest level of action was reported for this commitment. The Region has witnessed an increase in capacity, particularly in the area of accountability for emergency preparedness. In addition to reporting on IHR implementation, almost all countries noted the existence of health sector emergency plans, with clear direction and coordination mechanisms to ensure the availability of health services during emergencies and crises. The majority of preparedness plans are also intersectoral, where a public administration unit is tasked with coordinating the response to health emergencies.

71. More than half the countries also reported the existence of a mechanism to monitor and identify biological, chemical and physical hazards in the environment. A number of countries explicitly stated that mechanisms are in place to disseminate environmental and other health risk information and warnings to the public. Approximately a quarter of countries reported that existing emergency plans include provision for maintaining health security standards in travel and transport.

72. Considerable attention and investment have also been devoted to increasing access to emergency services across the Region and to establishing effective triage services as a means of responding to surges in demands.

73. The availability of financial resources not only within the Ministry of Health budget but also across sectors is essential to preparedness for and the management of emergencies.

74. Clinical experience remains the core of health professionals' training but, in addition, technology is being harnessed to support training objectives. Approaches such as simulation exercises and distance learning are increasing used in the Region. However, without reports on indicators or formal audits of health staff, it is difficult to identify gaps in knowledge, skills and capacities. Public health competencies to prepare and plan for and to prevent emergencies are being developed in a number of countries. The Association of Schools of Public Health in the European Region has been instrumental in defining such public health competencies.

75. The ability to respond effectively to emergencies relies on early preparedness with regard to medical products, vaccines and technologies to facilitate their effective use for admitting and treating casualties and patients. Depending on their location within the WHO European Region, countries reported facing barriers to and complications in ensuring sufficient medicines. Only a handful of Member States mentioned secured laboratory services. Experts have expressed concern that this is often a significant bottleneck in responding to biological/medical emergencies. Several Member States have invested in information systems to help in the surveillance, prevention and coordination of emergencies.

Conclusions

76. While direct attribution of specific activities, policies or interventions to the Charter is difficult, Member States have nevertheless reported a series of health systems strengthening activities under the banner of the Tallinn Charter over the past seven years across the four health system functions and in line with the seven commitments of the Charter (as mapped in the function-commitment matrix described in paragraphs 20 to 22 above).

Financial and economic crises

77. The Charter has been tested by the subsequent global financial and economic crisis. What countries have done with regard to their health systems in response to the crisis provides an insight into the strength of the commitments in practice, particularly in key areas such as promoting solidarity, fostering cross-sectoral partnerships and investment, and making health systems more responsive. In this regard, the emergence of Health 2020 as the overarching policy framework for the Region can only strengthen further activities to ensure more sustainable and resilient health systems in the Region.

78. The financial and economic crisis affected many health systems in the Region, some severely. Fiscal measures taken before the crisis (for example, accumulating financial reserves, establishing countercyclical formulas for government budget transfers and ensuring an adequately funded health system), as well as pre-crisis efforts to minimize gaps in health coverage and to 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 faced similar challenges.

- Health systems require stable, predictable sources of revenue. Sudden interruptions to public revenue streams can make it difficult to maintain the necessary levels of health care.
- Cuts to public spending on health made in response to an economic shock typically occur 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 an increased reliance on access to publicly funded 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.

79. In responding to the crisis, most countries introduced positive changes *(8)*. Many were resourceful in mobilizing public revenue for the health sector, sometimes in ways that brought additional benefits, for example, introducing taxes with public health benefits or measures to make health financing fairer. The crisis 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 also took steps to get more out of available resources. Efforts to strengthen pharmaceutical policy were especially common. However, countries did not always take the necessary action, were not always able to achieve the desired results and sometimes introduced changes likely to damage performance. As a result, a small number of countries 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 extensive spending cuts and coverage restrictions begin to be seen.

80. Tackling the inefficiency both of health systems and of health services has been an important priority for most European Member States in recent years, not only because of the crisis. Where the short-term situation compels governments to cut public spending on health, the focus of 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 run. 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, the implementation of supportive health workforce policies is a critical part of this process. With the often high cost of medical products, in particular many new medicines, countries have increasingly turned to the better use of evidence and guideline development to inform and justify the selection of medicines that are being made available and being reimbursed. Across the Region, the use of HTA and investment in e-health technologies have therefore been reported as useful mechanisms to direct countries in the process of introducing and using new products to guide reimbursement while also contributing to health system performance and strengthened accountability.

81. Member States that made strategic, transparent, intersectoral and far-reaching decisions, with a strong commitment to equity, solidarity and financial protection, were better able to avoid undermining performance.

82. The Tallinn Charter has therefore effectively made the case for the virtuous cycle of health-health systems-wealth. The commitments of the Charter, when cross-referenced with the functions of health systems, provide a valuable framework with which to prioritize and develop the information and capacity for health systems strengthening required to protect health budgets and improve the contributions of health and health systems to promoting wealth and the well-being of society.

Five-year anniversary of the signing of the Tallinn Charter

83. In order to mark five years since 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 *(10)*. The meeting confirmed considerable enthusiasm for implementing the commitments of the Charter and related them to the third pillar of Health 2020 in order to help identify priorities and directions for health systems strengthening in the Region.

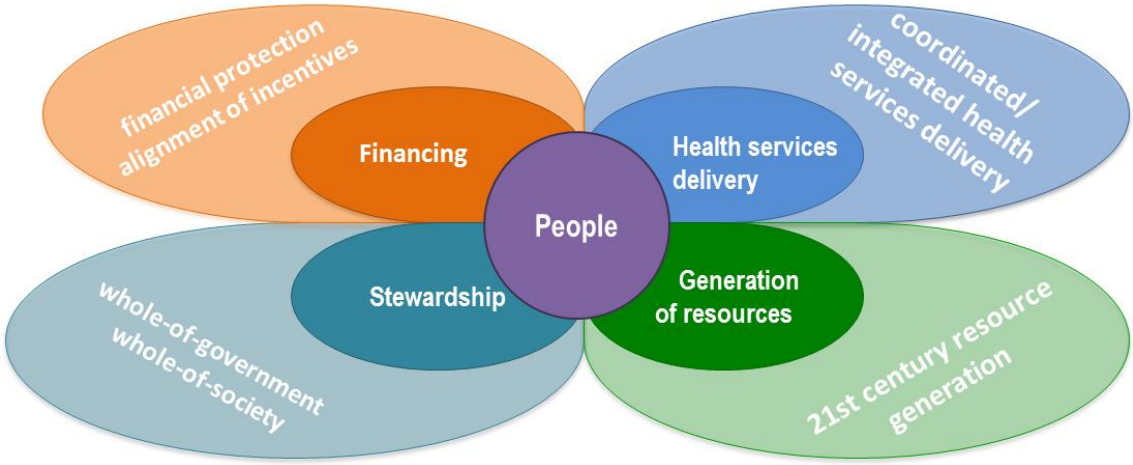
84. Despite the progress made in many areas of health systems strengthening since the adoption of the Tallinn Charter, several challenges persist. The reorientation towards primary care and public health can only be accelerated to achieve improved health outcomes in tandem with the development of a better understanding of patient needs. Millions of people continue to experience financial hardship when accessing the health services they need. More needs to be done in order to develop targeted health workforce strategies that better align with patient and population needs. Persistent silos and the lack of alignment of provider skills and organization with patient needs also remain areas for improvement. Health technologies and pharmaceuticals will also need to continue to keep pace with people's requirements and innovations. The availability of disaggregated information, which is crucial to targeting the social determinants of health and health inequalities, also needs improving.

85. It was therefore agreed that, while the Tallinn Charter has provided the systems thinking, Health 2020 provides a coherent policy framework for strategic objectives and priorities that links the right policies with the systems thinking. This context allows further elaboration of the functions in a more holistic way (see Fig. 2).

86. In keeping with Fig. 2 and based on reported country experiences, Member States proposed several strategic priority areas of work in terms of how to direct health systems strengthening activities in the coming years. They identified requiring more assistance in implementing Health 2020 and in strengthening public health services, as well as in reinforcing the capacities of local public health authorities, so as to implement the 10 essential public health operations set out in the European Action Plan for Strengthening Public Health Capacities and Services *(20)*. The integration and coordination of primary care services with hospital services and public health services were some of the greatest challenges identified by Member States, and guidance was also requested on how to strengthen the management of these arrangements and improve the training and deployment of the health workforce, in particular nurses and other primary health care personnel, so that it is equipped with the skills to promote

such care delivery models. Several Member States also called for support with HTA and the monitoring of health system performance.

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



87. Member States identified several strengths of WHO, including its credibility, impartiality, convening power and ability to organize peer reviews, as well as the visionary Health 2020 policy framework and the Tallinn Charter. For the Regional Office, four key ways of working were seen to be particularly effective: (a) generating and disseminating evidence; (b) holding countries to account before their populations; (c) building capacity at the regional and country level; and (d) providing country-specific technical support.

The way forward

88. The principles and commitments affirmed in the Tallinn Charter are being implemented in national 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 Tallinn Charter represents an important exercise, and valuable lessons have been learned from the experience of Member States and the Regional Office in its implementation.

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

90. Taking all the above considerations into account, the Regional Office has therefore developed a high-level strategic paper on priorities for health systems strengthening in the WHO European Region 2015–2020 (document EUR/RC65/13),

which will be presented to RC65. Through consultations with Member States, two key strategic directions for future work in strengthening people-centred health systems have been identified: (i) transforming health services to meet the challenges of the 21st century; and (ii) moving towards universal health coverage (UHC) for a Europe free of impoverishing out-of-pocket health expenditure.

91. In order to transform health services to meet the challenges of the 21st century, 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; and
- managing processes for better outcomes.

92. In order to move towards UHC for a Europe free of impoverishing out-of-pocket expenditure, the Regional Office will support Members States in:

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

93. The mission of the WHO Regional Office for Europe therefore continues to be to support Member States in strengthening their health systems in order to accelerate health gains, reduce health inequalities, guarantee financial protection and ensure efficient use of societal resources through whole-of-government and whole-of-society 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 necessary health services. It requires a focus on efficiency so that valuable resources are not wasted. It also requires greater transparency and a renewed commitment to performance assessment to ensure accountability. These are all reflected in the spirit and text of the 2008 Tallinn Charter.

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

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