



World Health
Organization

REGIONAL OFFICE FOR Europe

**HEALTH SYSTEMS IN TIMES OF GLOBAL
ECONOMIC CRISIS: AN UPDATE OF THE
SITUATION IN THE WHO**

EUROPEAN REGION

Oslo, Norway, 17–18 April 2013

Cover photo:

Fram ("Forward") is a ship that was used in expeditions of the Arctic and Antarctic regions by the Norwegian explorers Fridtjof Nansen, Otto Sverdrup, Oscar Wisting, and Roald Amundsen between 1893 and 1912. It was designed and built by the Norwegian shipwright Colin Archer for Fridtjof Nansen's 1893 Arctic expedition in which Fram was supposed to freeze into the Arctic ice sheet and float with it over the North Pole.

Fram is said to have sailed farther north ($85^{\circ}57'N$) and farther south ($78^{\circ}41'S$) than any other wooden ship. Fram is preserved at the Fram Museum in Oslo, Norway.

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EXECUTIVE SUMMARY

In April 2009 the Government of Norway hosted a WHO high-level meeting on “Health in times of global economic crisis: implications for the WHO European Region”. Since then, the crisis has deepened across the Region, with a damaging impact on the public finances of many Member States. Given the fast-moving economic and political environment, the WHO Regional Office for Europe decided to convene a follow-up meeting, held in Oslo on 17–18 April 2013. The objectives of the meeting were:

- to review the impact of the ongoing economic crisis on health and health systems in the WHO European Region;
- to draw policy lessons around three broad themes:
 - » maintaining and reinforcing equity, solidarity and universal coverage;
 - » coping mechanisms, with a focus on improving efficiency;
 - » improving health system preparedness and resilience;
- to identify policy recommendations for consideration by Member States and possible future political commitments.

The first session was introduced by Mr Jonas Gahr Støre, Minister of Health and Care Services, Norway, who gave a presentation on the economic crisis as a test of commitment to the values of equity, solidarity and universal coverage, and by Ms Zsuzsanna Jakab, WHO Regional Director for Europe, who addressed the crisis in the context of the Health 2020 policy framework and strategy. The session went on to provide an overview of the effects of the crisis on population health and health system performance. It explored the ways in which the crisis and policy responses to it affect health outcomes and identified the strategies and tools required to monitor and mitigate negative effects. It also explored the challenges and opportunities that the crisis poses for health systems, reviewing policy responses and discussing their implications for health system performance. The session emphasised the role of policy choices in addressing the challenge of financial sustainability and highlighted the importance of strong leadership and governance.

Session 2 explored the interplay between fiscal policy and health financing policy in times of economic downturn. Health expenditure is the second largest item in the budget of most European governments, making it a prime target for budget cuts. However, responsible fiscal policy takes account of the health needs of populations, especially during an economic downturn when the need for services increases. Conversely, responsible management of health budgets can contribute to avoiding fiscal imbalances. Fiscal sustainability has to be restored in the medium term for economic and social development, and all public sectors (including health) have to respect this requirement. However, the fiscal space for health is not static: it depends on government priorities, taxation policies and the performance of the health system itself.

The third session looked at the crisis as an opportunity for health system reforms, where countries could seek short-term returns while striving to implement a long-term vision. It was suggested that efficiency gains can moderate the effects of austerity, but only if



policy-makers focus on improving outcomes and physician behaviour, recognize and change the passive behaviour of health care funders, and proceed with care (undertaking scientific evaluation of new policies and expecting opposition from potential losers). Panel members from Austria, Greece, Ireland, Latvia, Portugal and Spain then described their countries' experience of responding to the economic crisis. A representative of the European Commission made an invited contribution.

The fourth session considered public health and prevention. The conclusion from the first presentation was that the selection of effective interventions (many of which involve substantial elements of prevention) can certainly help contain health system costs, but choices will have to be made between prevention and treatment, between treatments, and between more and less visible people and population groups. The second presentation found that the economic crisis is a challenge for health and social outcomes; public health can be part of the response to that challenge. The current costs of inaction are significant. The evidence shows that prevention is cost-effective and could save money; small investments promise large gains. Panel members from Estonia, Finland, Hungary, the Republic of Moldova, Slovakia and EuroHealthNet then reflected on how to divide up the sometimes shrinking public health and prevention budget in order to achieve the best return on investment.

The WHO Regional Director for Europe summarized the key messages of the conference and ten policy recommendations that were contained in the "outcome document":

- Short-term policy responses to fiscal pressure should be consistent with long-term health system goals and reforms.
- Fiscal policy should explicitly take account of health impact.
- Social safety nets and labour market policies can mitigate the negative health effects of the financial and economic crisis.
- Health policy responses make a difference to health outcomes, access to care and the financial burden on the population.
- Funding for public health services must be protected.
- Fiscal policy should avoid prolonged and excessive cuts in health budgets.
- High-performing health systems that are more efficient are better prepared and more resilient during times of crisis.
- Deeper structural change in health systems will take time to deliver savings.
- Safeguarding access to services requires a systematic and reliable information and monitoring system.
- Prepared and resilient health systems result primarily from good governance.

INTRODUCTION

1. In April 2009 the Government of Norway hosted a WHO high-level meeting on “Health in times of global economic crisis: implications for the WHO European Region”. Since then, the crisis has deepened across the Region, with a damaging impact on the public finances of many Member States. Given the fast-moving economic and political environment, the WHO Regional Office for Europe decided to convene a follow-up meeting, to review the latest evidence about how health systems have been affected by the crisis, to take stock of policy responses by governments and to assess the overall impact on health systems and health outcomes.
2. The meeting, held in Oslo on 17–18 April 2013, was opened by Ms Zsuzsanna Jakab, WHO Regional Director for Europe. Participants (see Annex 2) were welcomed by Mr Jonas Gahr Støre, Minister of Health and Care Services, Norway.

OBJECTIVES AND SCOPE OF THE MEETING

3. Dr Hans Kluge, Director, Division of Health Systems and Public Health, WHO Regional Office for Europe said that the objectives of the meeting were:
 - to review the impact of the ongoing economic crisis on health and health systems in the WHO European Region;
 - to draw policy lessons around three broad themes:
 - » maintaining and reinforcing equity, solidarity and universal coverage;
 - » coping mechanisms, with a focus on improving efficiency;
 - » improving health system preparedness and resilience;
 - to identify policy recommendations for consideration by Member States and possible future political commitments.
4. It was expected that the meeting would result in three outcomes:
 - a better understanding of the impact of austerity measures on health and health systems;
 - the identification of key areas for policy actions to address the current and future challenges posed by the crisis; and
 - recommendations for consideration by the WHO Regional Committee for Europe.

SESSION I - THE IMPACT OF THE ECONOMIC DOWNTURN ON HEALTH OUTCOMES AND HEALTH SYSTEMS IN THE WHO EUROPEAN REGION

The crisis as a test of commitment to the values of equity, solidarity and universal coverage

5. Introducing the first session, Mr Jonas Gahr Støre recalled that in 1993 the World Bank had published its paradigm-changing World Development Report, Investing in Health, which had documented the link between macroeconomics and health, concluding that investing in health benefitted the overall economy. Elaborating on that report, the WHO Commission on Macroeconomics and Health (established in January 2000 by former WHO Director-General Dr Gro Harlem Brundtland) had established a clear link between economic policies and health outcomes. In 2009, WHO's European Member States had met in Oslo to discuss what was then a serious crisis in the financial sector that was putting government budgets under pressure. One conclusion from that meeting had been the importance of ensuring universal access to health care, particularly when considering measures to address budget cuts. Times had changed, however, and the crisis had since spread to the wider economy, with many countries in the Region experiencing long periods of negative growth, while poverty and unemployment – particularly among young people – were at a peak. The question now was how to turn the crisis into something constructive, prioritizing wisely to ensure that budgets were not cut arbitrarily and that the opportunity was taken to make the necessary structural changes.
6. Four principles were important when external conditions made change necessary: equity, or the need to ensure that any changes introduced did not increase social inequity; a well-functioning primary health care system, accessible by all citizens; disease prevention and health promotion, which would require health ministers to adopt an intersectoral approach and work with other ministers (“Health is too important to be left to health ministers alone”); and innovation in health, introducing new technologies, structures and ways of working. In the years ahead, crisis or not, all European countries would have to take tough prioritization decisions in order to ensure the long-term sustainability of their health systems.

Addressing the economic crisis in the context of the Health 2020 policy framework and strategy

7. Ms Zsuzsanna Jakab noted that the financial and economic crisis was threatening the health gains that had been made across the WHO European Region in recent decades and was exacerbating the longer-term challenges faced by health systems. The crisis was deepening the health divide within and between countries by multiplying factors of exclusion, increasing vulnerability and depleting the coping capabilities of individuals and communities. At its sixty-second session in

September 2012, the WHO Regional Committee for Europe had therefore adopted a new European health policy framework, Health 2020, aimed at significantly improving the health and well-being of European populations, reducing inequalities in health and ensuring sustainable, people-centred health systems.

8. Health 2020 had been informed by a wealth of evidence gathered during a two-year process of generating and integrating information, connecting with Member States and partners, and undertaking stakeholder peer review. In particular, the impact of the economic crisis on health and health systems had been explored through two surveys of the policy responses to the crisis made by all WHO's 53 European Member States, a review of published literature and official databases, and in-depth studies of selected countries (which were currently ongoing). In addition to analytical work to build up the evidence base, WHO had intensified its engagement with the Member States on the financial sustainability of health systems in two other ways:
 - fostering policy dialogue and knowledge brokerage events to disseminate current evidence and share ideas and experience with respect to policy responses and lessons for the future; and
 - providing direct country technical assistance.
9. It was apparent that, following the initial fiscal shock and sharp declines in gross domestic product (GDP) across the Region in 2009, a prolonged crisis had set in, with government finances deteriorating in many countries and government debt as a share of GDP rising steeply in affected countries. Many governments had also faced a sharp increase in borrowing costs as a result. At the same time, there had been a rapid increase in unemployment, especially in the European Union (EU). The health sector was a major employer and accounted for some 10% of GDP in the 27 countries that were members of the EU (EU27). Unemployment was the single largest way in which financial crises directly increased the risk of ill-health, but evidence also showed increases in other risk factors or diseases (such as alcohol poisoning, liver cirrhosis, mental health problems and suicides). However, it was known that interventions to boost employment and ensure access to health and other social services could mitigate those negative effects: per capita spending on social welfare (including health) was associated with a greater reduction in mortality than a corresponding per capita increase of GDP.
10. A number of challenges and questions would therefore need to be taken up at the present meeting: how could the health sector spend the available resources more efficiently; how could the health effects of economic downturns be monitored more closely; how could funding for public health be protected; how could access to services be safeguarded; how could the poor and vulnerable be better protected; and how could health systems be made more resilient in the future?

Taking stock of the evidence

11. Dr Raisa Bohatyrova, Minister of Health, Ukraine took the chair and introduced the two keynote speakers and the moderator of the ensuing plenary discussion, noting that in times of profound crisis it was necessary to hold fast to the values and aims that had always inspired health professionals, of increasing people's life expectancy and improving their quality of life. Diseases were a consequence of a range of problems; healthy lifestyles and equality of opportunities were crucially important for solving those problems, and the whole community must be involved in efforts to achieve better health, as expressed in the United Nations Millennium Development Goals (MDGs).
12. Dr David Stuckler, Senior Research Leader, Oxford University, United Kingdom pointed out that different countries were adopting different policy responses to the economic crisis. Some broad patterns were discernible in the WHO European Region, however: in the packages of austerity measures implemented by countries in 2009–2011, large cuts had been made to government spending in the areas of community services, health, education and social protection. In the latter, the largest cuts had been to family, unemployment and disability support. Budgets were therefore being balanced at the expense of the most vulnerable population groups. As noted by the Regional Director, the short-term health effects of austerity measures included increased suicides and depression, rising alcohol-related harm, outbreaks of infectious diseases and restricted access to health care. Long-term effects could be expected to be an increased risk of cardiovascular disease, the emergence of drug resistance and increasing health care costs.
13. A recent working paper issued by the International Monetary Fund (IMF)¹ had found that fiscal multipliers were substantially higher than implicitly assumed by forecasters. In other words, the negative effect of austerity on job losses and the economy had been underestimated. Conversely, it had been found that greater public spending led to faster economic recovery. Following the lead of politicians such as Aneurin Bevan (the Minister of Health responsible for establishing the national health service in the United Kingdom in 1948) and Franklin D. Roosevelt (who had introduced a series of economic programmes for relief, recovery and reform in the United States between 1933 and 1936 known as the New Deal), Dr Stuckler called for a “new New Deal” with three components: “first, do no harm”; second, help people return to work: and third, invest in public health.
14. Dr Sarah Thomson, European Observatory on Health Systems and Policies, reported that a new survey had recently been made of key informants in 47 countries in the WHO European Region, asking what countries had done in response to the crisis², and new case studies of seven countries had been completed³, looking at why and how measures had been taken, and what effect they had had. A large

1 Blanchard O, Leigh D. *Growth forecast errors and fiscal multipliers*. Washington, International Monetary Fund, 2013 (working paper WP/13/1).

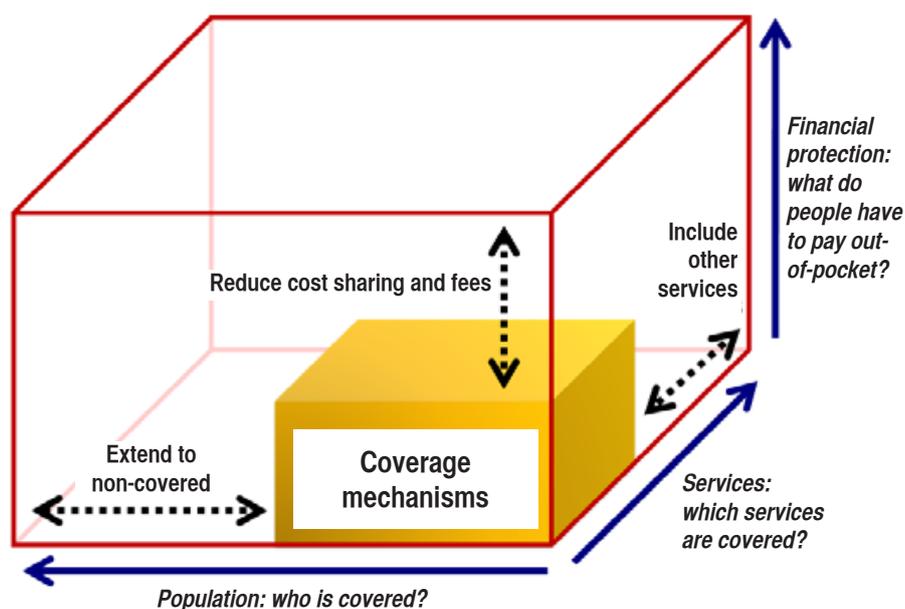
2 Mladovsky P et al. eds. *Health policy responses to the financial crisis in Europe*. Copenhagen, WHO Regional Office for Europe, 2012 (European Observatory on Health Systems and Policies, Policy Summary 5, <http://www.euro.who.int/document/e96643.pdf>, accessed 22 April 2013).

3 See, for instance, Thomson S et al. eds. *Health system responses to financial pressures in Ireland: policy options in an international context*. Copenhagen, WHO Regional Office for Europe, 2013 (Observatory Studies Series 31).

number of countries had experienced a decline in per capita public spending on health, some for as many as three years in succession, in addition to facing other constraints such as an uncertain economic outlook, limited time to act, and a lack of information and capacity. Their experience could be assessed in terms of the implications of the crisis for three aspects of health system performance: financing, access to care, and efficiency.

15. With regard to the first aspect (adequate, stable and fair financing), the crisis had offered an opportunity to demonstrate the usefulness of automatic “stabilizers” or counter-cyclical measures, to remove tax subsidies benefitting richer people, and to broaden the revenue base. Some countries had indeed acted quickly to protect the health budget, the labour market and poorer people; it was evident, however, that means-testing added to financial pressures and that policy responses (rather than automatic stabilizers) were the critical factor.
16. Access to effective care could be visualized in three dimensions, namely population coverage, service coverage and financial protection (see Fig. 1).

Fig. 1



17. The survey had found that 22 of 47 countries had made no change to population entitlement; 12 had expanded population coverage, while 4 had reduced such coverage. A total of 13 countries had made no change to the benefits package; 12 had expanded it, while 14 had reduced it. The picture with regard to user charges was more varied: 10 countries had made no change, 6 had achieved better coverage, 11 had increased user charges, and 12 had experienced mixed effects. In general, the trend towards better health care coverage had not been “bucked” during the crisis, but there was some evidence of increases in barriers to access. EU statistics on income and living conditions (EU-SILC) showed that the unmet need for

health care was rising in the poorest quintile of the population. In terms of lessons learned, it was clear that safety nets were not always safe, that voluntary health insurance did not fill gaps in coverage, and that there was a missed opportunity for value-based policy.

18. With regard to efficiency, the crisis had offered the opportunity to address waste in the health system, to cut wisely, to invest carefully, and to engage in structural reform. However, the survey had found that efficiency gains had been secured mainly in the area of pharmaceutical policy; otherwise, cuts had been made “across the board”, including in public health, and there had been very few attempts to cut wisely. Clearly, it was easier to increase user charges than to streamline the benefits package, and to cut health workers’ salaries rather than service prices. The pressure for short-term savings was apparently greater than that for efficiency.
19. Overall, it was evident that policy responses were critical, and that policy-makers had choices, although complex reforms were difficult to implement at a time of crisis and uncertainty. Governance (analysis, setting priorities and targets, monitoring and transparency) and leadership (insight, clarity, courage and communication) were both essential to health system performance, at all times.

Plenary discussion

20. The ensuing plenary discussion was moderated by Dr Josep Figueras, Director, European Observatory on Health Systems and Policies. One participant believed there was still a certain amount of controversy about the effects of the crisis on health outcomes: while healthy life expectancy had started to fall in the previous two years, life expectancy itself was still rising, suicides had risen only to fall back, and alcohol-related deaths were decreasing (albeit perhaps as a result of the introduction of price rises for alcohol). It was suggested that if safety nets were in place, the crisis did not necessarily undermine health.
21. Another speaker recalled that Article 168 of the Treaty on the Functioning of the European Union required that “a high level of human health protection be ensured in the definition and implementation of all Union policies and activities.” That would entail looking at the health “price tag” of different policies and working in a more intersectoral way.
22. In addition, evidence needed to be gathered about the suffering that people were experiencing as a result of the economic crisis. While mortality data were only available with a three-year time lag, morbidity data were hardly available at all; local-level surveys needed to be conducted, looking at aspects such as chronic stress in children, the number of pregnant women not taking up health care for fear of losing their job, or of people who experienced access problems owing to a lack of public transport. In addition, due account should be taken of people’s perceptions of the performance of health systems: in a Eurobarometer “social climate” survey, 50% of respondents believed that services had deteriorated in the previous five years. The reasons for that perception (i.e. the ways in which different parts of the health system operated) should be elucidated.

23. A recent report by the Organisation for Economic Co-operation and Development (OECD) had recommended cuts in public spending as a response to the economic crisis. One participant asked how best to defend spending on social and health questions, while another called for international organizations to develop tools that would support Member States in investing wisely and prioritizing where budget cuts should be made. Ministries of health would need to demonstrate to ministries of finance why it was important to maintain and improve health outcomes at a time of budget austerity. The final report of the Commission on Social Determinants of Health and the new European health policy framework, Health 2020, could help in that regard.
24. The representative of one country reported that compensatory financing and other non-financial measures had been taken to ensure continued access to health care by populations in rural areas. It was noted that, in some cases, “safety nets” (such as ensuring free health care for pregnant women and mothers of children up to the age of two years) could act as a disincentive for people to take out voluntary health insurance. A plea was made not to “pick the low-hanging fruit” by cutting health workers’ salaries: it was important to invest in people, not pills.
25. Several participants welcomed the emphasis that keynote speakers had placed on disease prevention and primary health care. An intersectoral approach should be adopted to ensure that capacity in those areas was not reduced.
26. Summing up the session, the Chairperson confirmed that the recent health system reform in her country had been informed by Health 2020 and focused on improving primary health care and disease prevention. The health sector’s budget had been increased in 2013 and funds were being channelled towards cancer and tuberculosis prevention, investment in new maternal and child health and emergency care centres, and increased salaries and better training for health workers. Equity was regarded as the cornerstone of health policy and more important than economic considerations.

SESSION 2 - THE INTERPLAY BETWEEN FISCAL POLICY AND HEALTH FINANCING POLICY

27. Session 2 was chaired by Mr Geert Van Maanen, Secretary-General for Health, Ministry of Health, Welfare and Sport, the Netherlands. As former Secretary-General of the Netherlands Ministry of Finance and former Chair of the OECD Working Party of Senior Budget Officials (SBO), he drew participants' attention to the SBO Network on Health Expenditures, which he chaired. A joint session of the Network and SBO-CESEE (central, eastern and south-eastern Europe) had been held in Tallinn, Estonia in June 2012.

Implications of the crisis for fiscal policy and public financing of the health and social sectors

28. Professor Peter Heller, Visiting Professor of Economics, Williams College, United States of America said that the crisis had led to large fiscal deficits, resulting in significant increases in public debt. For many countries, public debt had reached levels perceived as unsustainable. In some, the fiscal deficit had become excessive and there had been a "snowballing" of debt, with a consequent rise in the risk premium on borrowing, principally in southern European countries, that had led to strong fiscal austerity measures, often in the context of programmes implemented under the auspices of the IMF and the EU.
29. Public expenditure on health had fallen in some countries (e.g. Estonia, Hungary, Iceland) as early as 2008/2009, and in many more (Czech Republic, Denmark, Greece, Portugal, Slovenia and Spain) in 2009/2010; in all other European countries, the rate of increase of health spending had fallen dramatically relative to 2007/2008. Cutbacks had also been felt in other social sectors, such as pensions payments and unemployment benefits, and increased use was being made of targeting measures to restrict social sector spending to poorest households.
30. For most countries, fiscal austerity regimes would continue in the future. In Euro-zone countries, the lack of an exchange rate as a policy instrument necessitated the use of fiscal policy as a means of restoring current account viability. For some countries, significant "front-loading" of deficit reduction measures had already been put in place; fiscal gap calculations, however, suggested the need for further primary balance reductions and continued austerity.
31. Existing high overall tax ratios in European countries put all the pressure for fiscal austerity on spending cuts; nonetheless, there was a recognition that spending should be promoted in areas that fostered growth, and that cuts should be focused in expenditure categories that had low multiplier effects. Admittedly, there was a divergence of views concerning the advisability of significant fiscal austerity in the short-term environment of low growth or recession, but there was no disagreement

among leading international macroeconomic institutions about the need for medium- to long-term fiscal consolidation.

32. The fiscal gap arose not only from the effects of the financial crisis but also from the combined effect of an ageing population and the structural characters of social insurance systems. Health sector spending pressures resulted from excessive cost growth associated with technological change and from the higher probability of the need for arrangements to provide long-term care of the very elderly.
33. The obvious challenge was therefore how to cut spending optimally in the health and social sectors. Policy alternatives (pushing back retirement ages, reducing indexation of pensions, etc.) were far more obvious in the pensions sector. In the health sector, policy alternatives might include limiting the availability of new, unproven technologies that offered only marginal additional gain; using generic drugs and introducing national purchasing schemes for pharmaceuticals; pushing for the adoption of high-efficiency best practices; increasing cost-sharing mechanisms (particularly if progressivity measures were applied); and not cutting spending on preventive practices.
34. Dr Tamás Evetovits, Senior Health Financing Specialist, WHO Regional Office for Europe agreed that fiscal sustainability must be restored in the medium term, for both economic and social reasons. But balancing the budget should not be a simple accounting exercise; instead, it should be a matter of choice in public policy priorities, to minimize adverse effects on health, equity and financial protection.
35. Health spending had not “carved out” an unfair share of growing public expenditure in the previous decade (it had risen from 13.7% to 14.4% of total government spending between 2000 and 2010), and it was regarded as the top priority for more spending by European citizens. While health was taking a greater share of public spending in high-income countries, it was actually decreasing in upper-middle income countries, and in some countries the health share of the government budget had been disproportionately cut during the crisis.
36. It should not be forgotten that the main reason why health was the second largest sector in public spending was because redistributive public financing achieved better financial protection and equity in access to care; those considerations should drive fiscal policy as well as spending cuts when they were unavoidable. The “insurance function” of public spending called for counter-cyclical arrangements to avoid sudden, excessive reductions in health budgets. Options included the use of accumulated reserves, an increase in deficit financing (if fiscal health allowed it) and reallocation within the government budget.
37. Shifting the burden to patients was a poor alternative. Private (mostly out-of-pocket) expenditure on health was already high in several Member States, and the prolonged crisis carried the risk of further increases. User charges had also increased in many countries, but not all of them exempted the poor and vulnerable population. While it had proven difficult to selectively cut the least cost-effective services, the key message for health financing policy (as reiterated by Dr Margaret Chan, WHO

Director-General) was that “improving efficiency is a far better option than cutting back on services or imposing fees that punish the poor”⁴

Panel discussion

38. In the ensuing panel discussion, Mr Franck Von Lennep, Director, Department of Research, Evaluation and Statistics, Ministry of Social Affairs and Health of France noted that, in times of economic crisis, the power to manage the health system passed from the Ministry of Health to the Ministry of Finance. In his country, expenditure targets had been reached for the first time in 2010, and the Ministry of Health was now facing the challenge of implementing a new strategy of sustainability. Evidence needed to be gathered to demonstrate that a return on investment was being secured in terms of greater efficiency and higher quality care.
39. Mr Mark Pearson, Head, Health Division, OECD said that his organization did indeed believe there was a case for more fiscal stimulus in those countries that were less affected by the crisis. While it was necessary to consider both income and expenditure together, some trends (such as increases in out-of-pocket payments and cuts in spending on prevention) were unfortunate. It was inadvisable to rely on labour-based income for revenue, and efforts should be made to shift towards consumption-based income or property taxes. In any case, health systems were unlikely to secure the public’s acceptance of tax increases without evidence of efficiency gains.
40. Mrs Ana Xavier, Policy Coordinator, Directorate-General for Economic and Financial Affairs, European Commission said that there was a general need for health care reform, and that the economic crisis could give impetus to policy initiatives. A report issued by the European Commission in 2010⁵ had identified a number of reforms that could be made in the area of health system governance and had called for better pooling of resources. She welcomed the evidence base on measures to increase health system efficiency being built up by WHO. It would be important to look at the “starting point” for each country’s health system, and to distinguish between the impacts of the economic crisis, austerity measures and health care reform in general.
41. Mr Daniel Dulizky, Sector Manager, World Bank said that cuts in expenditure on medical care and pharmaceuticals needed to be accompanied by counter-cyclical targeted interventions or “safety nets” to protect poor and vulnerable populations. Efficiency measures should be implemented sensitively, using a tool akin to a scalpel (rather than a sword or machete) in order to cut waste and overprovision of services, if necessary in specific regions within a country, while retaining those that were necessary and cost-effective.
42. Mr Joseph Kutzin, Coordinator, Health Financing Policy, WHO headquarters, drawing lessons from WHO’s global experience, agreed that blunt policy instruments

4 Address to the WHO Regional Committee for South-East Asia, sixty-fifth session, Yogyakarta, Indonesia, 5 September 2012.

5 *Joint Report on Health Systems prepared by the European Commission and the Economic Policy Committee (AWG)*. Brussels, European Commission Directorate-General for Economic and Financial Affairs, 2010 (European Economy, Occasional Papers 74, http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf, accessed 24 April 2013).

and pro-cyclical measures were to be avoided. Policy choices had to be made in order to meet the commitments that countries had endorsed in the 2008 Tallinn Charter: Health Systems for Health and Wealth; the economic crisis had just made those choices more salient. A nuanced approach at the micro level would include acting on a number of principles:

- Don't make the situation worse for the most vulnerable population groups
 - Be more progressive in raising revenue (remove regressive subsidies, reduce tax deductions)
 - Move away from the tight link between wages and revenue – take in all sources of income
 - Recognize the accountability of the Ministry of Health (it can decide what and where to cut)
 - Ensure the preparedness of the health system (exercise restraint in favourable economic periods, limit deficits)
 - Engage in a continuing search for efficiencies.
43. In the following plenary discussion one participant noted that, while increased co-payments might not be the most desirable intervention, in an environment characterized by extensive informal payments they could in fact reduce people's overall health spending and increase health system revenue. On the other hand, introducing private funding was seen to be an inequitable, high-cost way of tackling financing difficulties. In general, it would be preferable to manage complex issues by adopting less complex yet still comprehensive approaches.
44. Another speaker questioned whether OECD and other bodies were moving away from using GDP to measure growth, and whether it might not be preferable to look at overall political accountability and governance, rather than purely fiscal responsibility. It was agreed that a distinction needed to be made between borrowing for investment (where the debt was matched by a corresponding asset) and borrowing for consumption (where it was not). At times, ministries of health did not fully appreciate their contribution to the broader agenda of jobs and growth.
45. Speakers from the eastern part of the Region emphasized that health systems could not be managed on purely economic principles: systems of financing did not guarantee a good quality of life, and market forces alone would not result in universal health coverage, without strong regulation.
46. The Chair of the session concluded that sustainability would continue to be a goal for health systems beyond the end of the economic crisis. Ministries of finance, and governments as a whole, would need evidence of where money could best be spent. To that end, WHO and OECD should continue and expand their work in the areas of policy review and analysis.

SESSION 3 - CRISIS AS AN OPPORTUNITY FOR HEALTH SYSTEM REFORMS: SHORT-TERM RETURNS AND LONG-TERM VISION

47. The third session was chaired by Dr Andrei Usatîi, Minister of Health of the Republic of Moldova.

Surviving austerity: Can efficiency gains help?

48. Professor Alan Maynard, University of York, United Kingdom said that health care objectives could be summarized under three headings: efficiency, or achieving maximum health gains at least cost; equity, which entailed ensuring financial protection against bankruptcy while securing equity in utilization and health costs; and expenditure control, or controlling unwarranted cost inflation. Continuing health care inefficiency was due to poor evaluation of medical care and health policy, large variations in clinical practice, medical errors and over-diagnosis, and poor outcome measurement.
49. Remedies for health care inefficiency had been proposed by reformers for hundreds of years and had been ignored. In the early nineteenth century, for instance, Thomas Percival had advocated measuring outcomes in terms of whether patients were “cured, relieved, discharged or dead”, noting that by means of outcome measurement “physicians and surgeons would obtain a clearer insight into the comparative success of their hospitals and private practice, and would be incited to a diligent investigation of the causes of such difference.” Ernest Codman, a surgeon, had lost his position at Massachusetts General Hospital in Boston, United States of America in 1915 for advocating the measurement of patient outcomes.
50. There were numerous examples of failed policies to improve efficiency. Reforming the structure of health care financing and delivery was, in most cases, an exercise in “re-disorganization” that was usually evidence-free and inefficient. User charges taxed the ill, privatized expenditure and might increase total expenditure, but they failed to reduce provider inefficiency. The purchaser-provider divide also failed to increase efficiency because purchasers were passive price and quality “takers”, rather than active price and quality makers. Health care reforms usually entailed high investment costs and produced no demonstrable efficiency gains.
51. Instead, policy interventions should focus on clinical decision-making teams, rather than on institutions or regions. Incentives, too, should be focused on physicians and their teams. The incentives “menu” raised a number of questions that needed to be investigated: whose performance was to be improved (the hospital, the clinical team or the individual physician); what performance should be considered (adherence to process guidelines or improvements in outcome); what incentives

should be employed (financial or non-financial, bonus payments or penalties) and of what size; what was the duration of effect: and what should be the measurement of success (effectiveness or cost-effectiveness)?

52. Efficiency gains could accordingly moderate the effects of austerity, but only if policy-makers focused on improving outcomes and physician behaviour, recognized and changed the passive behaviour of health care funders, and proceeded with care (undertaking scientific evaluation of new policies and expecting opposition from potential losers).

Panel discussion: Country experience

53. The ensuing panel discussion was moderated by Dr Matthew Jowett, Acting Head, Barcelona Office for Health Systems Strengthening, WHO Regional Office for Europe.
54. Dr Paulo Moita de Macedo, Minister of Health of Portugal said that, following debt regularization, his country's 2012 health budget had been adjusted upwards, from 4.6% to 5.9% of GDP. Strategic options adopted in the short and medium terms were to strengthen the primary care sector, to engage in hospital sector reform and to revise pharmaceutical products policies. In the long term, intensified health promotion and disease prevention efforts should ensure the sustainability of the national health service. Having described the goals set and measures taken in each of those areas, he identified expenditure on pharmaceuticals in inpatient settings as a particular challenge for the future. A balanced set of measures were also being taken to reduce out-of-pocket payments while preserving reasonable access to care. The equation expressed in his country's health sector reform rested on the interplay between improved care, reduced cost and waste, and improved health.
55. Dr Ingrida Circene, Minister of Health of Latvia said that, looking back, the economic crisis could be seen as an opportunity for accelerated reform of the health sector: her country had shifted the emphasis from hospital care to primary health care and had introduced social safety nets to protect poor people from having to make out-of-pocket payments. Priority was also being given to emergency medicine and to maternal and child health care. Intersectoral cooperation was key to the success of those efforts. Nonetheless, there were still challenges to be faced: reform initiatives were continuing as part of the government's agenda, and new programmes were being implemented. The continuing economic crisis made the need for such programmes even more urgent.
56. Mr Haris Kandiloros, Special Adviser to the Minister of Health of Greece said that the economic crisis starting in 2009 had led to reductions in government budgets and patient income. They in turn had revealed problems and inefficiencies inherent in the national health system that posed both immediate and long-term threats to public health. On the other hand, it was apparent that there was a "window of opportunity" for reform, since the majority of citizens were positive to reform efforts and the need for reform was admitted and welcomed throughout the government. The diversity and volume of reforms identified also pointed to the need to draw up a broad strategic action plan.

57. The main reform areas in Greece were: (a) the social security system, where a uniform benefit package was currently being delivered through the National Organization for Health Care Provision (EOPYY), with constant monitoring of the financing mechanism; (b) the pharmaceutical market, with the introduction of a reference price reimbursement system and co-payment percentages; (c) an electronic prescription system to control over-prescription and audit doctors' and pharmacists' behaviour; (d) health care establishments and national health system management (reductions in the number of hospital beds and departments, introduction of a costing system based on diagnosis-related groups); (e) procurement (centralized tenders and renegotiation of outsourced service contracts); and (f) primary health care (drafting of legislation to define procedures and enforce "gatekeeping" functions). In addition, a "health voucher" scheme was being piloted to ensure that uninsured citizens had access to primary health care.
58. With regard to governance, the Health in Action initiative launched by the Ministry of Health involved nine sub-committees, each focusing on a specific reform area and all reporting to a Health Reform Steering Committee chaired by the Secretary-General for Health. Long-term reorganization of the system was being realized through a broader strategic plan consisting of 7 "pillars", 47 strategies and 254 actions. One aspect of the country's continuous collaboration with WHO would be the development of a set of indicators to monitor the health impacts of the economic crisis on a real-time basis.
59. Ms Bairbre Nic Aongusa, Assistant Secretary-General, Department of Health, Ireland said that the collapse of the banking and construction sectors in 2008, and the increase in the ratio of debt to GDP, had led to a bailout by the "troika" of the European Union, the European Central Bank and the IMF in 2010. The impact on the health system had been severe: between 2008 and 2013, the health budget had been cut by 12% and the health workforce had been reduced by 11%. Ireland had the highest fertility rate in the EU and population growth had been exceptional, with an 8.5% rise between 2005 and 2011. Faced with that situation of increasing demand and shrinking resources, the strategy adopted had been one of cutting the cost (to the State) of services, rather than cutting services themselves. Prices (of pharmaceuticals, medical devices and capital expenditure) had been cut, payroll expenditure had been reduced, and costs had been shifted to patients through increased user charges (the instrument of choice for the Ministry of Finance and the troika, since it generated guaranteed revenue within a short time).
60. The Government of Ireland had adopted an ambitious reform programme in 2011, aimed at shorter waiting lists and waiting times for hospital services, free general practitioner care for all by 2015, universal health insurance by 2016, and improvements in services for people with disability and mental health difficulties. The case study carried out by the European Observatory on Health Systems and Policies, however, had found increased administrative costs associated with major reforms. Furthermore, a number of factors prevented the economic crisis from being seen unreservedly as an opportunity: each year it was more difficult to achieve savings, the underlying structural issues that had existed before the crisis (inflexibilities in the workforce, underdeveloped primary care, no equity of access, and safety and quality issues in hospitals) were still present, and further savings could not be

achieved without structural reforms. Lastly, some reform initiatives (such as free services for people over 70 years of age or the agreement concerning public sector pay levels) raised questions of intergenerational equity, and decision-making was at risk of being influenced by vested interests (pharmaceutical companies and the number of jobs they provided, or private health insurance schemes that were subsidized by the national health system).

61. Dr Clemens Auer, Director-General, Ministry of Health, Austria said that the strengths of his country's health care system were that it was highly regarded by the population, it provided a large number of services and it achieved reasonable outcomes. On the other hand, there were growing concerns about the performance of the system: it was costly in terms of the outcomes achieved, and health care expenditure was growing rapidly as compared to GDP. The "way out" was to increase both efficiency and effectiveness, and the approach of patient-centred integrated care had been adopted in order to improve health system performance. In view of the highly fragmented system of extramural and intramural care involving health care establishments and professionals, social insurance institutions, regional health funds, a federal health agency and three levels of government (federal, regional and local), steps were being taken to introduce a coordinated and cooperative governance system. With the aim of linking the increase in (public) health expenditure to projected growth in nominal GDP by 2016 (+3.6%), the one federal and nine regional governance commissions were engaged in concluding "contracts" on financial targets and those for health care processes and structures. The budget crisis had accordingly helped to push long-awaited reforms in the right direction.
62. Dr Pilar Farjas Abadia, Secretary-General, Ministry of Health, Social Services and Equity, Spain said that between 2009 and 2011 public debt in the Spanish national health system had increased by 173%. The increase in public expenditure on health care had exceeded that of GDP in the same period and, while pharmaceutical expenditure had fallen since 2009, the number of prescriptions written had continued to rise until 2011. A comprehensive set of health system reforms had therefore been introduced in 2012, targeting the basket of benefits, the pharmaceutical "portfolio", efficiency measures, health professionals, the social and health agreement, and health insurance rights. To date, they had resulted in savings of €1385 million on pharmaceutical expenditure, for instance, and a 50% decrease in hospital pharmaceutical debt. Those successes had been achieved while maintaining the performance of the national health system as measured in terms of self-assessment of health status, use of health services and insurance coverage. The reforms were thus ensuring the sustainability and equity of the system, and generating the stability and the predictable framework needed and requested by all stakeholders.

Invited contribution

63. Mr Artur Jose Moreira Coutinho De Carvalho, Health Care Systems Unit, Directorate-General for Health and Consumers, European Commission recalled one of the questions raised by the moderator of the plenary discussion in Session 1 the previous day: were the fundamental European values of health solidarity and equity being maintained? While the European Commission had different modalities for reviewing its cooperating with two groups of member countries, depending on whether they had concluded memoranda of understanding with the Commission,

the 2013 annual growth survey⁶ had recommended that “reforms of health care systems should be undertaken to ensure cost-effectiveness and sustainability, assessing the performance of these systems against the twin aims of more efficient use of public resources and access to high-quality health care.” On the question of the contribution of health expenditure to growth, a Commission Staff Working Document on investing in health⁷ had firmly established the role of the health sector in the framework of the EU strategy for 2020, addressing issues such as job creation, growth, universal access and disease prevention.

64. With regard to a longer-term vision, the European Commission was placing emphasis on the need for continued assessment of health system performance, with particular attention paid to questions of access to health care, especially by disadvantaged population groups. In that context, a number of issues would need to be addressed:

- Improve the analysis of existing data
- Define how access has been affected by the economic crisis
- Assess the public health consequences of certain groups not having access
- Ensure access by citizens moving between EU member countries
- Make sure that health systems compensate for, rather than exacerbate, health differences.

65. The European Commission was therefore very firmly committed to the values of equity and solidarity, but there was still much work to be done to ensure that they were put into practice.

Plenary discussion

66. In the ensuing plenary discussion, participants drew parallels between the experience of their countries and those described by the panel members, and asked what was the major factor that had enabled drug prices to be cut, especially in the context of the “clawback” measures taken by pharmaceutical companies. In response, panellists suggested that useful approaches had included increasing the use of generic drugs, introducing the reference price model, reducing fraud, and engaging in transparent price negotiations.

6 *2013 Annual Growth Survey*. Brussels, European Commission, 2012 (COM(2012) 750 final, http://ec.europa.eu/europe2020/pdf/ags2013_en.pdf, accessed 27 April 2013).

7 *Investing in health*. Brussels, European Commission, 2013 (SWD(2013) 43 final, http://ec.europa.eu/health/strategy/docs/swd_investing_in_health.pdf, accessed 27 April 2013).

SESSION 4 – PUBLIC HEALTH AND PREVENTION

Can prevention save us?

The economics of public health interventions

67. Professor Charles Normand, Trinity College Dublin, Ireland and Chair, Steering Committee of the European Observatory on Health Systems and Policies said that, while there was no inherent advantage for preventive over curative measures, in many instances prevention worked better and was better value. Careful analysis would be needed, however, in order to shift the balance towards more prevention. Some ways of classifying action were increasingly inadequate: palliative interventions prolonged life, and curative ones improved the quality of life. While strategic shifts were important, the key objective should be to use resources to best effect in reducing the burden of disease.
68. A number of factors militated against attempts to focus on outcomes and define the most cost-effective strategies to prevent disease burdens. Prevention was often seen as important but not urgent; the effects of prevention tended to be less visible and sometimes less individual, and the pathways of effect were more complex; prevention could lack the technical complexity and glamour of curative interventions; and prevention workers were often less well paid and lower in hierarchies.
69. Vaccination in children was cost-saving for some diseases and highly cost-effective for others. While there were many other cost-effective prevention strategies, the big impact on health would come from reductions in smoking and obesity rates. The case for prevention and public health action was particularly strong where the health effects of lifestyles were fully or partly irreversible. The general pattern was that earlier, more focused and better resourced interventions tended to be more cost-effective. Better prevention strategies could certainly allow slower growth in health spending, but saving money required effective budgeting and payments systems, and the will to say no to interventions that offered poor value. The “tyranny of the urgent” was a constraint, especially in the early days before the effects of prevention strategies were fully felt.
70. It was therefore important to build and understand the evidence on prevention, but a number of difficulties needed to be overcome or taken into account. Many interventions were not amenable to controlled trials or formal meta-analysis; many studies could not blind participants; and many effective preventive measures were inherently complex, difficult to standardize and might involve a wide range of individual interventions. Lastly, prevention often affected outcomes more than measured risk factors. In evaluating public health interventions, it was necessary to accept some analogy and extrapolation, and to show some understanding of time scales and complexity: weaker evidence was not the same as no evidence.
71. The selection of effective interventions (many of which involved substantial elements of prevention) could certainly help contain health system costs, but choices

would have to be made between prevention and treatment, between treatments, and between more and less visible people and population groups.

72. A short video film, *Public health – part of the solution*⁸, was shown.
73. Dr Joanna Nurse, Senior Adviser, Public Health Services, WHO Regional Office for Europe presented the case for investing in public health. At its sixty-second session in September 2012, the WHO Regional Committee for Europe had endorsed the European Action Plan for Strengthening Public Health (EAP) and its ten essential public health operations (EPHOs). The North Karelia project and numerous studies using the IMPACT model, among others, had clearly shown the large contribution of disease prevention to the reduction of coronary heart disease (CHD) mortality.
74. Building on that foundation, and as part of its work on developing public health tools and instruments, WHO/Europe had elaborated a number of tables quantifying the costs of not taking action on health outcomes and risk factors. From those tables, it had been possible to identify a set of “best buy” interventions for a number of risk factors (tobacco, alcohol, diet, physical inactivity, infection) and specific noncommunicable diseases (cardiovascular disease and diabetes, cancer and respiratory disease). Those “best buys” had been characterized in terms of the avoidable burden of disease (expressed in disability-adjusted life years – DALYs) and the implementation cost, feasibility and cost-effectiveness of the intervention.
75. Further analysis had then been done to identify the most cost-saving and cost-effective examples of interventions on factors affecting behaviour (mental health and violence), social determinants of health (housing, debt, employment) and environmental determinants (road traffic injuries, green spaces, active transport, environmental hazards), as well as screening and vaccination. That work clearly illustrated the multiplier effect, in terms of both health benefits and social gain, generated by interventions in the various areas concerned (promotion of mental well-being, safe urban design, etc.). It was therefore a cause for concern that, in certain OECD countries, prevention and public health was the category of health spending in which public expenditure had fallen most in 2009/2010, and that OECD countries continued to spend on average no more than 3% of total health expenditure on that category.
76. In summary, the economic crisis was a challenge for health and social outcomes; public health could be part of the solution to that challenge. The current costs of inaction were significant. The evidence showed that prevention was cost-effective and could save money; small investments promised large gains.

Panel discussion

77. Moderating the panel discussion, Professor Alan Maryon-Davis, King's College, London, United Kingdom asked panel members to reflect on how to divide up the sometimes shrinking public health and prevention budget in order to achieve the best return on investment.

⁸ See <http://www.euro.who.int/en/what-we-do/event/oslo-conference-on-health-systems-and-the-economic-crisis/multimedia/video-public-health-part-of-the-solution>

78. Dr Miklós Szócska, Minister of State for Health, Hungary said that, in addition to an intensive campaign against smoking, his country had introduced a public health tax (made up of taxation on salt, sugar and the ingredients in energy drinks), aiming to channel the revenue raised into public health programmes, although it was currently used for salary increases in the public sector. Sophisticated business intelligence had also been used to establish preferred reference price bands for certain generic pharmaceuticals, and an incentive model had been implemented to promote better diabetes management. In addition, savings measures such as national-level joint purchasing of energy for hospitals had been introduced. Results to date had included an increase in tax revenue, savings on drug expenditure and a decrease in private spending on pharmaceuticals.
79. Dr Andrei Usatii, Minister of Health, Republic of Moldova and Chair, South-eastern Europe Health Network (SEEHN) said that seven public health areas of common concern had been identified in the Dubrovnik Pledge as early as 2001⁹. The countries in the network were committed to implementing Health 2020 and the EAP. Through its regional development centres on noncommunicable diseases, blood safety, human resources for health, communicable disease surveillance and control, mental health, strengthening public health systems and services, and antibiotic resistance, SEEHN was advancing the reshaping of health systems with clear emphasis on health promotion and disease prevention. Joint efforts were being made by public health and the primary health care level to scale up prevention activities and the results of risk factor control programmes. An integrated policy response across sectors was needed at national and especially at community level, to translate national strategies into sound local action plans.
80. Dr Mario Mikloši, Director-General, Ministry of Health of Slovakia said that his country had had very good experience with preventive programmes in the previous year, and expenditure would therefore be maintained at the same level. Vaccination against tuberculosis had been discontinued the previous year but, in line with WHO recommendations, was being maintained for people in risk groups. The key role of general practitioners was acknowledged, but half of them were almost 60 years old, a major problem that would need to be solved. The conclusion was that prevention was good, but the “pay-off” would only be seen in the long term.
81. Dr Maris Jesse, Director, National Institute for Health Development, Estonia believed it was essential to demonstrate the efficiency and appropriateness of programmes in all areas, including public health. As had been stated at the ministerial meeting held in Oslo in 2009, it was important to prioritize where cuts should be made; she argued that infectious disease control programmes (HIV/AIDS, tuberculosis, etc.) should not be cut. Lastly, the economic crisis could be seen as an opportunity provided policy-makers agreed on policies that did not burden the public purse and did health good – the decrease in the affordability of alcohol being cited as one example.

9 *The Dubrovnik Pledge: Meeting the health needs of vulnerable populations in south-east Europe.* Copenhagen, WHO Regional Office for Europe, 2001 (http://www.euro.who.int/__data/assets/pdf_file/0009/99738/e94525.pdf, accessed 26 April 2013).

82. Mrs Taru Koivisto, Director, Health Promotion, Ministry of Social Affairs and Health, Finland recalled that her country had experienced a severe economic crisis in the early 1990s, with a 13% drop in GDP, an unemployment rate of 16 % and interest rates of over 20%. The government had been unprepared for that situation, and many of the measures taken had been exacerbated by cuts in social and health services. A decentralized system had been introduced before the crisis, and many municipalities had cut preventive services, in particular. The effects had been long-lasting and could still be measured. One lesson learned was that universal coverage did not have to be maintained; another was that an intersectoral, “health in all policies” approach was needed. Spending on preventive care for children and young people should not be cut. Public health capacity should be maintained, with a firm research and evidence base. Public health professionals had to play a strong advocacy role for prevention and primary health care.

83. Mr Clive Needle, Director, EuroHealthNet welcomed the opportunity to work on implementation of EAP. Building on the conclusions from the 2009 Oslo ministerial meeting, it was important not just to protect but also to strengthen public health and prevention, in three ways: (a) an integrated and multisectoral approach, focusing on the life course and led by a prime minister, would yield real, cost-effective benefits and health gains; (b) attention must be focused on avoidable inequities, as was being done by the host country of the conference; and (c) the watchword, as in the Ottawa Charter on Health Promotion, should be “reorientation”, keeping what was good while introducing new approaches that involved working with stakeholders such as not-for-profit organizations and social enterprises on EPHO 9 (communication, advocacy and social mobilization, especially directed towards other sectors).

SESSION 5 - STRONGER HEALTH SYSTEMS: PREPARED AND RESILIENT

Key messages of the conference and policy recommendations by WHO

84. Ms Zsuzsanna Jakab summarized the key messages of the conference. The macroeconomic outlook for the WHO European Region was not promising and was exacerbated by structural challenges. There was limited fiscal space, and caps on health spending were likely to continue, but governments had choice over where to allocate funds and should prioritize areas that encouraged economic growth and reinforced solidarity and equity. The economic crisis had had an impact on people's health and its determinants. While it might not be possible to fully quantify that health impact during the crisis, enough was known about the risks to health to allow mitigating action to be taken.
85. The ten policy recommendations issued at the end of the 2009 Oslo ministerial meeting remained valid. Areas in which reforms could be made to improve efficiency without hurting the poor or damaging equity included fostering prevention and health promotion, strengthening primary health care and engaging in hospital reform, refocusing pharmaceutical policy and streamlining benefit packages. User fees and other sources of private financing made only a limited contribution to the attainment of health sector goals.
86. Ten policy recommendations were contained in the "outcome document" from the Conference (Annex 1) and could be summarized as follows:
- Short-term policy responses to fiscal pressure should be consistent with long-term health system goals and reforms.
 - Fiscal policy should explicitly take account of health impact.
 - Social safety nets and labour market policies can mitigate the negative health effects of the financial and economic crisis.
 - Health policy responses make a difference to health outcomes, access to care and the financial burden on the population.
 - Funding for public health services must be protected.
 - Fiscal policy should avoid prolonged and excessive cuts in health budgets.
 - High-performing health systems that are more efficient are better prepared and more resilient during times of crisis.

- Deeper structural change in health systems will take time to deliver savings.
 - Safeguarding access to services requires a systematic and reliable information and monitoring system.
 - Prepared and resilient health systems result primarily from good governance.
87. The draft outcome document would be discussed at the open session of the Standing Committee of the WHO Regional Committee for Europe, to be held in Geneva on 18–19 May 2013 and would then be sent out for web-based consultation with Member States. Once the evidence-gathering process had been completed, the document would be finalized and presented for endorsement by the WHO Regional Committee for Europe at its sixty-third session in September 2013.

Reflections by Member States

88. Member States' representatives welcomed the outcome document. They suggested that a specific recommendation could be added concerning the interaction between Ministries of Finance and of Health, stressing that it was possible to align health gain and fiscal gain. In addition, greater emphasis could be placed on the need to approach health financing in a whole-of-government perspective: the outcome document could usefully be taken to all ministries, to make health policy in all policies.

FINAL REMARKS AND CLOSURE

89. Dr Hans Kluge said that the WHO Regional Office for Europe would continue to work on developing a communication tool that ministers of health could use to approach ministries of finance, and to generate further evidence in cooperation with the European Observatory on Health Systems and Policies. The Regional Office would also work with Greece, the country due to hold the presidency of the Council of the European Union in the first half of 2014, on a “toolkit” that Member States could use to monitor the health impact of the economic crisis. Lastly, WHO would continue to participate in the Network on Health Expenditures set up by the OECD Working Party of Senior Budget Officials (SBO). The Network had held a joint meeting with WHO in Tallinn, Estonia in June 2012 on the “Financial sustainability of health systems in central, eastern and south-eastern Europe” and had met for the second time in Paris in March 2013; it was hoped that further meetings would be held.
90. Dr Bjørn-Inge Larsen, Secretary-General, Ministry of Health and Care Services, Norway commended the WHO Regional Office for Europe for keeping attention focused on the health impact of the economic crisis in the four years since the first ministerial meeting in Oslo. The European Observatory on Health Systems and Policies had worked quickly and competently to provide some very good reports and constituted an excellent network of experts. The Conference had shown that countries were adopting innovative approaches to dealing with the repercussions of financial cuts, although they could usefully do more to identify services of low cost-effectiveness and limit the funding channelled towards them.
91. Ms Zsuzsanna Jakab, WHO Regional Director for Europe, closed the meeting by assuring participants that WHO would continue to provide both normative and technical support to its Member States in their efforts to strengthen their health services. A conference on health systems, scheduled for 17–18 October 2013 in Tallinn, Estonia, would mark the progress made since Member States had adopted the Tallinn Charter at the WHO European Ministerial Conference on Health Systems in 2008.

ANNEX I OUTCOME DOCUMENT – DRAFT FOR CONSULTATION

A. The current economic situation and medium term outlook

1. The onset of the global financial crisis in 2008 resulted in a dramatic initial economic shock: real gross domestic product (GDP) per capita declined by 4.5% across the WHO European Region in 2009. Looking forward, many countries expect little or no growth in 2013. As a result unemployment has increased sharply; within the European Union (EU) alone, unemployment rose from 6.9% in 2008 to 9.6% in 2010, with a figure of 11.9% estimated for 2013 by Eurostat.
2. Recognizing the diversity of the WHO European region, it is important to note that not all European countries were affected, or not to the same degree, by the economic crisis. Whilst overall, eastern Europe experienced negative real per capita GDP growth in 2009, central Asia and Azerbaijan were largely insulated from the economic downturn. Additionally, the effect of the crisis in eastern Europe and the Caucasus was brief, with positive growth resuming in 2010. Put together, these factors have led to deteriorating government finances in many countries, with government debt as a share of GDP rising sharply in affected countries. Many governments have also faced a sharp increase in borrowing costs as a result.
3. Affected European countries have now been navigating the crisis for five years indicating its prolonged nature. The tight fiscal context and high unemployment is expected to continue in the medium term. In several countries the crisis is having wide-reaching social and political consequences, destabilizing the status quo. Accounting for around 10% of the economy in many countries, the health sector itself plays an important role as an employer. It is therefore critical to take stock of the situation to be better prepared with policy responses which can ease the social and political tensions faced by communities, elected politicians and governments. Re-affirming commitment to solidarity and implementing this commitment will lie at the heart of the response.

B. Policy tools provided by the WHO Regional Office for Europe

The WHO Regional Office for Europe has engaged intensively with Member States to make effective policy decisions that improve health and reduce inequalities during the crisis period. Health 2020 is the foundation of its engagement and the strong emphasis on solidarity and equity, and on improving leadership and governance for health, anchors its support to Member States at times of economic crisis. The WHO Regional Office for Europe focuses its support on the two strategic objectives and the four priorities in Health 2020, and has developed and is refining a number of tools to provide countries with the best possible support, in the context of Health 2020, as they adjust to the current fiscal climate:

- **Analytical frameworks to review government policies in response to the financial crisis and synthesize evidence of impact on health and health system performance;**
- **Policy dialogue and knowledge brokerage events, and training courses;**
- **Direct technical assistance.**

At the request of Member States, WHO Europe has provided support to a number of countries including Greece, Estonia, Ireland, Kyrgyzstan, Latvia, Lithuania, and Tajikistan on analytical, policy development, implementation and evaluation work. WHO works closely with its partners in a fully coordinated manner including the European Observatory on Health Systems and Policies, OECD, and the World Bank. Significant support was also provided in producing the evidence base in support of Health 2020, including studies on the Economics of Prevention, the Report on Social Determinants of Health and the Health Divide in the WHO European Region, and the European Action Plan for Strengthening Public Health Capacities and Services.

C. Summary of the latest evidence

Impact of the crisis on population health status

a) Two broad observations stand out clearly from the evidence; first, as noted at the WHO Europe meeting held in Oslo in April 2009, the economic crisis has adversely affected “...*many of the **social determinants of health**, such as income, employment, education, nutrition, corporate practices (marketing and pricing, for instance) and taxation. Its effects are dependent on the extent of family assets, the basic family and welfare support models, etc.*”

Secondly, given that health needs tend to increase when unemployment rises and household incomes fall, the policy responses introduced may themselves have an added impact on population health. Both the **fiscal policy response** of a country i.e. the extent to which it follows a path of austerity versus one of counter-cyclical spending, and the **health policy response**, are important in ensuring that effective social safety nets are in place, and that access to needed services is protected as well as the quality of those services. The policy recommendations of Report on Social Determinants of Health and the Health Divide in the WHO European Region are also relevant in this context.

b) Although there are data limitations, and challenges when attributing certain health effects to economic crisis, it is clear that **mental health** is highly sensitive to economic downturn, both increasing the likelihood of falling sick, and slowing down recovery from illness; across the EU, suicides in under-65 year olds have increased since 2007 reversing a downward trend. Both unemployment and the fear of unemployment are major contributing factors. The incidence of **infectious diseases** (e.g. HIV infections) has increased sharply in some of the hardest hit countries, where preventive programmes (e.g. needle exchange) and early treatment services have been scaled back as a result of budget cuts. This demonstrates the importance of protecting preventive services for which demand increases during times of economic crisis. Similarly, protecting in

particular the poor and vulnerable from the financial risks of accessing care at a time of increased demand, is critical to avoid further impoverishment.

Falling household incomes also have an **effect on health adverse behaviours** such as harmful levels of smoking and alcohol consumption; many countries report reductions in health adverse behaviours overall. However an equity analysis is required here as some population groups show a marked increase in such behaviours which has a harmful effect on their health. Certain health effects do not manifest themselves immediately, but **changes in population access to needed services are likely to indicate where future problems may arise**. The evidence suggests that across the WHO European Region governments have made great effort to absorb budget cuts and protect access by lowering the cost of services, notably pharmaceuticals and public health sector salaries. However, some countries have reduced entitlement to effective treatment or increased user charges across the board, which may undermine access to needed services. If changes to the benefits package and user charges focus on services of low clinical value (cost-effectiveness), and the poor and vulnerable are exempt, the negative impact on access and health may be minimal.

D. Policy lessons from the evidence

1) It is critical to keep an eye on the longer-term challenges of health systems while navigating the crisis.

Short-term policy responses to fiscal pressure should be consistent with the health system reforms required to address the health challenges now facing European societies. These call for coordinated service delivery systems based on primary care and community care linked with social care, and health-in-all policies focused on risk factors related to non-communicable diseases, and an emphasis on health promotion and disease prevention. It is critical that providers invest adequately in professional education to meet the changing demands on health systems and to adapt to the necessary reconfiguration of service delivery; an expanded roles for nurses and midwives is likely to be part of this. Health 2020 provides the strategic framework to address these challenges.

2) Fiscal policy should explicitly take account of the likely impact on population health.

There is strong evidence that whilst there are some positive effects on health, the overall risk of negative health effects rises during financial crisis and economic recession, particularly for the poor and vulnerable. Large increases in unemployment are associated with higher levels of morbidity, in particular related to mental health, and increased mortality from suicides, and greater use of alcohol and tobacco. Fiscal policies, particularly those promoting austerity, should factor in this evidence as part of the policy-making process and take steps to mitigate negative health effects.

3) Social safety nets and labour market policies can mitigate the negative health effects of financial and economic crisis.

Evidence shows that despite the increased risk of ill-health during economic downturns, concerted intersectoral action such as active labour market policies, can limit lengthy unemployment, and effective safety nets for those without work can largely mitigate the negative health effects of economic downturns. The health sector plays a critical

part in overall social protection by ensuring sufficient absorptive capacity for increased demand for mental and physical health services.

4) Health policy responses influence the health effects of financial and economic crisis.

Reductions in public spending on health in response to a deteriorating fiscal situation come at a time when demand for health services tends to rise. Policy measures to absorb budget cuts through supply-side measures (e.g. price reductions) should be exhausted before costs are shifted onto patients especially the poor. Funding for essential, cost-effective, well-managed services should be protected at the expense of low value and poorly managed services. Across-the-board cuts may worsen the situation by failing to target areas of inefficiency, and inappropriate cuts may introduce new forms of inefficiency. Cutting wisely is critical to minimize the adverse effects on health as budgets fall.

5) Funding for public health services must be protected.

Fiscal pressure brings into even sharper focus the need to ensure that spending on health is cost-effective. Public health services (including health protection, disease prevention) are proven investments that can improve health outcomes at relatively low cost, and funding for these services should be protected. In addition, public health interventions can play a significant role in contributing to economic recovery by protecting mental health, improving workplace health, and focusing on interventions that save costs to the health system.

6) Fiscal policy should avoid prolonged and excessive cuts in health budgets, given that population health needs increase quickly and significantly as unemployment rises and household incomes fall, except where it is clear that such downward budget adjustments do not threaten population access to needed services. There is a strong case for a counter-cyclical approach to public spending, in order to maintain service provision at a time of growing demand, which in turn requires responsible fiscal and economic policies during periods of economic growth. Similarly, health systems can prepare better for a downturn through appropriate and efficient infrastructure investments, appropriate service delivery reconfiguration, a focus on cost-effective interventions, and careful expansion during periods of increasing health budgets.

7) High performing health systems may be more resilient during times of crisis.

Whether health budgets are growing or declining, continual efforts are required to improve efficiency. High-performing health systems may be more likely to have funding protected than those with considerable inefficiencies. Efficient health systems tend to have better management capacity which in turn strengthens resilience in handling cuts when unavoidable. Systematic gathering of information through health technology assessment to support strategic purchasing and setting appropriate incentives for all actors throughout the system combined with robust management capacity can help ministries to prioritize spending decisions and minimize negative effects on health when budgets are tight.

8) Deeper reforms are unlikely to deliver savings quickly under time pressure.

The prolonged nature of fiscal tightening, with some countries moving into a fifth year of budgetary pressure, makes it more difficult for system reforms to absorb further cuts in spending without avoiding damaging access to needed services. More fundamental

reforms for example which address the underlying cost base of service delivery, often require up-front investment which can be limited during a crisis, and are unlikely to be delivered in the short term. Budget allocations to health should take this into account. This point also highlights the need for health systems to continually seek efficiency gains and not only once crisis hits.

9) Safeguarding access to services requires a systematic and reliable information and monitoring system.

The identification and use of a set of readily available, specific and sensitive indicators, disaggregated at the sub-national level to monitor the impact of policies, for example on inequalities in access to care, should be established as a priority. Monitoring the impact on health over time or policy responses associated with the financial crisis includes fatal and non-fatal health outcomes and their determinants, including those of the health care system.

10) Prepared and resilient health systems result primarily from good governance.

Crises can create the political opportunity to introduce structural reforms in health systems, but pressure to make change rapidly can also lead to adverse effects. Major reconfiguration of service delivery systems or reforms of payment systems, for example, need to be implemented gradually, and may be more successful at times of growing budgets. Addressing these challenges in a timely manner is a test of good governance within health systems: continual attention to efficiency and responsible management of public resources in the health sector, combined with prudent fiscal policy, are the most effective strategies to protect equity and solidarity during economic downturn. Health 2020 provides the guiding framework for such an approach.

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