

HEALTH SYSTEMS FOR PROSPERITY AND SOLIDARITY

LEAVING NO ONE BEHIND

INCLUDE

INVEST

INNOVATE

HIGH-LEVEL MEETING REPORT
13–14 JUNE 2018, TALLINN, ESTONIA



CELEBRATING THE 10TH ANNIVERSARY
OF THE TALLINN CHARTER



Abstract

The high-level meeting Health Systems for Prosperity and Solidarity: leaving no one behind took place on 13–14 June 2018 in Tallinn, Estonia. Its purpose was to celebrate the 10th anniversary of the Tallinn Charter, to restate and emphasize its underpinning values and to explore opportunities within the WHO European Region that reflect those values and commitments, urging their ongoing development and protection.

The meeting aimed to celebrate the Tallinn Charter, its values and achievements; to share innovations and recent good practices from across the Region; and to outline a new vision for person-centred and resilient health systems of the 21st century in line with the SDGs and Health 2020, with a strong commitment to achieving equity.

Keywords

Delivery of health care
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Executive summary

The high-level meeting Health Systems for Prosperity and Solidarity: leaving no one behind took place on 13–14 June 2018 in Tallinn, Estonia. Its aim was to celebrate 10 years of the Tallinn Charter in the context of the Sustainable Development Goals. The Charter was a milestone in strengthening health systems and has had a lasting impact within the WHO European Region and beyond. In emphasizing solidarity, equity and participation as central commitments, the Charter reflected Member States' joint pledge to a values-driven agenda for health systems. This commitment to act on shared values has been a constant thread in the work of Member States and the WHO Regional Office for Europe ever since; the core values that underpin the Charter clearly remain relevant today, continuing to provide a focus within health systems. Nonetheless, 2018 may be a time to celebrate the anniversary, but it is not a time for complacency or to take anything for granted, as experience after 2008 (including the global financial crisis of 2008–10) has shown.

The meeting thus had two purposes. First, it represented a celebration of the achievements of the last 10 years that reflected the legacy of the Charter, acknowledging its role in the strengthening of Member States' health systems. Second, it provided an occasion both to restate the arguments for stronger health systems for better health and wealth in the light of further evidence and to leverage and build on present opportunities that reflect the values and commitments that lie at the heart of the Charter, urging their protection in the future.

The meeting's title, "Health Systems for Prosperity and Solidarity", was chosen to reflect this forward-looking view, and it focused on three overarching themes, referred to as the "three i's":

-  **INCLUDE** – improving coverage, access and financial protection for everyone;
-  **INVEST** – making the case for investing in health systems; and
-  **INNOVATE** – harnessing innovations and systems to meet people's needs.

The two days presented an opportunity to discuss and explore each of these in depth. The three themes should, however, should be seen not in isolation but as a matrix: their interdependence is clear and the links between them fluid, depending on the evolving context in each country.

This report captures the highlights of the discussions, focusing on new evidence and thinking, but most importantly investigating the experiences of individual countries since the Tallinn Charter first appeared. Participants drew attention to the complexities of transforming and reforming their health systems, balancing the desire to extend health coverage with the competing demands on finite resources and the urgency of encapsulating innovations in systems and service provision.

Reflecting on the experience of individual countries, a number of common themes emerged that cut across the three i's. An overriding message on improving coverage, access and financial protection was that although there is now far greater and more detailed evidence on the three factors of who experiences financial hardship as a result of accessing health care, which health care services are the drivers for this and which coverage policies have a positive impact, achieving universal health coverage remains a challenge for all countries in the Region, albeit to varying degrees. Participants gave details of a number of strategies, many of which are ongoing. It was evident that the success of their implementation, although clearly dependent on the country context, was also reliant on universal health coverage being an integral part of a range of measures to transform health systems to ensure equity, universality, solidarity and sustainability – values that lie at the heart of the Tallinn Charter.

On the theme of making the case for investing in health systems it seemed that, since the Tallinn Charter, data were no longer lacking to convince governments of the benefits of health spending for its own sake. Rather, evidence is needed to understand how it can best be used for the next steps in transformation or to make appropriate investment decisions that will reap benefits for service users and ensure quality provision and cost-effectiveness. Discussion focused on the tensions and balances in the decision-making process of where money should be spent within the health system and on the inherent lack of specific evidence on which measures, at what point and in what way would enable the shifting of health systems to ensure that the values of the Charter are maintained.

Meeting the challenges of delivering the objectives of transforming health systems, including the need for inclusiveness and appropriate investment, also entails keeping pace with changes both within and outside each health system, requiring health policy-makers to harness innovations to meet the needs of their populations. Developing alliances across and within borders, both inter- and intrasectorally, and understanding local ecosystems were all seen as part of the receptive context for the introduction of innovations. Governance – particularly that of public health – remained an issue, but debate also centred on the complexities that encouraged (or discouraged) the success of innovations within health systems and factors that would enable their scaling up or transfer. Critically, to preserve the values of the Tallinn Charter, constant vigilance is required to ensure that equity is maintained in the introduction of new treatments or new ways of delivering care. Greater patient and public participation in decision-making and service design and an acknowledgement of the importance of understanding the views of patients and patient experience are also needed. The narratives and perspectives of individuals would provide the context for, and understanding of, many of the nuances that are woven into the matrix of the three i's.

Acknowledgements

WHO is grateful to the Estonian government, Ministry of Social Affairs, for generously hosting the high-level meeting and for the excellent collaboration. Technical lead was with the WHO Regional Office for Europe, Division of Health Systems and Public Health, with the support of the European Observatory on Health Systems and Policies, and the WHO Country Office for Estonia provided key organizational support.

This report is based on the valuable inputs by presenters and participants of the meeting. It was written by Kate Melvin and David Hunter (rapporteurs). Guidance and review were provided by Elke Jakubowski and Gabriele Pastorino from the Division of Health Systems and Public Health of the WHO Regional Office for Europe, under the directorship of Hans Kluge.

Abbreviations

Abbreviations of the WHO/Europe Member States in Figures 4, 5, 6, 7 and 9:

ALB - Albania	GEO - Georgia	POL - Poland
AUT - Austria	DEU - Germany	POR - Portugal
CRO - Croatia	GRE - Greece	SVK - Slovakia
CYP - Cyprus	HUN - Hungary	SVN - Slovenia
CZH - Czechia	KGZ - Kyrgyzstan	SWE - Sweden
DEN - Denmark	LTU - Lithuania	UKR - Ukraine
EST - Estonia	LVA - Latvia	UNK - United Kingdom
FRA - France	MDA - Republic of Moldova	

1. Background

In June 2008 ministers and senior representatives from the 53 Member States in the WHO European Region met in Tallinn, Estonia, with partners, members of civil society and experts to discuss the evidence that investing in health systems contributes to improvements in population health, economic wealth and societal well-being. This groundbreaking event resulted in the Tallinn Charter: *Health Systems for Health and Wealth* (WHO Regional Office for Europe, 2008). Signed by all Member States, the Charter embodied a shared commitment to a values-driven agenda for strengthening health systems. This was reflected in the subsequent work of the WHO Regional Office for Europe, including the publication *Priorities for health systems strengthening in the European Region 2015–2020: walking the talk on people-centredness* (WHO Regional Office for Europe, 2015a), which was endorsed by Member States along with its accompanying resolution at the 65th session of the WHO Regional Committee for Europe in Vilnius, Lithuania, in September 2015. The values of the Tallinn Charter are also at the core of the people-centred health systems pillar of Health 2020, the policy framework for the WHO European Region (WHO Regional Office for Europe, 2013).

The Tallinn Charter remains a cornerstone and a continuing reference point for strengthening health systems in the Region 10 years on. Member States have, for example, cited it as both a direct and an indirect influence in a number of areas, some of which are reflected in *Implementation of the Tallinn Charter: final report* (WHO Regional Office for Europe, 2015b). At the same time, political, social and economic events and cleavages during the last decade have led to a vastly changed European and global environment, in which the values captured in the Charter have been – and continue to be – challenged. Signed before the 2008 global financial crisis, the Charter could not have foreseen the growing polarization in the geopolitical sphere, the potential threats to social cohesion, the remaining uncertain economic climate with the resultant concern for health and social budgets, the challenges of demography, the growth in health inequalities and especially the inequalities divide in, for example, the epidemiology of noncommunicable diseases (NCDs). All of these are now very much part of the fabric of European society. This serves as a reminder of the importance of equity, solidarity and a values-driven approach to strengthening health systems for all. Reviewing and reaffirming the relevance of the Charter within this broader context is integral to ensuring that citizens are equally able to benefit from their own health systems.

As in 2008, the high-level meeting *Health Systems for Prosperity and Solidarity: leaving no one behind* held in Tallinn, Estonia, on 13–14 June 2018 was generously hosted by the Government of Estonia, Ministry of Social Affairs; it was supported technically by the European Observatory on Health Systems and Policies, with the Regional Office's Division of Health Systems and Public Health taking the lead in designing the content. It coincided with the 20th anniversary of the European Observatory, the 40th anniversary of the Alma-Ata Declaration and the 70th anniversary of WHO. It also took place just over 20 years since the signing of the Ljubljana Charter on Reforming Health Care, which preceded the Tallinn Charter and emphasized the need for a value-based approach to health reform.

The 2018 meeting was attended by more than 240 participants from 41 countries in the WHO European Region including ministers of health; senior policy-makers; health policy, system and change-management experts; and many partners. It also attracted widespread attention on social media, with over 1000 tweets and an audience of approximately 50 000 on the WHO Regional Office for Europe Facebook page. Live web streaming related to the event also accumulated nearly 10 000 views across social media channels.

The occasion was not merely an opportunity to celebrate the 10th anniversary of the Charter and the ensuing achievements; it also provided a platform to restate the arguments for stronger health systems for better health and wealth. In short, it was an occasion to look forward as well as back.

The meeting also provided a unique opportunity to launch a review of the health system in Estonia (Habicht et al., 2018). This forms part of the European Observatory's Health Systems in Transition series, which describes each country's health system, its reforms and any policy initiatives in progress.

Within both the broader European context and, importantly, in the light of more recent evidence and knowledge, the meeting aimed to underline and build on a number of opportunities and directions that have emerged since 2008. These include:

- the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs);
- a renewed global commitment to universal health coverage (UHC);
- new experiences in the WHO European Region of positioning health systems as contributors to inclusive economic growth;
- innovative approaches to providing integrated, people-centred health services;
- a push towards increased public involvement in decision-making about care and greater individual responsibility for personal health;
- improved health data collection and use;
- new approaches for ensuring required medicines and health personnel; and
- novel experiences in managing system transformation and change.

The 2030 Agenda for Sustainable Development, for example, continues to gain traction: life expectancy has improved, the protection rate for tuberculosis and other infectious diseases has increased and, although remaining a major challenge, a steep decline in premature mortality from NCDs has been seen.

Reflecting on the need to transform health services within complex and diverse national contexts to meet the continuing challenges of the 21st century and to ensure that citizens of the Region have equal access to health and health care services, the meeting focused on three overarching themes, as detailed in the meeting background document:

-  **INCLUDE** – improving coverage, access and financial protection for everyone;
-  **INVEST** – making the case for investing in health systems; and
-  **INNOVATE** – harnessing innovations and systems to meet people’s needs.

All three themes underpin the values of the Tallinn Charter but should not be seen in isolation. Not only are they inextricably linked but the relationships between them are fluid and evolving, depending on the country context and on the mix of circumstances at any one time within and across systems and countries. Despite being immersed in complexity, the three themes nonetheless enable a focus on, and a detailed exploration of, the central tenets of UHC, investment and innovations – whether, to what extent and how innovations are able to improve health and health care. Such close scrutiny also facilitates greater understanding of the potential future direction and the subsequent and necessary implementation of strengthening and transforming health systems.

The meeting was structured around a series of plenary and parallel sessions focusing on each of the three i’s, as outlined in the meeting programme (Annex 1). This report details the debates that took place over the two days across the sessions, highlighting the key issues and themes addressed. The report is divided into the following sections: section 2 introduces the concept of the meeting; sections 3, 4 and 5 detail the thinking and nature of the discussions centred on the three overarching themes; section 6 focuses on key areas for further work as suggested by participants; and section 7 sets out the meeting’s conclusions.

2. Celebrating 10 years of the Tallinn Charter in the context of the SDGs

The Tallinn Charter set out seven commitments that underpin and drive the WHO's efforts to strengthen health systems throughout the European Region (Box 1; WHO Regional Office for Europe, 2008).

Box 1. The Tallinn Charter Commitment to Act

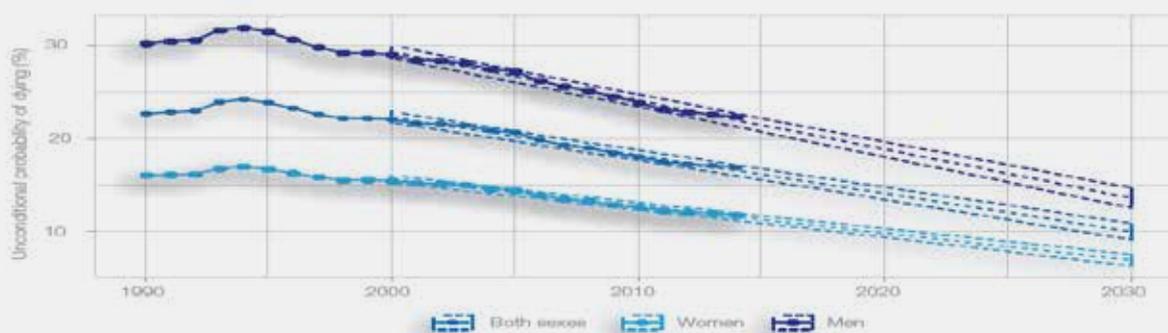
We, the Member States, commit ourselves to:

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

In the opening sessions of the 2018 meeting, participants were reminded of the continued relevance of these values and how the Charter remains able to influence the repositioning and transformation of health systems. In her opening address Dr Zsuzsanna Jakab, WHO Regional Director for Europe, celebrated the distance countries in the European Region had travelled since 2008 and the substantial progress that had been made. Life expectancy at birth, for example, had increased nearly two years on average, reaching close to 78 years. The European Region is also setting a great example by achieving an impressive reduction of premature mortality from NCDs (Fig. 1).

The Charter had galvanized the health system landscape with its values-driven approach; at its core were the shared European values of solidarity, equity and participation. These had been reaffirmed repeatedly by the commitment

Fig.1. Premature mortality from NCDs in the European Region



of WHO and Member States since 2008, including in WHO's thirteenth general programme of work 2019–2023, approved at the Seventy-first World Health Assembly in May 2018, when their global importance was underlined. Dr Jakob drew attention to how well the Charter encapsulated these values and noted that there was no better expression of the principles of solidarity, equity and participation than pursuing UHC. No one should become poor due to ill health.



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Dr Jakob emphasized, however, that complacency was not an option. Continuing to strive for faster health gains, narrowing the health gap and building on experience and knowledge have to be the way forward. Strong and robust health systems are not only important in themselves but are also a known contributor to social and economic development. The evidence is now unequivocal: health and prosperity go in tandem – neither thrives without the other.

Huge challenges remain, including addressing health inequalities, supporting public health, developing primary care, enabling access to affordable medicines and ensuring patients are at the centre of care and health systems. Pursuing the vision of Health 2020, the call for action to leave no one behind, the 2030 Agenda for Sustainable Development and the SDGs provide a tremendous opportunity to tackle these challenges within an integrated framework which includes, but goes beyond, health systems on their own.

Welcoming the participants to the meeting, Kersti Kaljulaid, President of Estonia, reaffirmed that the Charter's embodiment of the philosophy that health is a fundamental right for all is deep-rooted in European society. Since regaining independence Estonia has managed to invest in health care through raised income levels and an accompanying growth in wealth. Key to this investment has been the development of an e-health system, in which patient data are logged. This is also linked to the Estonian and Finnish shared e-prescription service, an example of international cooperation in e-health. The carefully regulated Estonian Genome Foundation is now also playing an important part within the public health system by being able to analyse individuals' blood for common markers of diseases. The greatest tension within the system remains the difficult choices concerning out-of-pocket-payments and which services should or should not be included, although the President was reassuring that compensation for the weaker and more vulnerable members of society was available within the system.

Throughout the meeting participants debated how best to understand the immediate challenges and to apply solutions to guarantee that the health systems of the future are based on solidarity, equity and universalism at the same time as ensuring sustainability.

3. Include – improving coverage, access and financial protection for everyone

Setting the scene, this first session of the meeting was framed within the WHO definition of UHC:

UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation and palliative care.

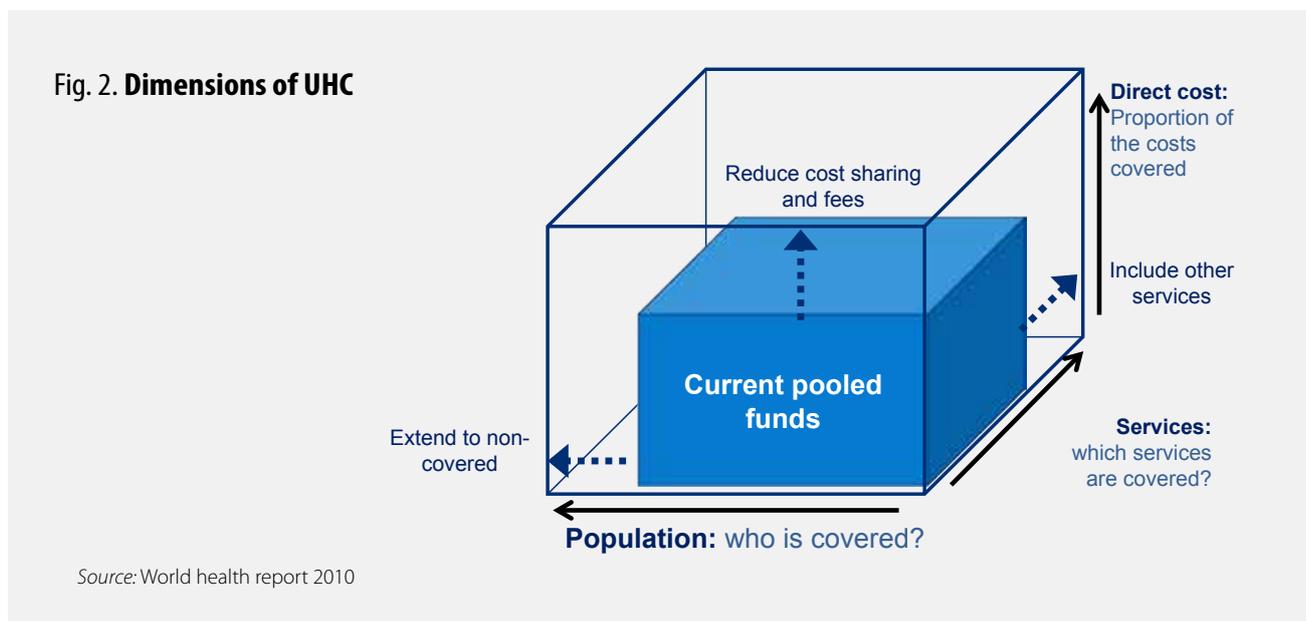
(WHO, 2017)

3.1. Understanding UHC

Ensuring that health systems reach and serve everyone is a key tenet of UHC and is central to the 2030 Agenda for Sustainable Development, explicit in SDG3 target 3.8. UHC is also the central aspiration of UHC2030, a major international partnership comprising governments across the world, multilateral organizations, philanthropic organizations and members of civil society working to build stronger and more inclusive health systems. The United Nations General Assembly will also hold a high-level meeting on UHC in 2019.

Participants debated how health systems might be transformed so that all citizens have access to appropriate and necessary health provision without facing financial hardship. Discussions began with an analysis of the central concepts of UHC. On the basis that a sustainable health care system should be efficient, effective and equitable, the aim of UHC is to provide access for the population to all services that are good value, but this does not mean unlimited coverage or unlimited costs. UHC is not universally popular, however. This may, in part, be because some may have to pay more or because it is not always possible to have the privileged access care to the extent either required or requested.

The concept of UHC is often represented by a cube (Fig. 2) depicting its three components: who is covered for access to care, to what extent are they covered in terms of costs and for what types of services are they covered.



Any health system can be designed in terms of where individual countries sit in the cube, but the essential tenet is to ensure that the right people receive the right services so that impoverishment as a result of being denied access is avoided.

Fig. 3 depicts the “ideal” cube. In an ideal system, since there is no benefit to exclude anyone, 100% of the population should be covered for all services that are good value within an individual country context. Services that are good value and cost-effective are also affordable – it is not possible for services to be good value but unaffordable.

User charges (or co-payments) are not considered a useful way of paying for effective care and their only benefit is bringing in revenue. They tend to deter those who need health care and are largely an inefficient way of trying to distinguish between those who should and should not receive services. Nevertheless, despite the evidence, user charges are likely to be in use for some time, not least since changing the system is complex and a long-term strategy. Further, cutting back on government health expenditure and increasing private expenditure will not increase economic growth, since the macroeconomic effect on prosperity and growth relates to what the money is spent on rather than the mechanism used to spend it.

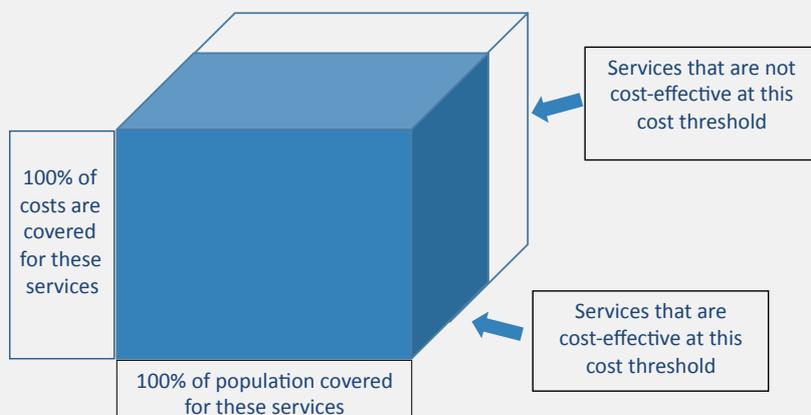
In practice, health systems need to ensure that people can access services without facing financial hardship, while ensuring their health needs are met. Participants acknowledged that when the Tallinn Charter was created 10 years ago it was not possible to have foreseen that the global economic crisis was going to strike and that all its commitments would come under threat, especially with reference to health coverage and financial protection. Indeed, it was the financial crisis that tested the Charter commitments for the first time. Box 2 outlines the response to this crisis in two countries.

Box 2. The impact of the financial crisis in Greece and Slovenia

In **Greece** the financial crisis lasted seven years and was reported to have slashed gross domestic product (GDP) by a quarter, putting huge pressure on the health system. Over 2 million people lost access to the health system because their insurance was linked to their employment.

Slovenia’s health system also suffered as a result of the financial crisis, largely due to its funding through the Bismarck system. Instead of reducing UHC, however, the financial burden was transferred to health providers and mainly to hospitals; these made substantial losses, resulting in long queues and poor access to specialist treatment.

Fig. 3. The ideal UHC cube



Source: World health report 2010

3.2. Recent evidence on health care affordability

When adequate financial protection – such as protective caps on expenditure, low fixed co-payments or payment exemptions – is not provided for those excluded from coverage, it can mean a choice between financial hardship and unmet need. This can lead to a range of negative health and economic consequences, including being denied access to health care and, critically, greater inequity and poverty. The issue is especially problematic where people are expected to make out-of-pocket payments that are large in relation to their ability to pay.

Central to this discussion were the findings of the WHO reviews of financial protection in several countries in the European Region (WHO Regional Office for Europe, 2018a). The five-year study involved over 50 national and international experts and covered 25 countries. It employed an advanced methodology, including household budget surveys, building on context-specific country-level analysis. This has led to a greater and more detailed understanding of who experiences financial hardship, which services are the drivers for this and which coverage policies have a positive impact. Although the reports detail findings for each of the 25 countries, it is important to emphasize a number of key insights that are common to all.

Households may be impoverished or further impoverished because they have to make out-of-pocket payments for health care and the levels of such impoverishment across the European Region are shown in Fig. 4. Households impoverished by out-of-pocket payments are those that are above the poverty line before using health care but pushed below it after the payments. In the case of those households already living below the poverty line, they can be further impoverished if there is a need to make out-of-pocket payments.

Incidence of impoverishing out-of-pocket payments is generally higher in countries to the east of the Region, but even Europe’s richest countries have households that are impoverished after paying for health care.

Fig. 4. **Proportion of households impoverished after out-of-pocket payments**

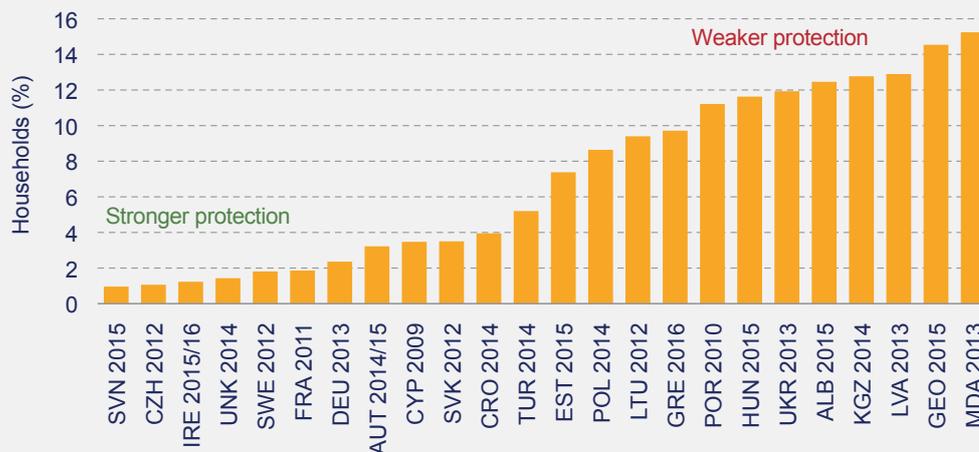


Source: WHO Barcelona Office for Health Systems Strengthening

Evidence is also now available on how many households experience catastrophic out-of-pocket payments: these occur when households spend more than 40% of their capacity to pay on health care (Fig. 5).

Where countries have stronger protection the incidence of catastrophic spending may be as low as 1%; where there is weaker protection this can rise as high as 15%, although there is a good deal of variation across the Region, as Fig. 5 shows.

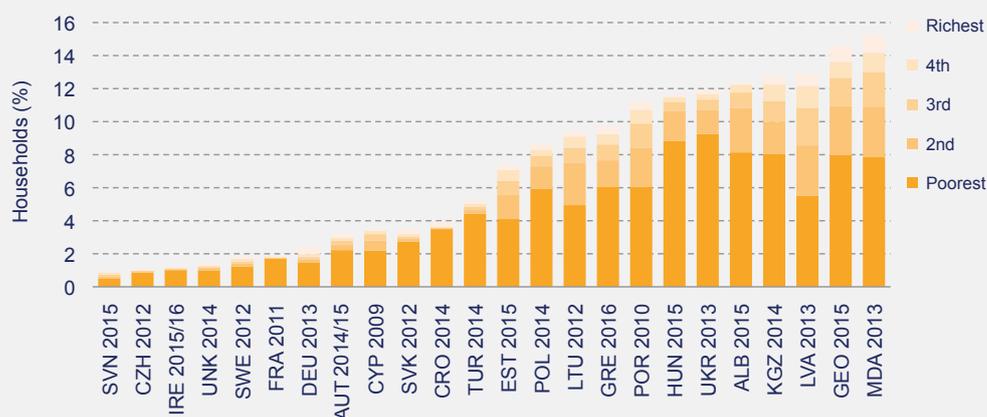
Fig. 5. Proportion of households experiencing catastrophic out-of-pocket payments



Source: WHO Barcelona Office for Health Systems Strengthening

Although the poorest households tend to be most affected by catastrophic spending (Fig. 6), their composition can differ. In some countries they may include elderly people, in others it may be people receiving social benefits and in a few countries it may be younger households with children.

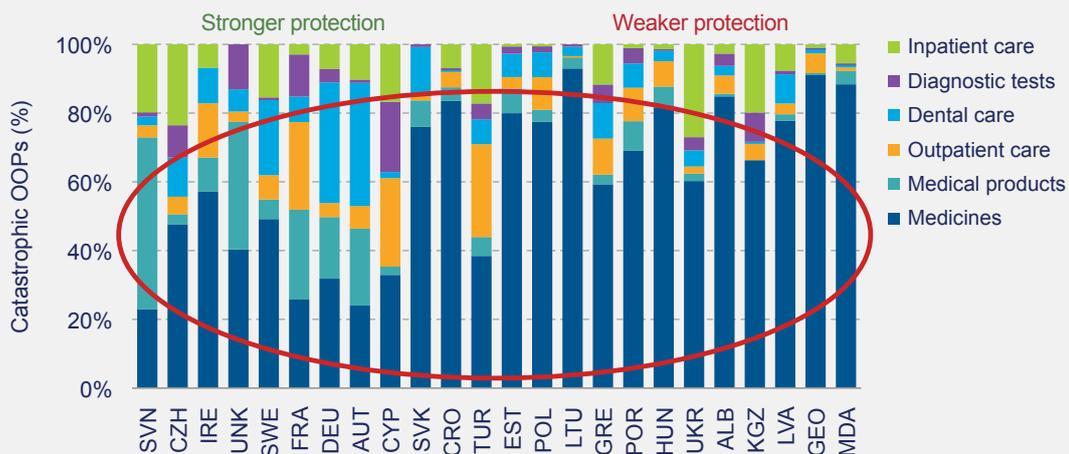
Fig. 6. Proportion of households experiencing catastrophic out-of-pocket payments, by wealth quintile



Source: WHO Barcelona Office for Health Systems Strengthening

A breakdown of catastrophic out-of-pocket payments by type of health service in each country reveals that in those with stronger protection dental care is the main source of financial hardship. Among countries with weaker protection the cause tends to be expenditure on medicines. Delving deeper into catastrophic spending among the poorest households shows that medicines are the main source of financial hardship, even in countries with stronger protection (Fig. 7).

Fig. 7. Health services responsible for catastrophic out-of-pocket payments

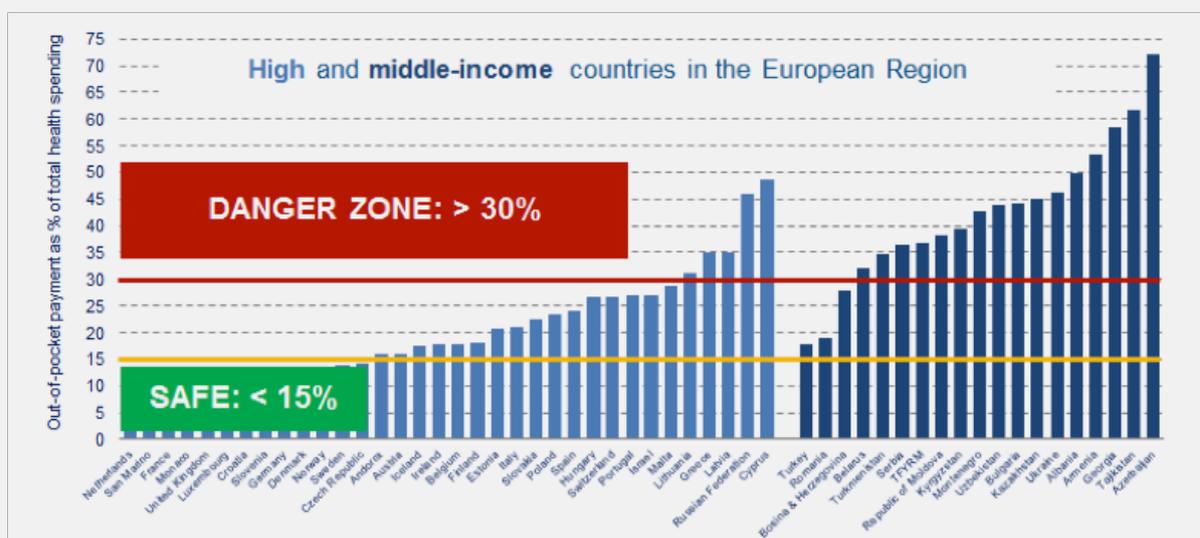


Source: WHO Barcelona Office for Health Systems Strengthening

Analysis also confirms a strong association between out-of-pocket payments and financial protection. Where the former are low, the latter is strong. Fig. 8 shows that financial protection is stronger where public spending on health is higher.

Reducing out-of-pocket payments is thus likely to reduce financial hardship, but this is only part of the answer. Population coverage, whether it is based on residence, employment and/or payment of contributions, is also critical. Nonetheless, even when there is full population coverage incidence of catastrophic out-of-pocket payments may still be high; although being covered is fundamental, it is not enough to guarantee protection. Some countries, for example, lack effective tax systems to collect payments and this is subsequently reflected in health system coverage. Gaps in service charges are equally relevant. Preventive services, in particular, need to be part of the benefits package for everyone. Patterns of richer households using services and experiencing financial hardship and of poorer households not using services such as dental care and thus experiencing unmet need are most likely to occur when preventive services are not fully covered.

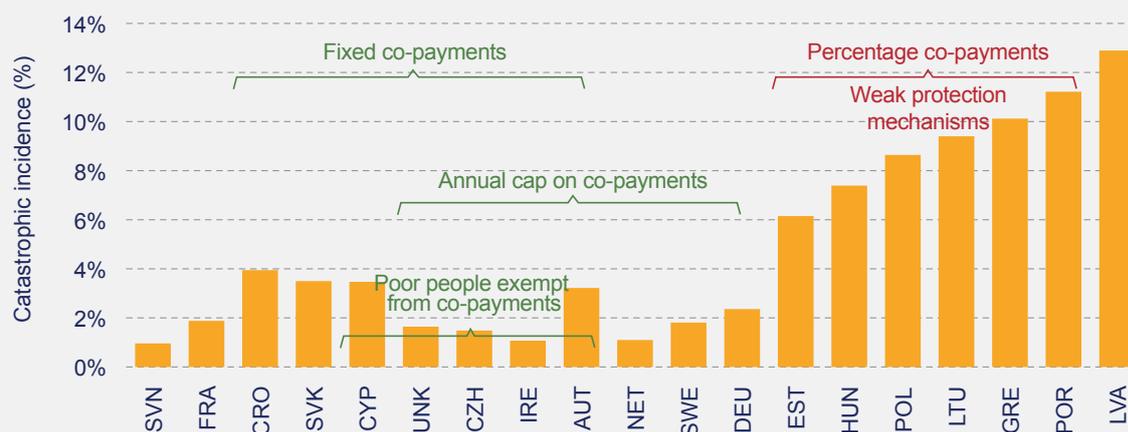
Fig. 8. Out-of-pocket spending as a proportion of total expenditure on health, by country



Source: WHO data for 2014

The final dimension of coverage is user charges/co-payments. Financial hardship through co-payments can be avoided through careful redesigning of the co-payments policy and ensuring that it is kept simple. Research has shown that in countries where financial protection is weak, protection against co-payments is also weak. Borne out by individual country evidence, exemptions from co-payments, protective caps on co-payments and using fixed low co-payments are all features of a strong co-payment design. Many of the countries with stronger protection, for example, use annual caps on co-payments and, in some cases, link the cap to income (Fig. 9).

Fig. 9. Using caps as a means of protection



Source: WHO Barcelona Office for Health Systems Strengthening

3.3. Strategies to achieve UHC

Participants were asked to vote via the meeting web application on what they considered the top three strategies most likely to strengthen health coverage in their own country. Results were close: addressing waste (20%) and reallocation of resources from secondary to primary care (19%) were of primary concern, but increasing public expenditure (16%) and extending coverage to the whole population (15%) were also considered important.

A balance of strategies, dependent on the country situation, for moving to greater health coverage was reflected in the panel discussions following the keynote presentations. Box 3 illustrates a number of strategies that have been explored. Some, like Slovenia's, demonstrate a case where political persuasion and proof of efficiency have been the key drivers in maintaining publicly funded UHC. For other countries, the process of moving towards UHC is a slow and ongoing process. Of particular note was the case of Austria, which argued that it was the last hurdle in achieving 100% UHC that was proving to be the highest and hardest to overcome. With almost total coverage, the issue is the complexity of understanding how to ensure protection for the final proportion of the population. One measure harmonizing the benefits between sick funds, however, has been crucial for the individual user.

The challenge for the pharmaceutical companies and multipurchasing agencies loomed large in discussions in a range of countries including Georgia, Greece and Lithuania. It was clear that disagreement remained among participants as to whether there were any benefits from user charges/co-payments, such as seeing them as a vehicle for steering people away from more ineffective care.

Finally, it was observed by some participants that the "elephant in the room" was the omission of social care from discussions. With the Region's ageing population and increases in social care expenditure, the boundary between health and social care was becoming increasingly blurred. This, in turn, raised the profile of primary care in the discussion, with calls for health and social care to work together more closely. Indeed, attention was drawn to the notion of primary care systems (rather than primary health care systems), which integrate both health and social care and are already operating in some countries. This theoretically avoids offloading the social care burden onto the health care system.

Box 3. A range of national strategies to achieve UHC

Slovenia concentrated on political persuasion and demonstrating efficiency to maintain publicly funded UHC. Despite poor public perception of the level of inefficiencies in the health system, exacerbated by the impact of the financial crisis, the ministry of health managed to avoid calls for privatization with the support of WHO and the European Observatory on Health Systems and Policies by demonstrating positive performance, value and health outcomes – not least by acknowledging the macroeconomic benefits. In addition to ensuring adequate budget allocations and political commitment, debate is now taking place on whether the complex system of complementary health insurance that has formed the second source of funding support for UHC to date should be abolished and replaced by compulsory levies, based on income levels.

Other countries like **Georgia** have shifted their policies a number of times. In 2004 only 2–3% of the population was covered by state funds; the rest had to pay for private health insurance. Following the 2012 election, however, health care became a priority for the new government, and a new universal health care system was introduced in 2013. Following an initial doubling of the budget allocation, government spending is increasing annually (with a projected target for health care spending of 5–6% of GDP in the next few years). The whole population now has access to a basic benefit package; although out-of-pocket payments remain relatively high, they are decreasing. A major challenge has been reviewing pharmaceutical reimbursements. Moving from multipurchasing agencies to a single purchasing agency, with the government now responsible for all health care, has been particularly cost-effective. The development of more productive public/private partnerships is also considered important. Currently, 90% of health care providers are private but they are regulated by the government. A recent example of the positivity of this relationship has been the success of the hepatitis C immunization programme.

Similarly, in **Greece** the dismantling of the previous complex system of multipurchaser provision in 2011, resulting in the government becoming the sole purchaser, has led to huge efficiency gains. Previously, multipurchasers had little power over the pharmaceutical drug companies and, as in Georgia, high user charges remained. Now, as a single purchaser, the government is in a position to negotiate prices more effectively and to promote the uptake and use of generic drugs – this has already increased from 10% before the financial crisis to 30%. Greece still has one of the highest levels of private expenditure on pharmaceuticals in Europe, however, and debate about user charges continues – whether, for example, they should be introduced for hospital and emergency care. A number of measures have been implemented to extend coverage since the impact of the financial crisis, however, including abolishing charges for the most vulnerable. Further, in 2016 UHC was formally introduced through a new law giving everyone the right to access the health system and to a benefits package, irrespective of employment status.

In **Lithuania** moves were made to adjust the tax on non-reimbursed medicines to align it with that on reimbursed medicines; this led to substantive savings. Conditions were also tightened for inclusion of medicines in the compensation list, which has mainly meant moving to generic medicines. Communicating the reasons for this decision has been difficult since, on the surface, it seemed contradictory: on the one hand, generic medicines have been introduced to save money; on the other, new expensive non-generic medications are being introduced for specialist care such as in oncology. A third policy measure has been to introduce fixed co-payments for all medicines, irrespective of the cost of the drugs.

Estonia reported that it had analysed the burden of out-of-pocket payments for years. The anticipated and gradual increase in overall spending, which is anticipated to reach about 5% of GDP over the next few years, will again be directed at increasing access and reducing charges. In addition, the pharmaceutical policy has been redesigned to cap total spending for those with pensions and those with chronic conditions. The implementation of this policy, which has been made easier through the use of information technology (IT) and e-prescriptions, has meant it is an automatic process at the point of use and works for everyone equally.

4. Invest – making the case for investing in health systems

4.1. Understanding the price of health

To achieve the values of the Tallinn Charter and establish a well performing, people-centred health system, considerable and consistent funding is a prerequisite. As noted in section 1, it is generally accepted that the health system is a driver not just of individual and population health and societal well-being but also of wealth and economic growth. Despite the growth of robust effective evaluations and clear implementation strategies, there remains scepticism across the board about further investment. Alongside this is an incumbent fear that health systems are something of a black hole into which money is poured with no real benefit or improved outcomes, characterized by high levels of waste or inefficiency. In particular, the difficulties experienced in raising funds for public health interventions exemplify this perception, despite evidence to the contrary provided by WHO, the Organisation for Economic Co-operation and Development and others. This may all be particularly pronounced when it is incumbent on policy-makers, as they see it, to keep public spending confined to levels deemed affordable to societies and not to compromise economic growth for future generations. But it is important to acknowledge that these are essentially political choices for each country to make as it sees fit.

This session of the meeting pulled together many of the strands entwined in the topic and sought to understand why, for example, the health sector is often not prioritized during difficult economic times, particularly when the evidence in favour of health system investment and spending is so clear and growing. During the plenary and subsequent parallel sessions, participants were provided with opportunities to focus on and debate the relationship between finance and health and, in turn, finance and health ministries, exploring how and in what ways the framework of the debate could and might change. As critical was an examination of how, and in what way, investment in health promotion and disease prevention – essential to UHC and the achievement of the SDGs – might be stimulated.

Underpinning many of the discussions was the debate aired in the plenary about whether it is appropriate to put a price on health or whether it is a basic human right. This was not a debate that participants who took part in the initial poll via the meeting web application believed was a primary reason to explain why requests for additional health spending meet with scepticism. Nonetheless, exploration of the concept during the first plenary set a useful backdrop for the remainder of the session. Economists, for example, tend to become the arbiters of what should and should not be spent on the basis of positive or negative externalities. Application of economic arguments to health can, however, be argued to be a flawed process, and the relationship is complex: does health depend on the economy or does the economy depend on health? It may also be useful to ask whether everything that has value has a price and – as noted several times during the meeting – to acknowledge that GDP is not an appropriate unit of measurement for health. Alternatively, it may be that it is more beneficial simply to regard price as something that does not convey all the respected societal values. Nevertheless, the challenges of the future are daunting, in particular the changing demographics, the development of increasingly expensive new technologies and even the possibility that health systems could become defined Europe-wide or internationally rather than nationally.

Recognizing the complexity of the health sector led to further analysis of the values of the Tallinn Charter. Ensuring solidarity within the matrix of the health system was especially complex, but it was necessary to strive for this in its many dimensions in order to preserve the intention. Many of the discussions in this session were also framed within the context of the analysis detailed in the policy brief *Making the economic case for investing in health systems* (Cylus et al., 2018), and attention was drawn to a number of central messages (Box 4). The brief builds on the Tallinn Charter and the emphasis on the impact of the contribution of health to social well-being and the wider economy. It argues not necessarily for higher health spending but for making sure that the argument for health spending is given a fair hearing and the evidence is not misunderstood. It also aims to steer a careful path between the need to appeal to evidence and measurement on the one hand and the recognition of health as a human and inalienable right on the other.

Box 4. Making the economic case – summary

- Contrary to general perceptions, there is an increasing body of evidence that suggests that greater health system spending does produce health gains.
- Most health systems are becoming more serious about rooting out inefficiencies that remain. These are hard to measure, but increasing numbers of instruments are available to tackle this.
- The health system is an important component of the economy, with the potential to improve workforce productivity and create employment opportunities (although health spending on individuals with no direct participation in the labour market is significant). Quantification of the impact, however, is difficult.
- A healthy older population is less costly, and maintaining health and improving welfare can lead to greater productivity in older ages. This can also allay fears of the level of dependency on the wider system.
- Health spending supports societal well-being, and UHC enhances social protection and reduces impoverishment. Good health makes a crucial contribution to human welfare, but GDP is not a sufficient measurement for this.

Source: Cylus et al. (2018).

4.2. Making the case for investment: the health and finance dialogue

The often perceived difficulties between health and finance ministries were exemplified to participants through a film (WHO Regional Office for Europe, 2018b). This pointed to a number of factors that tend to occur in discussions between ministries, which may also be exacerbated by conflicts in approach and thinking (Box 5).

The initial poll taken at the meeting revealed that 23% of participants believed that health policy-makers are not well versed in making the economic case for investment. Nevertheless, a number of participants clearly felt that the debates between finance and health were not as polarized as has been assumed, perhaps indicating greater awareness and acknowledgement of the relationship between health and wealth now than at the time of the Tallinn Charter. In the Russian Federation, for instance, as in other countries represented at the meeting, some people have served in both ministries. In Belarus there is considered to be a particularly robust relationship between the finance and health ministries since members rotate between the two, leading to a consensus of understanding. Further, given the high prioritization of health, this has also provided popular support and high political dividends.

In Germany the situation was reported to have changed considerably. Instead of discussion of the negative implications of additional funding, the conversation between the two ministries now focuses on fiscal multipliers, such as the economic importance of a health sector that employs 5.5 million people. Further, the health sector had acted as something of an economic stabilizer at the time of the financial crisis. Instead of reductions in public spending on health with the loss of revenue, public resources subsidizing health insurance contributions had been increased, funded by taxpayer money, thus safeguarding jobs as the employer and employee shares were reduced accordingly.

Evidence on the contribution of the health sector to the broader economy remains weak, however, despite the growing body of evidence demonstrating the benefits of increased health spending. This was undoubtedly reflected among participants: 18% of those who took part in the initial poll considered that finance policy-makers believed that health systems threatened economic growth. A further 10% thought there was insufficient evidence that health and health systems contributed to economic growth.

Further, it remains difficult to know how best to communicate the existing evidence. In conjunction with the need to convince others of the potential economic and macroeconomic positive effects, it is as important to focus on how to achieve objectives such as a healthy workforce or an inclusive society in the most cost-effective way. Some

Box 5. Investing in health

Arguments for

- Demands for money are ongoing, given the demographic challenges and the arrival of new technologies and medicine.
- The need is sometimes unpredictable, partly due to critical events such as epidemics; equally, need is growing for investment in prevention and primary care.
- Even low-cost initiatives are expensive when applied to the whole population, but they also pay off at the population level.

Arguments against

- Money appears to disappear into a black hole as pockets of inefficiencies are being fuelled.
- Despite health technology assessments and return-on-investment analyses, health spending is not well evaluated.
- The fiscal and economic returns from spending in other areas such as education are greater and more evidenced.
- The health system, not individuals, has to have a price.

Source: WHO Regional Office for Europe (2018b).

participants clearly considered that it was merely a matter of flexibility in approach. Rather than framing investment as a strategic choice and thinking it would always add something, it may be more effective or preferable in some cases to consider it as a practical course of action. In other cases, however – such as primary care – it may be better to consider spending as an investment, the value of which will be realized in the longer term.

It was repeatedly emphasized that health expenditure is ever increasing, absorbing more and more resources; that is the case even before the full effects of population ageing have taken hold. One difficulty for health ministries is that not only do they have to create a good case and communicate it effectively, it must be as good as – or better than – that of other departments, as well as reflecting the policies and priorities of the incumbent government. Discussions in both the plenary and parallel sessions illustrated the extent to which such conversations between ministries might vary and, importantly, the nature of evidence that might be needed, at what level and in what circumstances. Further, it became evident in discussions that instead of focusing on whether money will be forthcoming, more often than not the debate was on where it might be spent and its related cost-effectiveness. Again, the country context was observed to be critical. Box 6 highlights the nature of the debate in some participating countries.

The initial poll also revealed that just over a fifth of participants, who comprised both health and finance ministers, believed that one of the most common reasons for questioning the value of greater investment in health is that health policy-makers need to demonstrate efficient and responsible use of existing resources before being awarded further funds. Although likely to be a matter for all ministries, there needs to be evidence that waste is being eliminated, that there is a return on investment and that policies are cost-effective, at the same time as providing safe and appropriate high-quality services. The view that appropriate performance measures are also needed to take into account potential fiscal multipliers, including both “social” and economic efficiency, was as common.

Part of the problem, it was thought, is that it is not a simple equation: raising the budget does not automatically mean the well-being of people will be improved. Nonetheless, given the difficulties of using GDP as a measure, what has proved effective for encouraging investment in some cases has been to focus on specific government concerns, such as the employment rates of those aged over 55 years or showing how much it costs to save a life-year in a particular care programme. It was also pointed out that it might be more useful not to have specific and separate rates of return on investment for different conditions or for different services all competing for funds, but instead to monitor health budgets and spending as a whole, as was the case in the monitoring of budgets in some countries.

Collaboration and cooperation across the board would clearly always be more effective than competition over budgets between different parts of the health sector. Key, too, is ensuring a cross-departmental approach if need be, and one important example here is the need for cooperation on levels and use of taxation such as a sugar tax. Similarly, it is all very well having well laid plans in the development of the health care service, as a representative from Kazakhstan noted, but if the workforce or even appropriate health infrastructure is inadequate, the task is impossible. Considering investment within a paradigm of time is also important for thinking about cost-effectiveness in the short, medium or long term. Some argued strongly that instead of thinking about immediate health needs, it is the future that is of paramount importance. Multimorbidity and person-centred care, for instance, are likely to necessitate different provider structures that will demand reallocations of money – for example, from hospitals to primary care. This was seen to be a tall order but one that will become very important.

Box 6. Approaching the dialogue between health and finance

In **Austria**, following the financial crisis, the ministry of finance was shown, in an Excel format, what would happen if €3 billion euros was cut from the budget. This approach led to political agreement between the health and finance sectors. For the last few years, monitoring reports have been provided and, with the clarity of the numbers, no further discussions have occurred concerning overspending.

In **Lithuania** there has been a mix of both formal mechanisms enshrined in law and less formal negotiations. Since 1997 health insurance budgets have been the source of health financing, with contributions dependent on income levels and state support for those who are not economically active. The main debate has been over services that are provided irrespective of insurance status, such as ambulance care and some preventive services, since all others are decided by law.

In **Kazakhstan** it appears to be up to the ministry of health to make the difficult decisions and to reallocate funds in the short, medium or long term. Although this seems an ideal situation, it is clearly a double-edged sword. Hospital providers, for example, tend to have a stronger lobby than that of primary care providers, which tends to be far weaker and poorly organized. One observer also noted that such vested interests were more evident in the case of pharmaceutical companies. Tackling high drug prices may often conflict with the support companies receive from the finance ministry owing to the investments in the country.

During the crisis **Poland** encountered both social and political pressure to invest in health, bolstered by external investment, among other factors. The challenge had very much been to decide where investment should be allocated; in the end it was particularly targeted towards both specific areas of care such as hepatitis C and preventive health, including vaccinations. As pointed out later in the meeting, supporting an area of preventative care, however, may only be the first step. Exploring a package of interventions known to be successful in tackling obesity, for instance, might only be cost-effective in countries which could afford interventions such as one-to-one physician interaction.

4.3. Investing in primary care

Primary care investment was a subject of particular debate within the parallel sessions, given the rising need for primary health and health care services and in light of the dearth of measurement tools in this area of care. The vast majority of cases of NCDs, for instance, could be successfully managed at primary care level – only a relatively small proportion of cases need referral to specialist centres.

Opinion was divided, however, on whether investment in primary care would be cost-effective. Examples from the Nordic model based on strong primary care focused attention on the wealth of evidence available in this field and it was argued by some that unless there was investment in primary care, the battle in the secondary and tertiary care sectors will be lost. Others, on the other hand, suggested that not only is such investment costly, it demands a longer-term vision; this is made harder with budgets and monitoring that are often conducted on an

annual basis. In Belgium, for instance, owing to the fragmentation of primary care, it is predicted that it would take 5–10 years to lower costs and see promised efficiencies. A reorganization would also be needed prior to any investment. Austria, believed to have a weak primary care health system with one of the highest rates of hospital admissions in Europe, is tackling the challenge in a “piecemeal” fashion, but again whether this will be more cost-effective is unknown.

Although Slovenia had invested only relatively small amounts in primary care with a view to reaping the benefits in the longer term, it had started the process at a local level, establishing small health centres including appropriate specialists in local communities, thus bringing services to the population. As part of this process, partnerships were developed between local stakeholders such as the municipality, civil authorities, health institutes and so on. Three further pilot projects to include long-term care in these centres have been established.

The lack of access to health provision in rural areas had also been a driving factor for investment in primary care in Romania. As in Slovenia, there had been close collaboration with the local municipalities, who had been designated “lobbying partners” for the health ministry, given the important preventive element in primary care provision. In other countries there was evidence that sourcing investment for primary care had met with particular obstacles. In Kazakhstan there was seen to be mistrust of the quality of care at the primary care level, and substantial investment was needed not only to support the infrastructure and redesign of primary care but particularly in terms of the workforce in the face of a growing population.

In Lithuania decisions to rationalize hospitals and move care into the primary care sector had been made harder because hospitals are owned by municipalities, which are not responsible for the finance that comes through the national insurance fund. Of note, however, were countries where there is a strong tradition of primary care such as the Netherlands. While building new infrastructure such as hospitals, the health ministry was also responsible for steering the reorganization and reallocation of funds to the primary care sector, given the expected health and health care demands of the future at this level of provision.

Inherent in this discussion was also a focus on the nature of existing and needed professional competencies in terms of more patient-centred care to enable clinicians, for example, to help patients navigate chronic conditions. Involvement of patient groups and associations and the need to stimulate greater civic society participation in health governance, advocacy and in monitoring and evaluation was also seen to be of particular relevance in the development of primary care.

4.4. Getting serious about prevention: investing in public health

The burden of disease in the European population has shifted over time from a predominance of communicable diseases to one of NCDs (Jakab et al., 2018). Five conditions (diabetes, cardiovascular diseases, cancer, chronic respiratory diseases and mental disorders) account for 86% of deaths and 77% of the disease burden in the European Region, making it the WHO region with the highest NCD burden. Behavioural and metabolic risk factors play an important role in increasing NCD incidence, leading to calls for a fundamental reform of health systems and spending, with a radical shift towards prevention.

The policy brief *Using economic evidence to help make the case for investing in health promotion and disease prevention* (McDaid, 2018) provided the backbone for the session Getting serious about prevention: investing in public health. The central messages outlined in this session are listed in Box 7. Underpinning the discussions in this session was the realization that there is now a large evidence base in support of highly cost-effective actions. Although there are still gaps, this includes data on various preventive actions, different kinds of public health interventions, the economic return on investments and so on. Nonetheless, spending remains modest: even in the highest spending countries it is no more than 5% of health care expenditure, and the average is 3% (Gmeinder et al., 2017).

During ensuing discussions, it soon became evident that the notion and concept of prevention and public health was thought to have shifted since 2008. The goals may not have changed but the evidence base – and how it is portrayed and presented – was seen to have moved into a far more positive position: prevention programmes,

Box 7. Approaching the dialogue between health and finance

- Many reasons account for why spending remains low, including a need for better communication to create and facilitate partnerships by:
 - creating intrasectoral links such as with primary care and secondary care;
 - creating intersectoral links – for example, working with ministries of finance, education, transport, justice and local government; and
 - using financing mechanisms and economic evidence to stimulate collaboration and cooperation.
- Appropriate evidence should be highlighted at an intersectoral level by showing the benefits of investment in terms of mid- and long-term health system benefits, such as reductions in health care and especially long-term health care usage.
- Appropriate knowledge and evidence should also be highlighted at an intersectoral level to emphasize the wider benefits of healthier children, such as academic achievement, lower truancy rates, less teacher stress and so on.
- Use of return-on-investment tools, such as those commissioned by Public Health England for a range of interventions (see below), should be encouraged.
- Ways of working with others within and without the health sector to build up trust, common goals and common targets at a local or national level should be considered.
- The moral case for investing in prevention can be supported and enhanced by use of economic arguments. Highlighting the appeal of return on investment to those who work within or without the health sector is critical.

Source: McDaid (2018).

whether or not as part of a legal framework, were gaining traction, with increased enthusiasm for working both intra- and intersectorally.

Within this general framework, some participants observed that prevention – which is essential to UHC and particularly to the achievement of the SDGs – should be redefined and conceptualized within a different paradigm. It should be seen as a mechanism to improve or enable a better life at any stage of the patient journey. This led some to think that prevention should no longer be considered within the framework of hospitals, doctors and patients as a deficit model; instead, people, communities and populations should be considered assets who are able to help find solutions. Further, given that prevention can be an abstract concept to many, which may not inspire politicians to commit resources, segmenting the population and talking about groups in society may bring the narrative to life and be a far more productive approach. In the United Kingdom, for example, Londoners both young and old have been asked to work alongside Public Health England to help develop digital solutions to the kind of mental health service and provision they need. This is also being tracked with robust outcome measures aimed at giving politicians confidence about the use of resources.

As health care becomes increasingly expensive, prevention and public health input theoretically offers a glimmer of hope. Participants gave some indications, however, that politicians are slowly realizing that a preventive element should be included in any investment in a new programme of care. Of particular note was Public Health England's commissioning of return-on-investment tools, which bring together the best available evidence on costs, savings and health benefits for a range of interventions. So far, 10 models have been explored to look at areas of need across the health and social care spectrum. These have included colorectal cancer, diabetes, end-of-life care, weight management, oral health in pre-schoolchildren, mental health, movement into employment and falls prevention. Each model calculates a return on investment for interventions in various sectors over different time frames. For example, there might be a positive financial return for health and social care services through investment in

home assessment and modification services in the falls prevention model; in the mental health promotion model, investment in debt advice and management services might have a positive financial return for health and legal services and employers.

Although there may be areas where evidence remains limited, it was thought by some that the issue was not so much that data were lacking but rather how the evidence was presented and packaged. Many performance measures detail the effects of cure rather than prevention, and more attention and visibility should be given to metrics that clearly show relevant outcomes. On the other hand, it may be that the outcome measures should be seen within a different framework altogether and greater consideration should be given to societal values. Outcome measures could include, for example, whether a child is ready for school: a monetary value cannot be placed on this.

Others commented that although it was particularly important to demonstrate outcomes, it was equally pertinent to avoid the accusation that money was being “spent” rather than “invested”; for example, if new investment is made in nongovernmental organizations (NGOs), there is a need to ensure that built-in training is involved alongside evaluation and monitoring. An opposing view was also aired, though, that public health should not need to demonstrate outcomes. It is outcome focused, almost by definition, and, after all, the specialty grew up trying to prove itself. Exploring the various approaches to gathering support for public health outcomes, participants attending this session voted for two approaches from a choice of six that they considered the most relevant in the quest for investment: positioning prevention as an essential part of an overall health strategy, and highlighting all benefits of prevention to other sectors.

4.4.1. Positioning prevention as an essential part of an overall health strategy

It was stated early on in the discussion that there were always opportunities to ensure prevention was integral to an overall health strategy, not least because each political administration would want to make its mark and might well look for possibilities for aligning public health with political priorities. It was acknowledged that this approach would be very dependent on the individuals in power, and timing would be of the essence. If, on the other hand, a political administration is not interested in health, the only focus would be to try and find a place for prevention within the overall health strategy. Experience shows that this scenario requires building relationships and understanding, cooperating with clinicians at a local level and working together closely.

It was observed that a shift had taken place in the mindset of public health practitioners over the last few years, from having to explain the content and nature of the specialty to needing to be tactical, strategic and even politically astute. Nevertheless, an overall picture remains of public health potentially being a “Cinderella” service, always having to grasp opportunities when presented: it was noted that a chance to align objectives and goals and to collect and evidence outputs should never be missed.

A stronger legal framework, however, has now been applied in Germany, where the Prevention Act dictates that stakeholders from within and outside the health sector have to decide on a national prevention strategy with the aim of preventing disease and encouraging people to make healthy choices. A total of €500 million is invested annually, and a range of different sectors at both national and local levels have to define shared aims, goals and projects. For instance, one project focused on bullying, not least because of indications that it is linked to obesity. In Hungary, too, a prevention programme was activated under the auspices of the Ministry of Human Resources, which has responsibility for sport, education, social activities and families, with another to be launched.

In Finland, there have been shifts at both local and national levels. As in Germany, legislation is now in place and it is the duty of local authorities to consider prevention. It was the process of intersectoral activity, however, that had made the significant difference with everyone working to a common approach. Another interesting example is Slovenia, whose policies reflect a number of the discussion points raised in this section (Box 8).

Box 8. Public health initiatives in Slovenia

Public health professionals in Slovenia have always had to compete for resources with health care, but a new tobacco control law offered an opportunity to generate more funds for prevention and promotion from the state budget. It was proposed that an increase of 50 cents in the tax on each purchase of tobacco should be dedicated to funds predominantly directed to prevention and promotion. The proposal was strongly backed by an intersectoral partnership with NGOs. Initially rejected by the finance ministry, negotiations centred on prioritization of prevention activities that were evidenced based (healthy lifestyles, smoking cessation and similar) but costly. It was finally agreed that €4 million of additional resources would be assigned for the next two years, in addition to the €0.5 million already allocated.

The lesson learned was to “think big”. Demanding large investments with appropriate evidence worked; this included evidence on how much it would cost to do less or nothing.

In addition, Slovenia successfully secured financial resources from the European Cohesion fund to carry out several projects within the field of employment, for empowering target groups to enter the labour market, and in the field of social inclusion, in particular for population groups such as children with special needs and those unemployed for health reasons. It was argued that the empowerment of individuals in the areas of healthy lifestyle, reducing alcohol consumption and implementing harm-reduction activities for drug abuse significantly contributes to higher employment rates among vulnerable groups.

Strengthening primary care and upgrading preventative programmes are also predicted to provide an integrated community approach that would result in better social inclusion of the total population, including vulnerable groups. The development of 25 health promotion centres within primary care centres is already under way, as is the establishment of 10 mobile units that employ health professionals and social workers in harm reduction programmes.

The experience drew attention to the reality that in intersectoral negotiating it is necessary to prove that the impact of resources would be beneficial to all sectors including health. Involving institutions and professionals from other sectors in the development and implementation of such projects from the start is critical. In particular, a close working relationship between NGOs and the public health sector has been pivotal.

4.4.2. Highlighting all benefits of prevention to other sectors

Understanding and conveying how investment in health could benefit other sectors is important but, by the same token, it is equally important to describe to others how health could help their own investments. Indeed, one observer noted that it was not so much health in all policies but rather health for other policies. Once again, to achieve this there needs to be access to data, proof and appropriate knowledge.

Certainly, being far more aware of the finance sector, understanding investment priorities and enabling shifts and reallocations of money away from buildings and infrastructure and towards capacities, skills, prevention and promotion should be part of the overall context. Presenting appropriate evidence and offering guidance for evidenced-informed decisions would slot into this. In the United Kingdom again, social impact bonds, in which contracts are offered on the basis of achieving particular social and health outcomes, are being considered and under development.

Many acknowledged that including health in, or for, the policies of others is no mean task. It was, however, generally recognized that instead of telling professionals what to do or how to do it, participants now talked of a more conciliatory and empathic approach – offering advice, for example, to schools on food and nutrition or road safety – rather than being the central protagonists or what might be termed “health imperialists”. Some talked of the need to build high-trust relationships and emphasized the requirement for public health professionals to be imbued with emotional and social as well as intellectual intelligence. To work successfully with finance or transport sectors, a degree of humility is required and learning to live in others’ shoes becomes a priority.

Although it clearly varied between countries, contexts and individuals, there was a call not only for greater investment but also perhaps for a different kind of training for public health specialists. Today's public health training may become unrecognizable in the future, with the inclusion of social and emotional intelligence, governance, finance and knowledge of other sectors. In the United Kingdom, for instance, the problem is thought to be not so much the numbers wishing to enter the public health profession but how best to deploy them, maintaining motivation and ensuring that they are adequately supported, with the appropriate professionalism.

5. Innovate – harnessing innovations and systems to meet people’s needs

5.1. Understanding innovation

While it is clear that health systems must be inclusive as well as sustainably and strategically financed, they will not deliver without keeping pace with changes both within and outside the health system itself. Pressures come from within the system, such as the rising burden of chronic health problems and multimorbidity and the ageing population; equally, the health sector is confronted with rapid changes in technology and technological innovations. Policy-makers have recognized these challenges and opportunities, and many countries are considering how to introduce and manage system-wide and technological innovations, to steer them with appropriate policy regulations and to link innovations with relevant health system functions and objectives.

Innovation can be difficult to define in the context of health and health systems, given the elasticity of the concept, but in this context innovation was defined as something new and discontinuous with the past. For the sake of the discussions during the meeting, it was categorized simply as follows:

- new approaches to health services delivery and system design; and
- new technologies – including drugs, equipment and software.

Some participants noted the blurred distinctions between “evolution” and “revolution” and whether an innovation can be merely a service improvement. This also raised the question of whether innovation in technology can be disentangled from service innovation in practice. It was clear that definitions are fluid and there were calls for harmonization of meaning across Europe.

It is crucial that innovations are not deterministic for the system. Rather, health policy-makers and managers should steer innovation towards delivering people-centred, efficient and high-quality health services. It is equally important that health systems are able to respond quickly and effectively to the deployment of innovations. Ensuring the necessary and appropriate receptivity in the system as a whole and in service provision is, of course, essential; but in order to maintain the values of the Tallinn Charter continuous vigilance in supporting equity, solidarity and sustainability is needed.

A plenary introducing the central issues involved in making innovation programmes in health and social care work sparked the discussions that followed, including in the parallel sessions. The plenary was based on the nonadoption, abandonment, scale-up, spread and sustainability (NASSS) framework and the more recent update that concentrates on the NASSS complexity assessment tool (CAT) (Greenhalgh et al., 2004; 2017). Box 9 outlines the central tenets of the framework, which is further illustrated in Fig. 10.

Box 9. How to make innovation programmes in health and social care work

Many of the recent innovative developments in health systems focus on the integration of health and social care. Key areas of research interest have been a range of technologies for use in service provision.

Technologies can be divided into “simple”, “complicated” or “complex”:

- simple is easy but however simple it seems, it is never really simple;
- complicated is difficult, slow and expensive; and
- complex may be impossible – reducing complexity is therefore key.

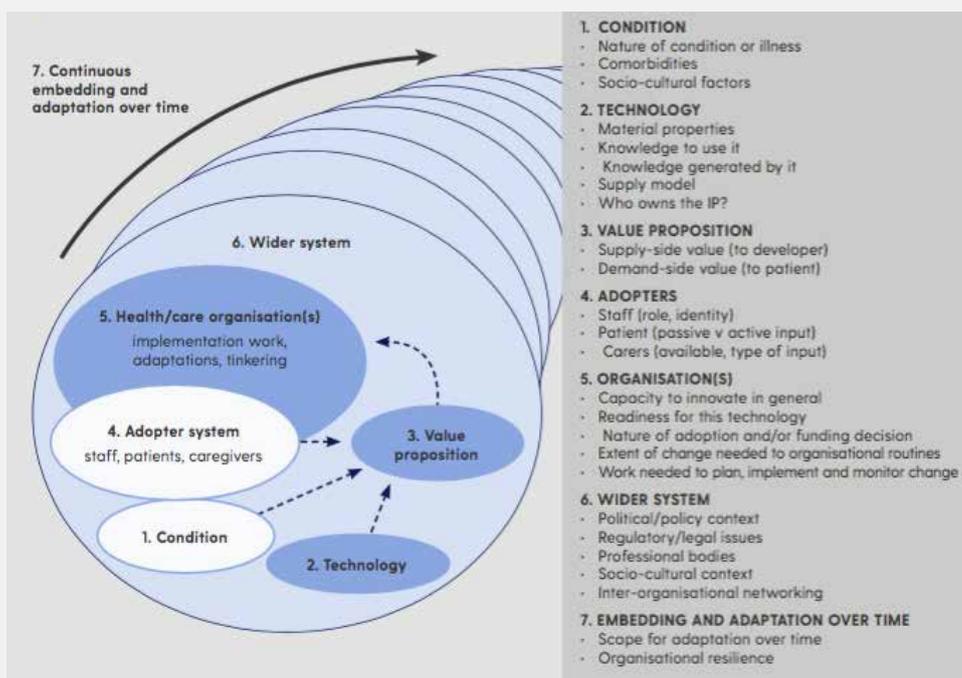
The NASSS framework has seven domains:

- the nature of the condition;
- the nature of the technology;
- the value proposition;
- the adopter system;
- the organization;
- the wider context;
- embedding and adapting over time.

Developing practical tools, the NASSS CAT is used to:

- identify and understand the complexities in the system to tease out uncertainties and interdependencies;
- reduce complexity wherever possible by limiting the scale and scope, unlocking the interdependencies and exploring the nature of the pace of implementation; and
- “run with the complexity” – for example, strengthening programme leadership, building relationships, managing conflict, co-developing a vision, developing staff teams and resourcing their creative action, controlling programme growth and improving the policy and/or regulatory context.

Fig. 10. The NASS framework



Source: Greenhalgh et al. (2017).

5.2. The wider context

Taking the relevance and importance of the wider context as the starting-point (NASSS domain 6), participants explored the complexities at the health policy level and strategies that had been and were being employed to encourage innovation. It is difficult to separate the interdependency of the need to accelerate health system reforms, given the challenges of demography and the co-morbidities of NCDs, and the role that innovation plays or could play. Clearly, innovation has the capacity to move reforms forward, but as the experiences listed in Box 10 show, it remains difficult to know how fast to go, and whether the various components – such as governments, organizations, the health system and the technology – are adequately robust to deliver success.

Box 10. Working with innovation

In **Belgium** access to innovation in both pharmaceuticals and technology was seen to be inadequate. Working closely with both sectors, greater space for innovation was found by lowering the prices of “off-patent” pharmaceuticals and reallocating the savings to innovation programmes. Notably, the partnership working is – and needs to be – on a continuous basis, not least since resources are limited. Thus, new drugs are now fast-tracked, with shortening of reimbursement procedures, and evidence shows that access to certain drugs has been faster.

Sweden has also adapted reimbursement processes so that decisions are made earlier and constant real-time follow-ups are carried out with help of the industry. Thus, although patients can access drugs earlier, there are also checks to ensure that decisions are correct and that the drugs are of the appropriate quality. The driving force in Sweden was very different, however. Aside from its pharmaceutical policy, the main concern had been with the implementation of innovations rather than their acceptance into the system or the lack of early adoption. As a result, the approach was to look more strategically at governance across the system. This included examining sustainability, pooling of funds, risk analysis, how the innovation might be dependent on or interdependent with other parts of the system and ongoing work with pilot schemes to ensure evaluation and monitoring. The process has meant travelling at a slower pace, but it has also enabled easier full-scale implementation.

One example is a website that has changed the delivery of health care services in terms of how personal information can be accessed, how a doctor can be contacted, the promotion of self-care and so on – all of which is evidence based. Promoting innovation by governance has also been central to the emphasis on health promotion and preventive measures in the primary care sector. Pilots have been implemented that are characterized by health dialogues taking a clear patient-centred approach, part of which involves using both visual and digital tools. Key to this process, too, are constant evaluations exploring health outcomes as well as cost-effectiveness. Linked to these processes is consultation with patients, families and other stakeholders to explore their needs of service provision. The key component of whether the innovation will be used appropriately and effectively is thus part of the initial programme design. Fostering new cultures to ensure prioritization and time to think, to make mistakes and to maintain the innovation drive across the organization and system has very much been part of the overall plan.

In **Finland** assuring multisectoral governance at the policy level has been particularly beneficial. During two consecutive coalition governments there has been political agreement between the ministries of education and science, economy and employment and social affairs and health. One practical outcome has been new legislation on the secondary use of health and social data, which should take effect late in 2018. This will lead to the introduction of a new public permit authority for access to various data sets including health data. Conscious of the proliferation of local and regional data warehouses since the 2013 Biobank Law, including the development of electronic health records and other registries, it was considered essential to have one entry point and access route rather than pursue the burdensome process of obtaining individual permits for each set of data. The new body will be able to assess each application and bring the data together for anyone with an appropriate permit. Although this move was a response to the rapid pace of technology, it was also prompted by a need to facilitate the framework of a national innovation platform. Conscious of the European Union’s General Data Protection Regulation and other ethical considerations, central to the development has been the involvement of and partnerships with stakeholders, including private and public bodies, regional authorities, academia, research institutes and the technology sector.

Countries have also followed a range of approaches to realize the possibilities of working through alliances to foster innovation both internationally and nationally. Belgium, for example, formed an alliance initially with Holland and Luxemburg, now to be joined by Austria and Ireland, to source medications against “orphan diseases”, given the low prevalence in each individual country. The Visegrad Group that includes Czechia, Hungary, Poland and Slovakia works in partnership to decide how to frame a common process for negotiations with the pharmaceutical industry. Such alliances also have the advantage of not having to depend on political administrations that may change; they facilitate pooling of research and resources and create a level of sustainability. The benefits of international health technology assessments were also seen as critical for smaller European countries – not simply to share knowledge and research but also to approach the more difficult ethical issues inherent in, for instance, collecting data on genomics.

Realizing the benefits of cross-border partnerships in the realm of public health, the European Public Health Association joined forces with 60 other European NGOs to act as a lobby group. This includes health workforce professionals, patients and NGOs active in the social and environmental sector, and involves working with consumer groups. The innovative move aims to create new narratives that engage and inspire people to promote the benefits of prevention such as health and well-being, rather than focusing only on economic dividends that are less likely to galvanize investment and support.

In the national context, the role of the National Health Conference in France, comprising 120 members representing all the stakeholders in the system – including local authorities, professional establishment organizations, unions, health and health care professionals, patient associations and service users – is to provide recommendations to the health ministry about health policy and the way it should be implemented. Part of its remit is also to implement innovation and ensure that everybody will benefit. Given the size of the group and the range of stakeholders, reaching consensus can be hard, but despite the sometimes slow and arduous process, the ministry does heed the Conference’s advice. There has also been a call to set up a specific department of innovation within the ministry of health to encourage greater coordination, new ways of delivering services and information sharing.

Through loans from the World Bank, alongside capitalizing on the country’s wealth, Kazakhstan was able to develop a national health technology agency, which is officially recognized by the ministry of health as the authority that decides on the health technologies to be recommended for state funding. The evidence for a technology is explored and decisions are made on that basis. Unlike the approval given for a new home-based defibrillator (see section 5.3), for which the benefits outweighed the costs, proposed neonatal screening for newborns with congenital immunodeficiency syndrome was rejected because of the cost and the low prevalence of the condition.

An additional concern raised concerned building internal partnerships and the nature of the relationship between academia and business. Academia may often be at the forefront of new initiatives, but it is the private business sector that subsequently carries them forward. There was a call among participants for greater partnerships between academia, industry, policy and citizens. In the United Kingdom there is a move to encourage greater intersectoral relationships, such as through students or career researchers being sent to work in policy or industry as “researchers in residence” and so on. Similarly, in Sweden a national authority fosters pooled resources from academia and the private and public sectors to promote innovation. Seed money is granted to projects to test innovations, but assessment and evaluation – to make it easier for transfer to other parts of the country or other organizations – are part of the conditions of the grant. It was noted that in the early days of the intersectoral partnerships and steering groups for the biobanks, genome centre and so on in Finland, there had been some anxiety on the part of representatives of academia that their impartiality might be compromised but it is thought this is no longer the case.

5.3. Governing technological innovation

Members of the panel in this session reiterated that innovation, as with any other health reform, has to have a clear plan and goal, a vision, an understanding of what needs to happen to enable it and how the new system will operate, appropriate access to data and information and requisite training of the workforce. Critical to the introduction of innovation is how it should be governed both to provide initial stimulation and to discover what is effective or worthwhile.

As observed earlier in the meeting, assessment of new technologies has to be ongoing, but a distinction needs to be made between drug assessment through randomized controlled trials and software, which is an evolving technology and a moving target. When drugs or other technological devices are introduced to the market, though, they also may – and some argue should – transform the delivery of care, adding another layer of complexity. This is exemplified by the introduction of a magnetic resonance imaging-compatible cardio defibrillator in Kazakhstan, which allowed patients to be monitored from home, potentially preventing unexpected and sudden death. The defibrillator necessitated a change in service provision, however, as the technology required staff monitoring 24 hours a day. Further, if a technological innovation is pushed through in a way that is not accompanied by other transformational processes, the costs are likely to be higher than improvements made in other sectors.

Awareness of the legal and regulatory framework that might be encountered was seen as a major hurdle, ranking alongside the necessity of being totally cognisant of the scientific evidence before a project starts. It is not appropriate, or even possible, for the drive for innovation to push through or force regulatory and legal changes that might be needed. Approaching a project from this standpoint could also exacerbate the sense of an innovation being “top-down” rather than one that might have developed more organically. Participants were reminded that it is often more effective to initiate a large number of small changes than a small number of large changes, which may get suffocated at birth by regulatory or quality assurance processes. In one example presented, a new practice of employing skilled nurses instead of junior doctors in hospital emergency departments was halted as it resulted in having the wrong ratio of doctors to nurses.

In some countries legal routes have been taken to ensure appropriate governance procedures. Due to its particularly cumbersome financial regulatory system, France has introduced a new law strengthening the country’s capacity to innovate, allowing general deregulation of the financial and organizational rules and encouraging a “bottom-up” approach with greater partnership working. It had previously been beset with examples of poor practice, such as that of telemedicine pilots, where effective technologies had not been disseminated or marketed effectively because of legal complexities, with the result that each fell at regional or national hurdles. This had also been the case in Poland where, due to the proliferation of departments, decision centres and a number of conflicting interests, a number of innovations had simply failed to get taken up. One example was the use of a T-shirt that could monitor the body functions of elderly people, which had been shown to be both cost- and clinically effective.

As in France, change occurred in Italy with a new law designed to limit the impact of litigation and malpractice, but also intended to counter the impact of the spiralling cost of drugs. Underpinning the law was a belief that if innovation in health provision is not approached in a systematic way, budgets soon become unsustainable. It will be compulsory for clinical practitioners to follow clinical guidelines that include drug and medical device innovations produced with the input of scientists and clinicians.

In the set-up of pilots comprising the use of mobile health units in different fields of care in Belgium, the regulatory framework involving all the stakeholders was considered as important as the financing and necessary data gathering. Ensuring that patients received the care more quickly at the same time as undertaking monitoring and evaluation was challenging and involved a concerted effort from parties to work together productively. In this case, doctors tended to have responsibility for the mobile health devices, while their quality remained the responsibility of industry.

Developing effective governance procedures is, of course, brought into sharp focus with the development of e-health. In Belgium a new web-based portal has been developed through which every citizen is able to consult their own health records, as well as past diagnoses and results. A new platform has not been initiated and, as a result, this has led to a good deal of discussion about linking and sharing the data and which authority has responsibility for which datasets.

Keeping up with software updates and their assessments has been a problem in Estonia, where it was noted that the present software does not necessarily support the format of the selection of data required. This has meant in practice that doctors have to delve into a number of digital documents, reading each one. More innovation was called for in devising new assessment tools; it was suggested that it may be appropriate to explore assessment processes and protocols used by those outside the sector, such as social media giants.

Incentivization was also a subject of debate during discussion. In the initial poll 22% of participants agreed that the lack of incentives for organizations to adopt, implement and sustain innovations was a reason the benefits of technology are not being reaped. Clinicians in Belgium, for example, are financially incentivized to use electronic prescriptions. Kazakhstan has introduced the United States Joint Commission International accreditation system for hospital standards. Although this may be a costly service for hospitals, they are awarded more money, which in turns stimulates greater investment; it also acts as an incentive to other hospitals to become accredited. It was also argued that, given the resistance to change in Austria, for example, one successful method had been to attract younger general practitioners (GPs) by giving them more resources and encouraging them to consider that the innovation was not the technology itself but the way it was used in practice.

Nevertheless, incentivizing through financial resources raised questions for some participants. On the one hand, carrots and sticks may work well, and payments may also have the benefit of drawing attention to the new technology and providing an opportunity to encourage the spread of information and changes in practice. On the other hand, the workforce may become more self-interested and, more importantly, the process can reinforce a negative perception that the initiative in question is being imposed by managers, resulting in a lack of buy-in from clinicians.

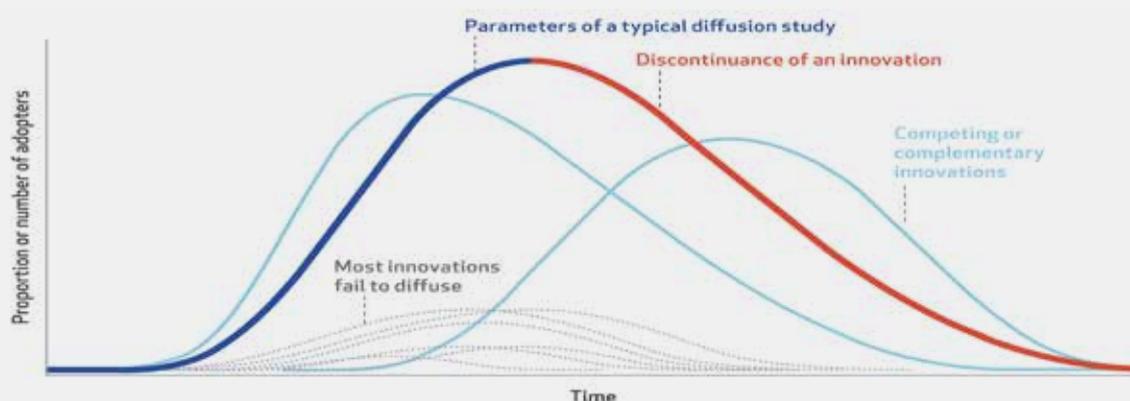
5.4. Innovative service design and delivery

Building on the plenary session, the central tenets of the policy brief *How do we ensure that innovation in health service delivery and organization is implemented, sustained and spread?* (Nolte, 2018) were outlined. Emphasizing the numerous challenges that health systems face, countries have unsurprisingly invested and experimented with novel ways of designing and delivering services, ranging from disease management programmes to health population management systems.

Terminology in this field is complex and it is important to acknowledge that change and innovation processes are not linear. The related concepts of adoption, implementation, sustainability, diffusion, dissemination and scaling up are often ill defined, with interdependent complex relationships; for example, there are feedback loops between adoption and implementation, between implementation and sustainability, and so on.

One of the main barriers that countries face is the need to “spread” the success of pilots to go beyond the initial phase or local setting. Most innovations fail to diffuse effectively, and even if they have been spread successfully, they are often discontinued (Fig. 11).

Fig. 11. Why innovations fail to spread



Source: Dearing & Cox (2018).

Empirical evidence on which factors are most conducive to the successful “spread and share” and scale-up of innovations is limited, however. From the examples of three countries where models of care coordination and integration between primary and secondary care were introduced successfully, a number of key factors were identified (Box 11).

Box 11. Facilitators and key questions for the spread of innovation

Facilitators of innovation diffusion are:

- leadership and management at different tiers that are supportive of and committed to change, including appropriate governance and management mechanisms, a clear and compelling vision for the innovation and sustained support for those involved;
- early and widespread stakeholder involvement, including staff and service users securing buy-in through structures, guidelines and so on – this also includes buy-in from the medical profession, involving clinicians throughout the process;
- dedicated and ongoing resources, including funding, infrastructure, capacity-building, staff development and enough time devoted to enable organizations and services to learn to work in new ways;
- a strategy designed to ensure effective communication across the organization;
- ongoing adaptation of the innovation to the local context, focusing on what is relevant and works locally;
- ongoing monitoring and timely feedback about progress, systematically collecting data to assess performance and identify opportunities for further improvement and/or problems and ensuring costs are set aside for this;
- evaluation and demonstration of the (cost-)effectiveness of the innovation being introduced, including assessment of health benefits;
- strong political support and (probably) adaptation of funding models, as well as evidence of effectiveness vital for spread and scale-up.

Key questions to ask include:

- Is the innovation worth introducing? Who will benefit and how? Will it further inequalities? Are there other unintended consequences? Do other local factors work against it?
- What is the commitment to continued monitoring and evaluation? What type of evidence is available and what is needed? How can evidence of costs, quality and outcomes be balanced?
- How, and in what ways, will the perspectives and priorities of the public and service users in service innovation be considered and heard?

Although international and national cooperation was clearly seen by participants to be part of the wider picture, innovation is ongoing within the local ecosystem, and this raises important questions when it comes to sharing learning and understanding the introduction of new technologies. One example that was noted repeatedly concerned video consultations. Although widely used, these still raise a number of questions, such as how reimbursement might take place, what kind of health matters most appropriately lend themselves to video – or even audio – consultations, how patients are prioritized, the differences in the use of the technology in rural or urban areas and so on.

It was clear from the debates at the meeting that there was general consensus that innovations need support and leadership at multiple levels, from the political to the local context. A quarter of participants in the initial poll, for instance, believed that benefits from innovations are not seen due to the lack of professional leadership, incentives, skills and training evident in the failure to adopt and implement them. Coherent vision and planning need to be there at the outset. In this context, an additional barrier to creating the necessary receptive context is a concern that hospitals and other organizations within the health sector are often not able or ready to become “learning organizations”. These require the necessary leadership, an appropriate organizational culture and, above all, money and time in order to take stock and reflect. As significant is the ability of organizations to allow for failure in introducing innovations and the need for a pragmatic balance between a robust approach to due diligence on the one hand and having a climate where both people and organizations are confident enough to take risks on the other.

A further concern voiced was that innovations in medical practice often precede any accompanying necessary policy, reflecting a broader issue of the pace of innovation in comparison to that of policy implementation. As a result, parallel, competing or complementary innovations are often all running concurrently. This was noted in Sweden, for example, where there was awareness that the assignment to evaluate physician audio consultations took place within a three-month period, but during that time such consultations were taking place all over Sweden. This has also been observed in the United Kingdom. It often leads to duplication and a resultant waste of resources; it thus becomes a daunting challenge to integrate the different models locally and regionally.

Moreover, the significant shift from piloting to mainstreaming the innovation can come into conflict with governance processes. Pilots can have the full support of management and staff, but to become part of the mainstream and standard operating procedure often results in removal of the leeway and flexibility allowed in the demonstration project. In pilots, too, factors such as opportunity costs are not taken into account. For example, in New Zealand a key success factor in one pilot was that the strong pre-existing network of professionals working together. During the pilot, the head of the network travelled to every single GP practice to keep them on board; this was clearly not sustainable in any scale-up. One option, adopted in the Netherlands with GP care groups, was to “dilute” the original innovation, which involved specialist nurses supervising GPs, but the roles had to be reversed once it was scaled up, owing to local situations. Flexibility and adaptation to the local context are critical. Box 12 reflects the varied experiences of health policy-makers in three different countries.

Box 12. Spreading innovation – examples

Experience in the Emilia-Romagna region of Italy shows the effect of a number of key factors, such as having a cohesive policy and clear priorities, one budget, appropriate evaluation and stakeholder participation and so on. The regional government supported a new social and health plan with a top priority to tackle frailty, poverty and social exclusion through social and health integrated policies, prompted by poverty among young people and demographic changes. Involving 500 stakeholders, including a range of institutions, unions, third sector organizations and patients, a large participatory process was launched using a number of innovative approaches. Three clear priorities emerged: making the best of the new legislation the region was approving on social and employment inclusion; strengthening the role of the social and health district; and supporting the development of community care settings and promoting home care. Five cross-cutting areas were identified, one of which was to support the autonomy of people within their life context. For example, one initiative was to change service delivery for patients with mental health problems. The Regional Board for Mental Health, which includes active participation from patients and families, agreed to customize services around the patient, including all the social determinants of health and well-being, with full agreement from both patients and families. Controlled by a centrally held budget, the project was very much rooted in the local health and social community, with services provided within that context. In two years, 2500 schemes were launched; as most patients are still involved, evaluation has been ongoing and constant. There is already evidence that those diagnosed with schizophrenia are coping significantly better than those not covered by the project, and the length of stay in one residential care unit has dropped from 30 days to 12 days a year. Despite early successes, however, a number of barriers remain that may prevent national take-up. These include some difficulties with professionals in their support for the new approach, and the continuing stigma of mental health, which is thought likely to cause difficulties in other social and economic contexts, making scaling up difficult. Nonetheless, the same approach is being tested for other targeted groups such as substance misusers and those with disabilities.

....continued **Box 12. Spreading innovation – examples**

Norway is a good illustration of the lack of linearity in health reforms and the importance of taking small steps. The 1999 Patient Rights Act and the subsequent practitioner regulation meant that everyone had access to a family GP; this was followed by a further reform in 2012 that aimed to create better cooperation between specialist health care and primary care, with an emphasis on improving prevention and local health provision. Nonetheless, unintended consequences began to emerge, such as the legal ramifications of the reforms, which created some inflexibility in provision. Moving specialist care to the primary sector also proved difficult due to the difficulties of transferring resources. Consequently, structured clinical pathways are now being set up, ensuring rights for patients and increasing coordination. The intention is to avoid unplanned admissions and to ensure coordinated care through best practice, supported by a digital framework monitoring the data. Using the NASSS framework to ensure management and leadership support, adequate resources and buy-in from both health workers and patients, 50 such pathways have since been set up in areas such as cancer, stroke and mental health. Similar programmes for patients returning home, substance misusers and those with mental health problems are now in development.

Ukraine presents a very different picture. Here health reforms have been fast, almost “leap-frogging” (European Observatory on Health Systems and Policies, 2018), and have occurred within a shorter space of time than those of other countries. In particular, there has been a drive to transform and grow primary health care, including creation of a new e-health system. All citizens are now able to choose and sign a declaration confirming their primary care doctor. At the same time, however, there is a need to keep track of who patients were choosing and how doctors were to be paid through the health insurer. A consortium that comprised the private sector, NGOs, patient organizations, experts (both national and international) worked together to create an e-health system considered to be open and transparent to provide the data. The e-health records belong to the patient rather than to the government or the medical information system, and agreements were made with the 11 medical information services that their use comes at no cost. The system will improve primary care but will also enable tracking of patients, providing necessary public health data and producing the requisite information for clinicians to be paid through the health insurer. Sign-up has exceeded all expectations. Of particular note is that the unintended consequences have been positive: 30% of Ukrainians had no Internet coverage but this is fast changing – there was a requirement for physicians to have access to e-health and local authorities have subsequently provided the service. In partnership with Canada, Ukraine is also developing telemedicine connections to remote areas to enable patients to self-monitor. The Canadian experience has seen a reduction in hospitalizations and significant savings in terms of travel costs for both health professionals and patients.

The example of Ukraine also draws attention to the fact that innovations do not happen organically: future health care depends on the growth of new technologies and innovative practices. As a result, more resources are being invested in research and development in the country, as well as in the development of partnerships between government, academia, industry and NGOs.

During the discussion in this session, the work of the European Innovation Partnership was discussed. Described as a bottom-up initiative comprising a range of players including payers, buyers, purchasers, services deliveries and local authorities, it examines good practice in different settings and whether it could be scaled up to other settings. It is working on several guidelines developing a step-by-step approach to scaling up, underpinned by the principle of focusing on what is effective and possible, and acknowledging that not everything that is possible should be done or be included. It also attempts to shift the dialogue away from looking at the receptive context in isolation to looking at how innovative solutions and models will be able to serve other objectives of the transformation of a health system to make it more accessible, effective and sustainable.

Finally, it was suggested that the word “pilot” should not be used, since it implies a short-term time-limited phenomenon. Instead, it was considered by some that more appropriate terminology would be “phase 1”, “phase 2” and similar.

5.5. The question of equity

Some participants felt that it is not necessarily the role of government or policy-makers to control the implementation of innovative programmes at every level, but it is incumbent on them to ensure the quality and safety of care and – most importantly – equity. Underpinning almost all discussions within the “innovate” theme was an underlying doubt as to whether equity was threatened and not bolstered by new innovations. Technological innovation in health care should, and at one level does, go hand in hand with the Tallinn Charter values of equity and solidarity.

Certain innovations, such as the Ukrainian example, had increased access and equity but this was not always the case. Although the results to date of the Norwegian clinical pathways project had been positive, there were unintended consequences (see Box 12). Research is as yet inconclusive, but there was a consideration that using these structured clinical pathways for only some diagnoses makes it difficult for those with other health problems to access appropriate care, and there is pressure from both patients and politicians for further dialogue with patients’ groups. There is also a concern in Norway that concepts and the language of innovation that is beginning to develop are not always easily understood and may even be alienating, not just for patients but also for the workforce.

Frequently, new technologies and innovations mean that those who may have the most need for the particular device or technology in terms of their care can be the least able to access it due to a lack of digital literacy, technical skill and so on. Although drugs such as cholesterol-lowering PCSK9 inhibitors are known to be very effective and may improve care, this might be at the expense of equity, solidarity and fiscal stability, since not all will have access. One participant believed that there needs to be greater concerted action across Europe to challenge the power of the pharmaceutical industry in this respect.

Separating technological innovations between novel treatments on the one hand and new forms of delivering or practising medical treatments on the other, participants were invited to explore this issue further. Novel practice, for example, might include digital health care, such as artificial intelligence (AI)-based algorithms that enable targeting of special populations or assist in medical decision-making.

Box 13 outlines the key messages detailed with respect to equity and solidarity in technological innovation.

Box 13. Equity and solidarity in technological innovation

In the case of novel treatments, the more they are used, the higher the cost; but in the case of novel clinical practice the cost outlay is only incurred at the outset: once developed, it does not matter how much it is used as the cost will remain the same. Thus, novel practice is more equitable and sustainable than novel treatments, given the issues of access and cost.

Novel treatments work like a well oiled machine, backed by the financial interests of the pharmaceutical companies alongside regulations.

Introducing novel practices confronts a number of barriers:

- IT barriers, such as up-front costs, integration and agreed sharing of data, adapting computer systems;
- physicians’ reluctance, including a lack of acceptance of input into decisions or ownership of them, learning to trust AI systems, retraining as needed to work within new parameters and understand their new role towards patients, particularly enabling a holistic approach that AI will not be able to provide.

Digital innovation can increase quality of care, increase equity, reduce costs and bolster sustainability, but IT barriers and the interface with the human factor remain.

6. Next steps

Over the course of the two day meeting, some clear take-home messages emerged that brought together the thinking behind the opinions and experiences expressed during the discussions of the three i's.

- Implementation of health system reform, coupled with analysis and evaluation and linking research to policy action, remains challenging. Measurement, including that related to health system performance, is insufficient on its own and does not necessarily help countries understand what to do next. The balance of decision-making and questions of how decisions are reached – such as where new monies should be spent, the extent to which politics should be involved or what is effective and ineffective in each specific context – continues to be a source of concern and debate.
- Evidence to encourage investment is needed at both a strategic level and at meso (for instance, institutional) and micro (for instance, at the level of individual service provision) levels, but attention also needs to be focused on the nature of the evidence presented. Further evidence is needed on the cost–effectiveness of different approaches and systems and on health-related policies to address and benefit the wider social determinants of health.
- Governance and, in particular, public health governance, remains a challenge at all levels and throughout policy directions towards inclusiveness in health systems, sustainable investment and system innovations.
- Facing the challenge of planning ahead for longer-term time frames, workforce issues – especially those affecting public health – merit particular focus throughout the system.
- Prevention and primary care must become a major focus, with greater vigilance paid to people-centred care, alongside more concentrated efforts to increase investment and scale up service delivery innovations.
- Running through almost all discussions was an emphasis on understanding and capturing the stories and experiences of individual people. Complexity and anomalies in the system were often only understood or fully appreciated through such means. Patients' stories should be considered part of the evidence, and there should be greater consultation with advocacy groups and patients' associations. People's perspectives on, and priorities for, service innovation should be considered explicitly if countries are serious about achieving people-centred systems.
- International and national alliances may reap many benefits. Inter- and intrasectoral relationships should be encouraged and developed at all levels in all professions, both within and outside the health sector, particularly with respect to public health.
- Responsible innovation is needed to ensure that the benefits of innovation are widely distributed and shared, are sustainable and meet societies' needs more widely. Again, greater levels of engagement are needed with the potential users of innovation.
- Analysis is required to understand further which strategies work in which contexts and why, in order to achieve greater health coverage, access appropriate investment and develop a receptive context for innovation. Giving organizations and services the necessary support, time and flexibility to learn to function in new ways will be key to successful service innovation.

7. Conclusions

In the closing presentation, Dr Hans Kluge, Director of the Division for Health Systems and Public Health at the WHO Regional Office for Europe, emphasised above all else the importance of maintaining the essence of the Tallinn Charter not simply because of the significance of the document itself but more importantly the people of the Region deserved no less.

The Charter and its legacy remained a constant reminder of the need to reaffirm the commitment to value-based health systems in Europe and, within the context of the three i's, include, invest and innovate, this would mean:

- Scaling up efforts to achieve UHC so that no one is left behind;
- Placing greater focus on making sure that people and their needs are at the core of health systems; and
- Building resilience and work in partnership to plan and prepare for the future, both from within and from outside the health system.

Attention was again drawn back to 2008 and participants were reminded of the changes of the last ten years both within the European region and globally which have had clear implications for health systems. It is, however, only in retrospect that it is possible to acknowledge that at the time there had been perhaps too much optimism. The subsequent economic crisis and the emergent political and social schisms have shown that the Region rather took for granted that the positioning of health systems, as the drivers of health, wealth and societal well-being, was and would remain as the embodiment and expression of shared European social values. Challenges since 2008 have been widespread and across the board. Shifting political directions and allegiances, greater influence of 'for-profit' companies within personal lives and health systems, increasing costs of healthcare, demographic change and ageing populations, uneven patterns of need, changing health workforce and growing patient demand have all contributed to a questioning and testing of the commitment to solidarity. It is, thus, once again time to reassert the core values and repositioning of health systems within the new and challenging environment facing us, thereby reaffirming the adaptive capacity of the Charter to address the contemporary challenges facing health systems.

There were, nonetheless, reasons for celebration, many of which had been noted throughout the meeting. In particular, the 2030 Agenda for Sustainable Development remains underway, continuing to gain traction and, in spite of the challenges, the environment for collaboration and sense of working together for improved health is ironically stronger than it was ten years ago.

As Dr Kluge stressed, improving coverage, access and financial protection for everyone, the focus of Sustainable Development Goal 3, forms the backbone for further developments. This, of course, cannot be separated from the need to ensure adequate and sustained funding as well as ensuring that all elements of government recognise the importance and interdependence of health spending and investment in delivering solid returns in both economic and social terms. At one and the same time, health systems have to be shown to provide good public stewardship, contribute to macro-economic growth, societal wellbeing and fiscal sustainability. There is, though, a perennial dual agenda, a constant battle between fire-fighting while also enabling the growth and transformation of health systems. This is precisely why there was a need for the third central tenet of the meeting. Unless systems innovate, it will not be possible to deliver the services the European Region needs. Technology and system innovations can and will drive each other so that the new technologies are steered to minimise rather than maximise or increase the health and social divide.

The "three i's" - include, invest and innovate - are interlocked, driving and supporting each other. Populations will only be able to benefit from effective equitable and appropriate services and care if health systems are inclusive, able to benefit from sustained investment, and are innovative in delivering services.

Dr Kluge reminded that putting this into practice demands a redoubling of efforts to ensure UHC, transforming the system to make people centredness a reality but, at the same time, thinking and planning ahead. “Leaving no one behind” must not be simply a buzzword. The heartbeat of health system planning, design and reforms must be focused on reducing inequalities and inequities and crucially this has to go beyond simply extending coverage or widening the basket of services. Equitable and fair access to medicines is central to this, demanding a holistic approach. It necessitates Regional cooperation, going beyond national boundaries, negotiating political and health economies within a multi-sectoral framework in order to ensure that medicines help to minimise inequalities rather than exacerbate them.

None of this should be done in isolation from making the concept of people-centredness a reality but again this is not about empty statements and promises. The importance of involving patients in their own health and decisions about care cannot be over-stated even where difficult decisions need to be taken. On the one hand, this requires closer engagement with the health and medical profession, the core of health systems, but, on the other hand, it also means involving both the public and the patient in health decision making and policy design. Co-design runs alongside health literacy and both must be on the agenda.

This undoubtedly requires a well-functioning and appropriate health workforce, access to effective and affordable medicines, tools and technologies, fair and equitable health financing policy, strong primary care and public health interventions but, today, it means more than this. Now, there is an urgency to leverage the three i’s, causing a reorientation of care, the introduction of new technologies, the development of new perspectives and ways of working, greater investment in healthcare and in prevention and promotion and an understanding of people’s needs, where and how they live and how this has impacted on their health status.

Health systems have to be able to deal with any crisis or shock, either endogenous or exogenous and be able to anticipate change rather than merely reacting to it. It is about planning for the future and, critically, “thinking outside the box”. Being a “doer” is no longer enough. Instead, the time has come to be a “thinker” and being aware of changes that are taking place in the wider society that might have implications for health systems in the present and in the future. The need to create a culture of health, acknowledging that health systems are central to promoting health and wellbeing, which is the essence of the Tallinn Charter, remains but the journey requires new enthusiasm and new thinking.

Dr Kluge concluded, echoing the core values of the Charter, that it is still unacceptable that citizens become poor as a result of ill health, but the inalienable right of UHC may once again be imperilled owing to current threats to the social values of solidarity, equity and participation within the wider context. There is therefore an urgent need to pursue faster health gains, capitalize on innovations, further understand the drivers of financial hardship and act upon their mitigation. Efficiency, transparency and accountability must remain the cornerstones of health system performance.

Unless health systems innovate and adapt to changes, appropriate services will not be delivered. Dialogue, including an emphasis on intra- and intersectorality, must be an integral part of new developments in order to strengthen economic arguments and investment in health, leading to greater inclusiveness. The borders of health care need to be more flexible to encompass social care systems that should be further transformed to put people-centredness at the heart of policy and practice.

The 2018 meeting offered a unique and valuable opportunity to reflect on the last 10 years and, more importantly, to look forward to what needs to be done to promote health and well-being and to transform health systems across the Region. In this spirit, the final outcome statement (Annex 2) was adopted by proclamation. This action endorsed Member States’ commitment to take the Tallinn Charter forward and, through being “realistic optimists” to redouble efforts to ensure that the values of equity, solidarity, universalism and participation are enshrined in European health systems for the sake of future generations.

ANNEX 1



HEALTH SYSTEMS FOR PROSPERITY AND SOLIDARITY: LEAVING NO ONE BEHIND

PROGRAMME

Tallinn, Estonia, 13–14 June 2018

INCLUDE

INVEST

INNOVATE



CELEBRATING THE 10TH ANNIVERSARY
OF THE TALLINN CHARTER

OPENING
08:30-09:55

**CELEBRATING 10 YEARS OF THE TALLINN CHARTER
IN THE CONTEXT OF THE SUSTAINABLE DEVELOPMENT GOALS**

Welcome address: Kersti Kaljulaid (President of Estonia), Riina Sikkut (Minister of Health and Labour, Estonia)

Opening address: *Health systems for prosperity and solidarity* – Zsuzsanna Jakab (Regional Director, WHO EURO)

Technical opening: Include, invest, innovate in health systems: Building on the 2008 Tallinn Charter – Hans Kluge (WHO EURO)

High level Panel: Zsuzsanna Jakab (WHO EURO), Maris Jesse (Ministry of Health and Labour, Estonia), Enis Bariş (World Bank), Safarali Naimov (Stop TB partnership)

Chair: Yelzhan Birtanov (Minister of Health, Kazakhstan)

Panel moderator: Josep Figueras (European Observatory)

09:55-10:00

HEALTH BREAK

INCLUDE
10:00-11:00

PLENARY 1

INCLUDE: Improving coverage, access and financial protection for everyone

Introduction: Tamás Evetovits (WHO EURO)

Keynote: Charles Normand (Trinity College Dublin, Ireland)

Panel: David Sergeenko (Minister of Labour, Health and Social Affairs, Georgia), Panos Papadopoulos (Ministry of Health, Greece), Milojka Kolar Celarc (Minister of Health, Slovenia)

Chair: Naoko Yamamoto (WHO HQ)

Panel moderator: Josep Figueras (European Observatory)

Objectives:

- Set the scene and highlight the links between universal health coverage (UHC), poverty and health inequalities;
- Draw attention to lessons learned from the economic crisis;
- Emphasize the importance of assessing financial protection and unmet need for health care;
- Underscore the need for systematic monitoring of financial protection in Europe.

11:00-11:30

COFFEE BREAK

INCLUDE
11:30-13:00

PLENARY 2

INCLUDE: Can people afford to pay for health care?

Introduction to the regional report on financial protection: Tamás Evetovits (WHO EURO)

Technical presentation: Sarah Thomson (WHO EURO)

Panel: Riina Sikkut (Minister of Health and Labour, Estonia), Aurelijus Veryga (Minister of Health, Lithuania), Clemens Auer (Ministry of Health, Austria)

Chair: Naoko Yamamoto (WHO HQ)

Panel moderator: Charles Normand (Trinity College Dublin, Ireland)

Closing reflections from a global perspective: Joseph Kutzin (WHO HQ)

Objectives:

- Identify trends in the incidence, distribution and drivers of financial protection across countries;
- Draw attention to systematic inequalities in financial protection;
- Illustrate the role of outpatient medicines in driving financial hardship;
- Highlight the design of coverage policy as a key determinant of financial protection.

13:00-14:30

LUNCH

13:30-14:15	LAUNCH OF THE ESTONIAN HEALTH SYSTEM IN TRANSITION PROFILE
INVEST 14:30-16:00	<p>PLENARY 3 INVEST: Making the case for investing in health systems</p> <p>Introductory video: The health-finance dialogue</p> <p>Keynote: Tomáš Sedláček (Charles University Prague, Czech Republic)</p> <p>Panel: Maxim Yermalovich (Ministry of Finance, Belarus), Lutz Stroppe (Ministry of Health, Germany), Marcin Czech (Ministry of Health, Poland), Mary McCarthy (Structural Reform Support Service, EC), Enis Bariş (World Bank)</p> <p>Reflections: Geert van Maanen (Ministry of Health, The Netherlands)</p> <p>Chair: Dmitry Kostennikov (Ministry of Health, Russian Federation)</p> <p>Panel moderator: Martin McKee (London School of Hygiene & Tropical Medicine, United Kingdom)</p> <p>Objectives:</p> <ul style="list-style-type: none"> • Consider the perspective of a ministry of finance in providing resources for the health system; • Identify the challenges commonly faced by health ministries, health insurance funds and other related agencies when seeking to obtain more resources for health systems; • Explain how and why investing in health systems is a sound investment from economic as well as social perspective.
16:15-17:45 PARALLEL SESSIONS	
<p>PARALLEL 3.1 Reframing the dialogue between health and finance on investing in health systems</p> <p>Technical introduction: Peter Smith (Imperial College London, United Kingdom)</p> <p>Panel: Jūratė Sabalienė (National Health Insurance Fund, Lithuania), Patrick Jeurissen (Ministry of Health, The Netherlands), Francesca Colombo (OECD), Per Eckefeldt (DG ECFIN, EC)</p> <p>Chair: Sorina Pinteau (Minister of Health, Romania)</p> <p>Moderator: Jonathan Cylus (European Observatory)</p> <p>Objectives:</p> <ul style="list-style-type: none"> • Demonstrate ways in which health systems can be aligned with and further the economic and fiscal objectives of finance ministries; • Provide examples of economic gains associated with health system investments; • Ascertain the way that a ministry of health presents its case for additional resources including in the language and taxonomy it uses, and the way that it monitors and reports on its achievements; • Help the ministry of finance better understand the needs and priorities of the ministry of health by also promoting the capital good argument around investing in health and health systems. 	
<p>PARALLEL 3.2 Getting serious about prevention: Investing in public health</p> <p>Technical introduction: David McDaid (London School of Economics, United Kingdom)</p> <p>Panel: Vesna-Kerstin Petrič (Ministry of Health, Slovenia), Yvonne Doyle (Public Health England, United Kingdom), Natasha Azzopardi Muscat (EUPHA)</p> <p>Chair: Ministry of Human Capacities, Hungary</p> <p>Moderator: Annemiek van Bolhuis (National Institute for Public Health and the Environment, The Netherlands)</p> <p>Objectives:</p> <ul style="list-style-type: none"> • Highlight successes in increasing the allocation of resources to public health interventions; • Identify examples of successful human resources for health policy implementation; • Provide institutional examples on the effective reform of public health; • Reflect on the use of primary care teams to work with municipal authorities and scale up public health interventions. 	
19:30	OFFICIAL DINNER

INNOVATE
08:30-10:00

PLENARY 4

INNOVATE: Harnessing innovations and systems to meet people's needs

Keynote: Trisha Greenhalgh (Oxford University, United Kingdom)

Panel: Maggie De Block (Minister of Social Affairs and Public Health, Belgium), Liisa Maria Voipio Pulkki (Ministry of Health, Finland), Olivia Wigzell (National Board of Health and Welfare, Sweden)

Chair: Adalberto Campos Fernandes (Minister of Health, Portugal)

Panel moderator: Rafael Bengoa (Institute for Health and Strategy, Spain)

Objectives:

- Consider the uptake and diffusion of innovations by and in health systems;
- Distinguish different types of innovation and the role of policy-making;
- Provide a sounding board for health policy-makers to express their expectations and concerns with respect to innovation;
- Present practical experiences and approaches to align innovation with the shared values in the Tallinn Charter.

10:00-10:30

COFFEE BREAK

10:30-12:00

PARALLEL SESSIONS

PARALLEL 4.1

Innovating service design and delivery

Technical introduction: Ellen Nolte (London School of Hygiene & Tropical Medicine, United Kingdom)

Panel: Bjørn Guldvog (Directorate of Health, Norway), Ulana Suprun (Minister of Health, Ukraine), Bernadette Devictor (National Health Conference, France), Kyriakoula Petropulacos (Emilia Romagna Region, Italy), Sylvain Giraud (DG Sante, EC)

Chair: Mila Carovska (Minister of Social Policy, The former Yugoslav Republic of Macedonia)

Moderator: Matthias Wismar (European Observatory)

Objectives:

- Explore experiences of 'innovative solutions' in the organisation and delivery of services in different system settings;
- Understand the specific contextual factors, enablers and barriers that 'make or break' innovative solutions;
- Discuss system levers to nurture and scale up innovative solutions in services;
- Reflect on possible unintended consequences;
- Inform a policy and research agenda.

PARALLEL 4.2

Governing technological innovation

Technical introduction: Noa Dagan (Clalit Research Institute, Israel)

Panel: Tom Auwers (Ministry of Health, Belgium), Dominique Polton (Strategic Council for Health Innovation, France), Walter Ricciardi (National Health Institute, Italy), Ainur Aitypkhanova (Ministry of Health, Kazakhstan), Harold Wolf (Healthcare Information and Management Systems Society, USA)

Chair: Vilborg Ingolfsdottir (Ministry of Health, Iceland)

Moderator: Reinhard Busse (Berlin University of Technology, Germany)

Objectives:

- Consider the types and potential benefits from emergent new technologies for health systems;
- Showcase country experiences of successful uptake of technological innovation;
- Promote better understanding of barriers, enablers and system levers to harness technological innovations;
- Discuss governance strategies and tools to ensure that new technologies serve solidarity and equity.

DAY 2 THURSDAY, 14 JUNE 2018

CLOSING
12:10-13:00

HEALTH SYSTEMS OF THE FUTURE: INCLUDE, INVEST, INNOVATE

Chair: Elke Jakubowski (WHO EURO)

People-centred health systems for the 21st century – Hans Kluge (WHO EURO)

Meeting outcome statement: Adoption of outcome statement by acclamation – Zsuzsanna Jakab (WHO EURO)

Closing: Riina Sikkut (Minister of Health and Labour, Estonia) and Zsuzsanna Jakab (WHO EURO)

13:00-14:00

LUNCH



HEALTH SYSTEMS FOR PROSPERITY AND SOLIDARITY:

LEAVING NO ONE BEHIND

Tallinn, Estonia, 13–14 June 2018

HIGH-LEVEL MEETING

Outcome statement



CELEBRATING THE 10TH ANNIVERSARY
OF THE TALLINN CHARTER

Outcome statement

Health Systems for Prosperity and Solidarity: leaving no one behind

High-level meeting

Tallinn, Estonia, 13–14 June 2018

This document contains the text of the outcome statement by participants in the high-level meeting Health Systems for Prosperity and Solidarity: leaving no one behind, held in Estonia in June 2018.

1. We, participants in this high-level meeting Health Systems for Prosperity and Solidarity: leaving no one behind, have come together to reaffirm the commitment to the values enshrined in the Tallinn Charter: Health Systems for Health and Wealth¹ on its 10th anniversary. Building on those of the 1996 Ljubljana Charter on Reforming Health Care, these shared values have informed the people-centred health system approach in Health 2020 and set the direction for much of the regional and country work on health system strengthening over the past decade.
2. The Tallinn Charter has emphasized the common value of the highest attainable standard of health as a fundamental human right. We record a series of achievements across the WHO European Region that reflects the legacy of the Charter. Life expectancy has improved by two years on average. We observe paradigm shifts towards people and their needs as the centre of our efforts, and a reorientation towards better-performing health systems with greater focus on primary care and public health. We see progress in performance measurement in health systems and observe a high willingness to continuously learn from other countries' experiences, as well as endeavours to increase transparency and accountability. Many health outcomes amenable to health system interventions have improved, and Member States have themselves pointed to the important role played by the Tallinn Charter in strengthening their health systems. We can all share in this success.
3. Nonetheless, we recognize that the political, economic and social environment for European health systems has changed drastically since the signing of the Tallinn Charter. The political climate is uncertain and the social context strained. Economic outlooks predict wider income inequality with sustained pressures on health-care spending and health and social budgets. The broader health picture in Europe has changed too, with noncommunicable diseases now the leading cause of death, disease and disability. Infectious diseases remain a threat to population health, especially due to increasing antimicrobial resistance. Some of the attributes we assign to European health systems – solidarity, equity and universalism – are thus at risk. We see the need, therefore, for more inclusive policies, wiser investments in health and more value added by technological and service-delivery innovations to meet people's needs.
4. At the same time, we see global opportunities for collective cross-sectoral action to promote adequate and sustained investments in health and stronger, more resilient health systems with a greater focus on promoting equity. Most notably, Europe's governments have committed themselves to the global 2030 Agenda for Sustainable Development and its 17 Sustainable Development Goals. The global push towards universal health coverage by 2030 runs in parallel, and is at the core of offering value-based policy directions for governments.
5. To tackle the health challenges of the 21st century, we recognize the need to accelerate action for people-centred health systems and subscribe to a number of clear policy directions in the context of the three overarching themes of this high-level technical meeting.

¹ The Tallinn Charter defines the health system as the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health.

(a) Include: This theme focuses on the importance of moving towards universal health coverage for a Europe free of impoverishing payments for health, specifying ways of improving coverage, access and financial protection for everyone. We thus:

(i) take note of inequalities in financial protection within and across countries in the Region and commit to supporting systematic monitoring of financial protection and unmet need for good-quality health services at national and regional levels;

(ii) agree on the need to revisit and strengthen coverage policies in countries by extending coverage to the whole population for all needed, quality and cost-effective health services, including prevention and health promotion, taking into account the capacities of each national health system; by improving access to medicines; and by carefully redesigning policies on user charges towards protecting all households from financial hardship, recognizing that out-of-pocket payments on outpatient medicines are a significant source of financial hardship in many countries in the Region; and

(iii) affirm that the causes of limited access are complex and depend on a wide range of factors, including the scope of services provided, service delivery models, referral systems, patient preferences and cost-sharing arrangements, and that the alignment of policies is crucial to improving access and reducing out-of-pocket spending on health.

(b) Invest: This theme resituates the Tallinn Charter’s call for “health systems for health and wealth” in the current context, offering more specific options for health policy-makers to make the case for investing in health systems. We will thus:

(i) continue to strive to secure and sustain adequate resources through greater public investment, make use of efficiency gains and, towards leaving no one behind, ensure an effective (re)allocation of resources to meet health need, especially towards poorer people and regular users of health services, for whom the economic gain is most evident;

(ii) intensify efforts to bring health and finance decision-makers together around shared goals by taking note of public finance objectives and correspondingly demonstrating the economic and social returns of investing in health systems; and

(iii) elevate our efforts to enact cost-effective and evidence-based public health approaches, services and interventions by improving cooperation with key stakeholders inside and outside the health system, including non-governmental organizations; by improving human resources for health policies through training and broadening the range of professionals and skills; by introducing financial mechanisms to increase the share of resources to public health; and by adapting the organization of public health services to better meet population health needs, coordinating with the health and social sectors.

(c) Innovate: Acknowledging the need for health systems to strategically accelerate up take, roll out and scale up innovations to meet people’s needs, reconsidering governance mechanisms for

harnessing future generations in Europe with technological and systems innovations, also with a view to promote resilience. We will thus:

(i) work to ensure that WHO European Region health systems are open and able to adapt to new thinking and policy innovations, including to foster the participation of patients, communities, non-governmental organizations and health professionals; to ensure quality services; to enhance human resource skill mix and training; and to improve delivery models to meet peoples' needs; and

(ii) support policy action and the strengthening of applied research to ensure that our health systems are modern with up-to-date health information systems, fit-for-purpose, and able to harness new technologies in a manner that seeks to minimize current inequities in access to and quality of services.

6. We therefore further commit to scaling up work on health system transformation, and will invest in mechanisms and processes to manage the transformational change required of our health systems.

7. Within this framing, we aim to ensure that health systems are pro-active in responding to the challenges of the new context. In view of these directions, we support the continued work of the Health Systems Foresight Group within the WHO Regional Office for Europe to support Member States and the Secretariat in their planning and decision-making on the basis of informed considerations of potential future trends and directions for health systems that reflect societal preferences.

8. We reaffirm the value base of European health systems as set out in the Tallinn Charter, will continue to embrace its commitments, and will help to position regional and country-level efforts to strengthen health systems in the global context of the 2030 Agenda for Sustainable Development, with our regional emphasis on equity.

9. We, the participants of this high-level meeting, call upon European leaders to recognize the centrality of strong primary care oriented people-centred health systems, based on the need to include, invest and innovate, where equitable healthy populations are the bedrock of delivering on governmental and social commitments, and to pursue these policy directions.

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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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