Meeting report

Health Systems Charter
Fourth preparatory meeting for the
WHO European Ministerial Conference on Health Systems:
“Health Systems, Health and Wealth”

Brussels, Belgium, 6 June 2008
Introduction

The fourth and final preparatory meeting for the WHO European Ministerial Conference on Health Systems was held at the National Social Security Office in Brussels on 6 June 2008, hosted by the Belgian Government and attended by representatives of 42 of the 53 Member States of WHO in the European Region and of partner organizations, as well as European experts in the field of health systems (for the list of participants, see Annex 1).

The preparatory meeting was preceded by a short meeting of the Charter Drafting Group for the Conference, at which it reviewed comments submitted by representatives of Estonia, Finland, Norway and the European Investment Bank since the previous meeting of the Group, held in Moscow on 12–13 May 2008 (for the draft of the Charter discussed at the Brussels meeting, see Annex 2).

Drafting Group members agreed that most of those comments were aimed at rearrangement or “fine-tuning” of the text. Outstanding or additional questions concerned the legal implications of the Charter (notably related to the “commitments” being made by partner organizations and the Member States) and the need to make reference to health research, development assistance to countries within and outside the WHO European Region, and gender equity. Those issues were subsequently taken up in more detail at the preparatory meeting.

The preparatory meeting itself was opened by Dr Johan de Cock, Administrator-General, Social Health Care Department, National Institute for Health and Invalidity Insurance, who welcomed participants on behalf of the Belgian government and explained that the National Social Security Office had been chosen as the venue of the meeting in part because social security was a vital framework for statutory health insurance. He was pleased to see the outcome-oriented approach evident in the draft Charter and the importance it attached to health system performance, quality of care, equitable access to primary care and increased value for money: the aim was to ensure that health systems were affordable today and sustainable tomorrow.

Session 1. Charter drafting process: an update

Dr Fiona Adshead, Chairperson, Charter Drafting Group, recalled that following the Group’s second meeting in Valencia, Spain, on 8–9 February 2008, a third draft of the Charter had been circulated to Member States on 10 March. A third pre-Conference meeting had been held in Rome, Italy on 3 and 4 April, and fourth and fifth drafts of the Charter had then been sent out to countries for comments, leading to the preparation of the sixth draft, currently under discussion.

The aims of the final preparatory meeting were to review comments on the latest draft, to agree on the political handling of the Charter, to resolve any final issues that required attention before the Charter was launched in Tallinn, and to begin to consider how the Charter would be used after the Ministerial Conference.

Session 2. Charter content: questions and discussion

Dr Joe Kutzin, Regional Adviser, Health Financing, WHO Regional Office for Europe, gave an overview of the structure and content of the current draft of the Charter. In the ensuing discussion, participants confirmed that the current version of the Charter was broadly acceptable and that the comments they had made on successive drafts had been taken into account. They would therefore endeavour, in the present meeting, to keep proposed changes to a minimum, in order to avoid the need to engage in fresh consultation at national level.

Nonetheless, some raised the concern that the Charter might be construed as containing legally binding commitments. The Secretariat confirmed that the wording of the text (especially in Russian) would be reviewed and amended, if necessary, to allay that concern. WHO’s Legal Adviser explained that the
Charter would embody the positions adopted by representatives of Member States during the drafting process and that it would be a political statement of adherence to principles, not a legal instrument. Its formal endorsement by the WHO Regional Committee for Europe would not alter that fact, since resolutions adopted by the Regional Committee (and indeed even by the World Health Assembly) had only recommendatory effect.

It was agreed that the title of the Charter should be amended to “The Tallinn Charter: Health systems for health and wealth”. The footnote to the first paragraph in the preamble should include a reference to the 2004 Mexico Statement on Health Research, and the phrase “the right to health” should be aligned on the wording contained in the WHO Constitution, namely “the right to enjoyment of the highest attainable standard of health.” The notion of epidemiological change should be included as part of the context in which countries were addressing major health challenges (paragraph 3), to ensure that subsequent references to health care were understood as covering both acute and chronic conditions. A new footnote to paragraph 5 should make it clear that the statements which Member States and partners believed to be true were based on evidence, particularly the background material produced by WHO for the Conference.

In the section on “Commitment to act”, the term “pro-poor planning” was not readily understood and should be replaced by a phrase such as “ensuring that due attention is paid to the needs of the poor”; in addition, the target audience should be broadened to take in other vulnerable groups. The aim of investing in health systems and across sectors should be made more specific, by referring to the need to “foster investment across sectors that influence health”. It was recognized that incorporating a commitment for countries to provide development assistance probably exceeded WHO’s mandate and would entail further consultation at national level; however, one of the Member States’ commitments could be amended to read “foster cross-country learning and cooperation on the design and implementation of health system reforms …”. In general, the Secretariat was advised to keep the wording of the section in its current form, in order to engage ministers and attract political support for the Charter.

The Drafting Group agreed that it was important to recognize the contribution made by partner organizations to drawing up the Charter, and that they should therefore be mentioned by name in paragraph 8. However, it would be necessary to distinguish the subject of each sentence in that paragraph (partner organizations and WHO; the European Commission and related institutions; the European Investment Bank; and Member States). The sentences could be qualified, as required, by making reference to the mandates and statutory provisions of the respective organizations, and declarations by the partners could be annexed to the Charter if necessary (as had been done at previous WHO ministerial conferences).

In the section on “Strengthening health systems: From values to action”, the wording from the WHO Constitution should be used again in paragraph 9, and reference should be made to people’s particular health needs related to gender, age, ethnicity and income. In paragraph 13, the introductory sentence should refer merely to a “common set of functions” of a health system, given that countries might choose to group them in ways other than the four categories set out in the Charter. It would be worth making an explicit statement that the holistic approach to delivering health services involved health promotion, disease prevention and integrated disease management programmes.

The notion of ensuring fiscal responsibility should be introduced in the sub-section on “Financing the system”, while the aim of sustainability and stability could be couched in terms that referred to the need for the overall allocation of resources to address current and future health needs. There, too, an appropriate balance should be struck between health care, disease prevention and health promotion.

With regard to the sub-section on “Creation of resources”, and specifically the question of investment in the health workforce, participants noted that a global process was currently under way to draw up a code of practice on the international recruitment of health personnel. They accordingly asked for reference to be made to “a code of practice”, with the relevant resolutions of the World Health Assembly and the WHO Regional Committee for Europe cited in a footnote. The call to foster research should be worded so as to emphasize research on health policy and health systems.
New wording was proposed, in the sub-section on “Stewardship”, to make it clear that health ministries had the mandate and responsibility for legislation, regulation and enforcement of health policies, and that they should promote the inclusion of health considerations in all policies.

**Conclusions**

Participants agreed with the proposal that the Charter, once adopted at the WHO Ministerial Conference, should be signed on behalf of all those present by the WHO Regional Director for Europe and the Minister of Social Affairs of Estonia, the host country. It would then be submitted to the WHO Regional Committee for Europe for endorsement at its fifty-eighth session in September 2008. The draft resolution presented to the Regional Committee in that connection would make reference to a process for evaluating the implementation of the Charter, including the development of a common set of indicators that countries could use to assess the performance of their own health systems.
Annex 3. List of participants

List of participants

Member States

**Albania**
Dr Ehadu Mersini  
Head, Hospital Service Standards Sector, Directorate of Hospitals, Health Policy and Planning, Ministry of Health

Dr Alban Ylli  
Director, Institute of Public Health

**Armenia**
Professor Vladimir Davidyants  
Director, Information and Analytical Centre, National Institute of Health, Ministry of Health

Dr Tatul Hakobyan  
Deputy Minister of Health

Mr Arman Melkonyan  
Adviser to the Minister of Health

**Azerbaijan**
Professor Rauf Maksud Agayev  
Deputy Head, Science and Human Resources Department, Ministry of Health

Ms Gulsom Gurbanova  
Ministry of Health

**Belarus**
Dr Igor Vladimirov Brovko  
Director, Department for Organization of Medical Assistance, Ministry of Health

**Belgium**
Dr Johan De Cock  
Administrator-General, Social Health Care Department, National Institute for Health and Invalidity Insurance (RIZIV-INAMI)

Ms Leen Meulenbergs  
Head of Service, International Relations, Federal Public Service for Health, Food Chain Safety and the Environment

**Bosnia and Herzegovina**
Dr Goran Cerkez  
Assistant Minister, Department for International Cooperation, Federal Ministry of Health

Ms Mirha Osijan  
Senior specialist, Department for Health, Ministry of Civil Affairs of Bosnia and Herzegovina

Dr Andreja Subotic  
Ministry of Health and Social Welfare of Republika Srpska

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1 In alphabetical order
Bulgaria
Dr Svetlana Spassova
Director, National Health Policy, Ministry of Health

Croatia
Dr Danica Kramaric
Head, Directorate of Medical Affairs, Ministry of Health and Social Welfare

Czech Republic
Dr Lucie Bryndova
Adviser to the Minister, Cabinet of the Minister, Ministry of Health

Ms Martina Tothova
Director, Department of International Affairs and the European Union, Ministry of Health

Denmark
Ms Marianne Kristensen
Senior Adviser, National Board of Health

Estonia
Dr Maris Jesse
Director, National Institute for Health Development

Finland
Dr Marjukka Vallimies-Patomäki
Ministerial Adviser, Health Department, Ministry of Social Affairs and Health

France
Mme Géraldine Bonnin
Délégation aux affaires européennes et internationales, Ministère de la santé, de la jeunesse et des sports

Georgia
Dr Sofia Lebanidze
Head, Health Department, Ministry of Labour, Health and Social Affairs

Professor Nikoloz Pruidze
Deputy Minister, Ministry of Labour, Health and Social Affairs

Germany
Dr Birgit Cobbers
Strategic Planning of Health Policy, Federal Ministry of Health

Greece
Dr Efstratios Geragotis
Special advisor on European Affairs, General Secretariat, Ministry of Health and Social Solidarity

Hungary
Dr Katalin Rapi
Deputy Director-General, National Health Fund Administration

Ireland
Dr John Devlin
Deputy Chief Medical Officer, Department of Health and Children

Italy
Dr Fabrizio Carinci
SIVEAS National Expert, Directorate-General for Health Planning, Ministry of Health
Dr Francesco Cicogna  
Senior Medical Officer, Directorate General for the EU and International Relations, Ministry of Health

**Kazakhstan**  
Dr Kadyr T. Omarov  
Deputy Minister of Health

Professor Alexander Nersessov  
Director, Department for Strategic Development and International Cooperation, Ministry of Health

**Kyrgyzstan**  
Dr Ainura Ibraimova  
Deputy Minister of Health

Dr Liudmila Davydova  
First Deputy Director-General, Department of State Sanitary and Epidemiological Surveillance, Ministry of Health

**Lithuania**  
Mr Martynas Pukas  
Chief Specialist, Foreign Affairs Division, Ministry of Health

**Moldova**  
Dr Ghenadie Turcanu  
Director, Policy Analysis, Monitoring and Evaluation, Ministry of Health

**Montenegro**  
Mrs Smiljka Kotlica  
Secretary, Ministry of Health, Labour and Social Welfare

Ms Nina Milovic  
Adviser, Ministry of Health, Labour and Social Welfare

**Netherlands**  
Mr Fred Lafeber  
Head, Global Affairs Unit, International Affairs Department, Ministry of Health, Welfare and Sport

Ms Carola van den Brink  
Policy Advisor, International Affairs Department, Ministry of Health, Welfare and Sport and Ministry for Youth and Families

**Norway**  
Mr Arne-Petter Sanne  
Director, Multilateral Affairs, Secretariat for International Cooperation

**Poland**  
Mr. Wojciech Kutyla  
Director-General, Ministry of Health

Dr Michal Marek  
Adviser to the Minister, Department of Health Insurance, Ministry of Health

**Portugal**  
Professor José Maria Albuquerque  
Deputy High Commissioner of Health, High Commissariat for Health, Ministry of Health
Romania
Dr Vlad Iliescu
Secretary of State, Cabinet for European Integration, Ministry of Public Health

Dr Laurentiu T. Mihai
Director-General, Department for International Relations and European Affairs, Ministry of Public Health

Russian Federation
Dr Oleg Chestnov
Deputy Director, Department of Cooperation and Public Relations, Ministry of Health and Social Development

Ms Nadezhda Kuleshova
Chief Specialist, International relations department, Ministry of Health and Social Development

Slovakia
Ms Klara Frecerova
Director-General, Department of International Relations, Ministry of Health

Dr Daniel Klacko
Deputy Minister of Health

Slovenia
Dr Radivoje Pribakovic
Analyst/Researcher, Institute of Public Health

Spain
Dr Concepcion Colomer-Revuelta
Director, National Health System and Women Observatory, Ministry of Health and Consumer Affairs

Sweden
Ms Anna Halén
Deputy Director, Division for EU and International Affairs, Ministry of Health and Social Affairs

Ms Maria Nilsson
Head of Section, Ministry of Health and Social Affairs

Switzerland
Mrs Delphine Sordat Fornerod
Scientific adviser, International Affairs Division, Federal Office of Public Health

Tajikistan
Mr Ilhom S. Bandaev
Head of unit, Department of Reform and International Relations, Ministry of Health

Mr Mahmadullo Kasymov
Principal specialist, Health and Social Affairs Department, Office of the President

The former Yugoslav Republic of Macedonia
Ms Angelina Bucanovic
Sector head, Normative/Legal Issues, Ministry of Health

Dr Vladimir Lazarevick
Deputy Minister of Health
Turkey
Dr Banu Ayar
Family Physician Specialist, Refik Saydam Hygiene Centre and Office of the President, School of Public Health, Ministry of Health

Dr Fehmi Aydinli
Deputy Director-General, Directorate of Primary Health Care, Ministry of Health

United Kingdom of Great Britain and Northern Ireland
Dr Fiona Adshead
Deputy Chief Medical Officer, Health Improvement Directorate, Department of Health

Uzbekistan
Dr Ulugbek Begiev
Specialist, Directorate of Therapeutic and Preventive Care, Ministry of Health

United Nations and related organizations
Dr Dragoslav Popovic
Project Officer – Immunization, UNICEF Regional Office for CEE, CIS and the Baltics

Temporary advisers
Ms Christine Blades
Senior Economist, European Investment Bank

Mrs Nathalie Chaze
Administrator, Directorate-General for Health and Consumer Affairs, European Commission

Dr Arun Nanda
WHO Liaison Officer, European Centre for Disease Prevention and Control (ECDC)

Dr Andrzej Jan Rys
Director, Public Health and Risk Assessment, Directorate-General for Health and Consumer Affairs, European Commission

World Health Organization
Regional Office for Europe
Ms Albena Arnaudova
Communications Adviser, WHO Office at the European Union

Dr Enis Barış
Director, Division of Country Health Systems

Mr François Decaillet
Senior Adviser, WHO Office at the European Union

Dr Antonio Duran
Adviser

Dr Josep Figueras
Director, European Observatory on Health Systems and Policies

Ms Elena Galmond
Health Systems Conference Secretariat
Dr Jarno Habicht  
Head of WHO Country Office, Estonia

Ms Tine Hansen  
Health Systems Conference Secretariat

Ms Kaja Kaasik-Aaslav  
Health Systems Conference Secretariat

Mr Joseph Kutzin  
Regional Adviser, Health Systems Financing

Ms Fatima Ludin  
Programme Assistant

Dr Nata Menabde  
Deputy Regional Director

Ms Tanya Michaelsen  
Health Systems Conference Secretariat

Dr Maria Cristina Profili  
Health Systems Conference Coordinator

Mr Charles Robson  
Health Intelligence Service (Rapporteur)

Dr Vladimir Verbitski  
Translator/Reviser (Russian)

**Headquarters**

Ms Egle Granziera  
Associate Legal Officer

**Interpreters**

Mr Aleksandr Reshetov

Mr Andrei Reshetov

Brussels draft, 21 May 2008

Preamble

1. The purpose of this Charter is to commit Member States of the WHO European Region and partners to improving people’s health by strengthening health systems, while acknowledging social, cultural and economic diversity across the WHO European Region. It reaffirms and adopts the values embodied in earlier charters and declarations.2

2. Within the political and institutional framework of each country, a health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, and activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health.

3. All countries in the European Region have to address major health challenges in a context of demographic change, widening socioeconomic disparities, limited resources, technological development and rising expectations.

4. Beyond its intrinsic value, improved health contributes to social well-being through its impact on economic development, competitiveness and productivity. High-performing health systems also contribute to economic development and wealth.

5. Therefore we, the Member States and partners, believe that:
   • investing in health is investing in human development, social well-being and wealth;
   • today, it is unacceptable that people become poor as a result of ill-health;
   • health systems are more than health care, and include disease prevention, health promotion and efforts to influence other sectors to address health concerns in their policies;
   • well-functioning health systems are essential to improving health: strengthened health systems save lives; therefore,
   • health systems need to demonstrate good performance.

Commitment to act

6. We, the Member States, commit ourselves to:
   • promote shared values of solidarity, equity and participation in health policies, pro-poor planning and resource allocation, and implementation;
   • invest in health systems and across sectors, using evidence on the links between economic development and health;
   • promote transparency and be accountable for health system performance to achieve measurable results;

2 The Ministerial Conference is taking place as we mark the thirtieth anniversary of the Alma-Ata Declaration on Primary Health Care, whose recommendation that health systems should be centred around citizens, communities and primary health care services is as relevant today as it was 30 years ago. The Charter also acknowledges the importance of other charters and declarations on health promotion (1986 Ottawa, 1997 Jakarta, 2005 Bangkok), the 1996 Ljubljana Conference on Reforming Health Care, and the 2005 update of the Health for All policy framework for the WHO European Region. The right to health is also expressly included in the WHO Constitution, the Universal Declaration of Human Rights, the Convention on the Rights of the Child, and the United Nations-sponsored Millennium Development Goals.
• make health systems more responsive to people’s needs, preferences and expectations, including those that are not expressed, while recognizing their rights and responsibilities with regard to their own health;
• engage stakeholders in policy development and implementation;
• foster cross-country learning 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.

7. WHO will support Member States of the WHO European Region in the development of their health systems and provide cross-country coordination in the implementation of the Charter, including in measuring performance and the exchange of experiences on the above commitments.

8. WHO, the European Commission, European Investment Bank, World Bank, United Nations Children’s Fund, and Council of Europe commit to working with Member States on the implementation of this Charter in accordance with the provisions of our statutes and mandates, to help improve the performance of health systems. We, the Member States and Partners, invite other willing partners to join.

Strengthening health systems: From values to action

9. All WHO European Member States share the common value of health as a human right; as such, each country shall strive to enhance the performance of their health systems to achieve the goal of improved health on an equitable basis.

10. Each country shall also seek to contribute to social well-being and cohesiveness by ensuring that its health system:
• distributes the burden of funding fairly according to people’s ability to pay, so that individuals and families do not become impoverished as a consequence of ill-health or use of health services; and
• is responsive to people’s needs and preferences, treating them with dignity and respect when they come in contact with the system.

11. Countries shall pursue these broad performance goals to the greatest extent possible given their means. This requires efficiency: making the best use of available resources.

12. The practical application of these goals requires, as a first step, identification of objectives that are linked to these goals and that are “actionable” by policy, as relevant and applicable to each country, given its sociopolitical priorities and economic and fiscal means. Improving access to high quality medical care, and enhancing people’s knowledge of how to improve their own health are examples relevant to all countries. The objectives should be specified in a measurable way to enable explicit monitoring of progress. Taken together, these steps orient the design, implementation, and assessment of health system reforms.

13. We recognize that health systems are diverse, yet share a common set of four functions under which can be identified the aims and actions laid out below.

• Delivering health services to individuals and to populations
  – Policy-makers throughout the Region value and strive to make possible the provision of quality services for all, particularly for vulnerable groups, in response to their needs, and to enable people to make healthy lifestyle choices.
  – Patients want unhindered access to quality care, and to be assured that providers are relying on the best available evidence that medical science can offer and using the most appropriate technology to ensure improved effectiveness and patient safety.
  – Patients also want to have a relationship with their health provider based on respect for privacy, dignity and confidentiality.
– Effective primary health care is essential for promoting these aims, providing a platform for the interface of health services with communities and families, and for intersectoral and interprofessional cooperation and health promotion.

– Health systems should strive for the integration of single-disease programmes into existing structures and services in order to achieve better and sustainable outcomes.

– Health systems need to ensure a holistic approach to services, involving coordination among a variety of providers, institutions and settings, irrespective of whether these are in the public or the private sector, and including primary care, acute and extended care facilities, people’s homes, etc.

• Financing the system

– There is no single best approach to health financing; distinctions between “models” are blurring as countries develop new mixes of revenue collection, pooling and purchasing arrangements according to their needs, their historical, fiscal and demographic context, and their social priorities and preferences.

– To the extent possible, financing arrangements should ensure the means to redistribute resources from areas of lower need to areas of higher need, reduce financial barriers to the use of needed services, and protect against the financial risk of using care.

– Financing arrangements should also provide incentives for the efficient organization of health service delivery, link the allocation of resources to providers on the basis of their performance and the needs of the population (“strategic purchasing”), and promote accountability and transparency in the use of funds.

• Creation of resources

– In a rapidly globalizing world, generation of knowledge, infrastructure, technologies, and, above all, human resources with the appropriate skills and competence mix requires long-range planning and investment to respond to changing health care needs and service delivery models.

– Fostering research and making ethical and effective use of innovations in medical technology and pharmaceuticals are relevant for all countries; health technology assessment should be evidence-based and support more informed decision-making.

– Investment in the health workforce is also critical as it has implications not only for the investing country but for others as well; ethical considerations and cross-country solidarity regarding the mobility of health professionals must be ensured through a common European code of conduct and principles.

• Stewardship

– While each Member State has its own way of governing its health system, ministries of health promote the politically set goals by playing a predominant role in the legislation, regulation and enforcement thereof, and in gathering intelligence on health and its social, economic and environmental determinants.

– Health ministries, through their leadership in “healthy public policy”, should steer effective implementation across all sectors to maximize health gains.

– Evidence-based policy evaluation, technical audit for health system performance, and balanced cooperation with stakeholders at all levels of governance are essential to promote transparency and accountability.

14. We recognize that health system functions are interconnected. Improving performance demands a coherent approach involving coordinated action on multiple system functions; our experience suggests that action in one single function or programme is unlikely to lead to substantial progress or the desired results.
15. We, the Member States, WHO and partners, commit ourselves to using this Charter as a basis to transform our common values into action and as a milestone to catalyse implementation of the commitments therein on strengthening health systems.