Meeting report

Improving the performance of health service delivery/
putting patients at the centre of health systems

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

Bled, Slovenia, 19–20 November 2007
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Opening of the meeting

The second preparatory meeting for the WHO European Ministerial Conference on Health Systems was held in Bled, Slovenia on 19 and 20 November 2007, hosted by the Government of Slovenia. Representatives of 46 of the 53 Member States in the WHO European Region, as well as European experts in the field of health systems and representatives of the European Centre for Disease Prevention and Control (ECDC), the European Commission (EC), the European Investment Bank (EIB) and the World Bank (WB), took part in the meeting.

The purpose of the meeting was threefold: to provide an update on preparations for the Ministerial Conference; to review evidence on strategies to improve the performance of health service delivery and establish recommendations for the Conference; and to discuss a preliminary draft of a health systems charter. With reference to health service delivery, the meeting focused attention on primary care, integrating vertical programmes into horizontal health system structures, empowering health service users, and strategies to ensure coordination and continuity of care.

The meeting was opened by Dr Nata Menabde, Deputy Regional Director, WHO Regional Office for Europe, who introduced Ms Zofija Mazej Kukovič, Minister of Health of the Republic of Slovenia, and Dr Marc Danzon, WHO Regional Director for Europe.

The Minister welcomed participants to Slovenia and asked them to reflect on the changes needed in health systems so that they respond to current and future health needs. She believed that health should be at the core of every policy, from the environment to agriculture: the environment and food were key determinants of health, and prevention should come before curative care. In her opinion, the challenges facing the European Region included an ageing population, the cost of new medicines, making effective use of information technology and, with specific reference to the new member countries of the European Union (EU), how to balance public and private partnerships in health systems. The Slovenian presidency of the EU (from January to June 2008) would focus on e-health and the prevention of cancer. With that in mind, she said that ministries of health needed to build trust with both providers and patients, and to ensure access to health services, as that created a good basis for health service delivery. In conclusion, she suggested that people needed to pay more attention to their physical and mental health and take steps to avoid stress, a primary factor for illnesses.

The Regional Director thanked the Minister of Health and the Government of Slovenia for hosting the meeting. There was increasing recognition of the importance of health systems, which represented the framework and a way of integrating different sectors for health. Public health specialists tended to think in terms of health and disease, but if progress in health was to be made, knowledge about health systems had to be created and the technical, political and cultural vision had to be added in order to support ministers in advocating for health. Preparatory meetings for the Ministerial Conference were being organized in four areas: health systems performance, health workforce policies, health service delivery, and governance, and the first area was a key one. Through performance assessment, productivity could be improved and evidence gathered on the effectiveness of investing in health. Ministries of health should learn the economic lessons of other sectors but imbue them with the values of health systems – equity and solidarity. Health care should be combined with a focus on disease prevention and healthy lifestyles, as well as on the determinants of health, so that health systems helped to solve rather than to exacerbate problems such as poverty. It was an enormous challenge to find the right balance integrating human rights and the modern health systems approach, and the Ministerial Conference would be a major moment in health that would be remembered for years to come. He welcomed the focus on cancer given by the Slovenian presidency of the EU and expressed his interest in the results and case studies on that subject which would contribute to the key messages given to ministers in Tallinn the following year.
Session 1: Preparations for the WHO European Ministerial Conference on Health Systems: “Health Systems, Health and Wealth”

The rationale behind the WHO European Ministerial Conference on Health Systems is to contribute to the mission of the WHO Regional Office for Europe: “to support Member States in developing their own health policies, health systems and public health programmes, preventing and overcoming threats to health, anticipating future challenges, and advocating public health.” The Conference is being organized at the request of Member States, as expressed in the resolution adopted by the WHO Regional Committee for Europe in 2005 (resolution EUR/RC55/R8). The intention is that it will lead to a better understanding of the impact of health systems on people’s health and wealth, while taking stock of recent strategies to improve their performance. Based on the WHO definition of health systems and their functions, as expressed in *The world health report 2000*, the Conference will focus on the relationship between health systems, health and wealth, and examine how they contribute to health, economic growth and social welfare. This relationship is reflected in the Conference logo and is the main theme running through the research work currently being undertaken.

The present meeting is one of four preparatory events on subjects identified by Member States; the first preparatory meeting, on assessing health systems performance, was held in Brussels, Belgium on 29 and 30 March 2007; the subject of health workforce policies was discussed and a resolution adopted at the fifty-seventh Session of the WHO Regional Committee for Europe in Belgrade, Serbia, in September 2007; the next, on health system governance, is due to take place in the spring of 2008. An external advisory board of leading health system experts from ministries of health, universities and partner organizations meets regularly to provide advice to WHO during preparations for the Ministerial Conference, on technical issues including themes and key topics, and the involvement of partner organizations and key institutions. A European charter on health systems is also being prepared for adoption at the Conference, under the guidance of a charter drafting group consisting of representatives of 26 Member States, including Chairs.

The Conference itself will take place in the Estonia Concert Hall and National Opera, in Tallinn, Estonia, over 2.5 days from 25 to 27 June 2008, with 500 participants from ministries of health and other relevant ministries, key partners, experts, civil society and the media. A photo competition “Images of health systems” is also being organized to mark the Conference, and further information on that competition, the Conference itself and the preparatory work being done is available at [www.euro.who.int/healthsystems2008](http://www.euro.who.int/healthsystems2008).

Session 2: Improving the performance of health service delivery

Introduction

Within the triangular conceptual framework linking health systems, health and wealth, the main technical session of the second preparatory meeting for the WHO European Ministerial Conference was focused on the relationship between health systems and health. The aim of the session was to examine (taking into consideration the objectives and functions of a health system) a subset of strategies for improving the performance of health service delivery, while demonstrating the evidence and need to make the case for investing in health systems as a productive sector in terms of both economic growth and social welfare.

Innovations in service delivery: assessing performance

At the outset, it was recognized that all innovations in service delivery should promote one or several of the health system objectives: improving health, improving equity and financial protection, improving responsiveness and improving efficiency. Examples were given of delivery innovations in need of

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evaluation; they include screening for disease, moving treatment from inpatient to outpatient settings, public health initiatives and integrated care. Any evaluation requires information, which can be classified into four main categories: epidemiological data, information related to patient outcomes (mortality, readmission, etc.) and to the processes of care (stage of disease when treated, sequence and volume of interventions), and accounting data (costs, resource use). A good case can be made for measuring both the processes and outcomes of care; the Organisation for Economic Co-operation and Development, for example, is implementing a health care quality indicators project that covers these two aspects, as well as epidemiological data per se.

A case study was presented of “programme budgeting” in England, the aim of which is to develop a primary source of information that can be used by all bodies to give a greater understanding of the value obtained from the money invested in the National Health Service. To that end, all public expenditure on health is mapped to 23 programmes of care based on medical conditions (grouped according to the tenth revision of the International Classification of Diseases – ICD10). Noteworthy findings include the fact that the highest programme expenditure per capita in 2004–2005 was on mental health conditions, followed by circulatory disorders, and that there is little correlation between the prevalence of disease and levels of expenditure. From an analysis of the four types of information gathered on cancer in England (reported prevalence, five-year survival, stage at diagnosis and expenditure per case), it is apparent that poor primary service delivery in urban areas is leading to ineffective and inefficient care. Nonetheless, the implicit costs of saving a life year in specified programmes of care are found to be lower than expected, and one of the challenges for public health services is to demonstrate a similar degree of cost–effectiveness.

In summary, without performance information countries will have no means of identifying good (and bad) delivery practice, no evidence with which to design delivery experiments and no instrument with which to evaluate them, as well as no case for balancing investments in public health and personal health care.

In the ensuing discussion, it was emphasized that such information was needed not just for biomedical treatment or curative care but also for preventive medicine, non-personal public health services and intersectoral action. In terms of the “political economy” of obtaining the necessary information, it was recognized that, paradoxically, the more decentralized a health system is, the more there is a need for information, and hence for sustained leadership and commitment by clinicians: England’s programme budgeting approach has taken decades to bring to fruition. Lastly, it was agreed that there is a need for disaggregated data that differentiate between the sexes and take account of referral from rural areas (primary care) to urban districts (specialized treatment).

**A case for coordinated delivery: approaches, models and financial incentives**

The case for coordinated delivery of care is clear-cut: more people are living with increasingly complex health problems that require complex organizational interventions, yet health care is still largely built around a model of acute, episodic treatment, with fragmentation of services, which acts as a barrier to the coordination of services along the care continuum. This leads to suboptimal quality of care for those with chronic health problems. To date, however, the evidence for the value of different forms of coordination has remained uncertain. Additionally, European health systems are diverse, and each system has to find its own solution, drawing on the lessons learned by others.

Broadly speaking, there are two models of coordinated delivery: integrated care and disease management. The former is traditionally focused on people with multifaceted problems who require assistance with activities of daily living. The aim is to link the cure and care sectors, in order to enhance outcomes for those with complex needs. Such integration can take different forms, depending on the target (functional, physical, or emotional) and the type of care required. In some cases, this may involve reorganizing care pathways to ensure seamless transitions between different levels of care, while in others, it may involve developing new models of service delivery that are better suited to the needs of patients with complex health problems.
organizational, professional or clinical arrangements), the level (horizontal or vertical) and the degree
(full structural integration or “virtual” integration of the form of linkages or looser collaboration). Disease
management, on the other hand, is traditionally focused on people with a single (chronic) disease or
condition. While first-generation disease management aims to promote medication adherence and
behaviour change among such people, the second-generation approach currently being adopted shifts the
focus of attention to the multiple needs of patients with co-morbidities or multiple conditions. There is
clearly some overlap, therefore, between disease management and integrated care: what is important is to
build on the commonalities, rather than to highlight the differences between the two models.

There is evidence that certain elements of care improve outcomes for people with complex, chronic health
problems. They include quality primary care, multidisciplinary teams, nurse-led strategies, self-
management support, evidence-based practice guidelines or protocols, provider education, and audit and
feedback. The Department of Health in England has adopted a combined approach originally advocated,
for financial reasons, by a United States health insurance company, Kaiser Permanente: building on a
foundation of population-wide preventive measures, the first level (which covers 70–80% of a chronic
disease population) consists of supported self-care; higher up the pyramid come specialist disease
management for high-risk patients, with case management applied to the small number of patients with
highly complex needs at the top of the pyramid.

The rationale for reforming payment systems is that payment modalities have largely developed around
the acute model of care, that poor quality care is often costly and that health care providers respond to
financial incentives. The relationships between the four “players” involved in chronic care can be
represented schematically as shown in Fig. 1.

Against this background, it is important to adopt blended or mixed approaches to provider payment.
Financial incentives can be introduced along all axes of the quadrilateral: between the patient and
provider, for instance, in the form of exemption from or reduction of co-payments (as is being done in
France and Germany), or between the patient and financial pooler through reductions of insurance
premiums for participation in disease management programmes (as in the Netherlands). In all cases,
however, a number of prerequisites need to be met if an effective payment system is to be established:
there has to be continuity of patient enrolment with the payer/insurer (since returns on investment are
typically achieved only after five years); the workforce has to be flexible and motivated; and, most
importantly, there have to be systems in place to identify and stratify patients in terms of severity (need) and to measure and assess the structure, process, quality and outcomes of care.

Member States’ representatives on the discussion panel for the session drew attention to the characteristic of patient mobility, both between urban and rural areas and between the public and private sectors of the health system. Epidemiological information should be focused on the incidence, rather than the prevalence, of diseases. The gap between clinicians and public health practitioners will need to be bridged (the latter were said to be more accustomed to a systemic approach). For countries in economic transition, the assessment of health service delivery and health system performance will be of crucial importance for persuading governments that investing in health is indeed investing in the future.

One risk identified by participants in the following discussion was that focusing attention on specific diseases, through disease management programmes, may lead to further fragmentation of services. They therefore made a strong call to concentrate on individual patients, backed up by improved arrangements for the first point of contact in primary care. As highlighted in the previous session, there was general agreement that good information systems (notably those based on patient registration) and, more particularly, greatly heightened analytical capacity are needed in order to ensure properly coordinated delivery of care. In cases of chronic conditions, accurate patient-based data can be used to forecast long-term needs and hence the volume, mix and intensity of the care required (the measure of disability-adjusted life years, or DALYs, commonly used in Europe is not precise enough for that purpose, and regional surveys may be necessary).

Another prerequisite is the flexibility of resources with which to create integrated, multi-level groups. It will also be necessary to involve social services in coordinated delivery. One hypothesis is that personal services as a whole (including health, housing, education and welfare) can be provided more efficiently if the lead is taken by local government bodies, but that will need to be tested through rigorous research and analysis. For the purposes of making cross-country comparisons, uniform definitions will be required, and diagnosis-related groupings (DRGs) should be harmonized.

Finally, the importance of linking financial incentives to values was mentioned, and that link should be made explicit in the Charter being prepared for endorsement at the Conference.

**Responding to the challenge of cancer control in Europe: the Slovenian presidency of the European Union**

During Slovenia’s presidency of the European Union (EU) from January to June 2008, the Ministry of Health intends to build on the work done under the three previous EU presidencies and focus on health promotion and disease prevention, innovation and access to health care. In the first area, it will be giving priority to cancer, while in the second it plans to take forward the e-health initiative, leading up to a conference on that subject from 5–7 May 2008 in Portorož, Slovenia.

Cancer remains an important health challenge in Slovenia, in Europe and globally, especially in view of ageing populations. It consists of a complex set of diseases that have serious repercussions on individuals, societies and health systems. Also, despite the fact that there are evidence-based public health measures to lower mortality from breast and colorectal cancer, and that the incidence of lung cancer and several other forms of cancer could be reduced by better tobacco control, the public health response to that major threat is often still fragmented.

The European Code against Cancer (http://www.cancercode.org/) contains recommendations that constitute a “road map” for reducing the risk of cancer in Europe, but Slovenia is concerned to see whether it is possible to reduce the burden of cancer through a more intense action-oriented, integrated and multisectoral response in the EU. Such an approach will involve promoting healthy lifestyles, detecting at an early stage those cancers that are not prevented, giving cancer patients the best possible treatment and care, and strengthening cooperation in research. Slovenia believes that cancer represents a good model for efficiently applying a range of findings on how best to tackle chronic diseases.
Integrating preventive, curative and rehabilitative interventions in cancer control

The driving forces behind health care reform include both demand-side factors (demographic changes, epidemiological transition, rising expectations, etc.) and supply-side ones (such as advances in medical technologies and teledmedicine, information systems and economic pressures). Better coordination (“integration”) of services can be seen as the link between those two sides, with the aim of achieving greater user satisfaction. In the case of cancer, demographic trends and, to a lesser extent, lifestyle changes are determinants of the increased demand for care. At the same time, people have rising expectations of successful treatment, and patients are becoming involved in shared decision-making at all stages of the disease. Information systems, and especially patient registries, provide excellent tools for comprehensive management of cancer. Technological advances are offering new possibilities and hopes for patients but pose a threat to publicly financed health systems in the form of spiralling costs.

Integrated cancer care therefore faces a number of challenges: the increased incidence and complexity of the disease, coupled with its increasing prevalence (and hence the importance of rehabilitation), as well as the rising costs of health technology at all levels. Responses to those challenges span the spectrum of service delivery, ranging from ensuring early diagnosis and treatment (to secure better survival and quality of life), through providing quality care at all levels of the health system, to promoting international efforts in health technology assessment.

A number of measures can be taken to improve the quality of cancer care. They include identifying gaps and engaging in systematic planning of care for each patient; improving coordination and communication between general practitioners and consultants; developing community-based services; improving hospital discharge planning; and developing and making use of more effective information systems for tracking and managing patient services. In the context of Slovenia’s EU presidency, specialists from the London School of Hygiene and Tropical Medicine, the European Observatory on Health Systems and Policies and the Slovenian Institute of Public Health are collaborating on a book (to be issued in January 2008) that will examine in detail how to respond to the challenge of cancer in Europe.

While participants recognized in discussion that cancer offers an opportunity for a multisectoral, better coordinated (“integrated”) response at both country and EU levels, they also acknowledged that prevention does not come cheap. For instance, further evidence needs to be gathered about the cost–benefit of systematic administration of a vaccine against human papillomavirus (HPV) infection, which can lead to cervical and genital cancer. In addition, it was noted that a distinction needs to be made between different types of cancer, and more detailed information should be collected on the role of environmental and lifestyle factors (such as exposure to occupational carcinogens).

Emphasis was also placed on the fact that improved coordination has to be achieved not only within the health system itself but also across sectors, and especially with social services. In addition to formal mergers, possible measures to that end include the conclusion of agreements and the offering of incentives for cooperation.

Primary care in the driving seat: the evidence

Primary health care (PHC) has a critical role to play in each country’s health system. It enhances links within the sector both vertically, between primary and secondary care and public health services, and horizontally, among the various health professional working at the primary level. It provides a platform for the care continuum and is critically important in managing chronic conditions, where successful health outcomes are influenced by continuity and personalized care. Lastly, it enables multisectoral responses to be made, by linking the health system with the social and education sectors.

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Coleman M et al., eds. Responding to the challenge of cancer in Europe. Ljubljana, Institute of Public Health of Slovenia (in press).
There is good evidence that the strength of a country’s primary health care (PHC) system is significantly associated with improved population health outcomes (as measured by indicators such as all-cause mortality rates), even after controlling for population health determinants at macro- and micro-levels (GDP per capita, physician/population ratio, per capita income, alcohol and tobacco consumption, etc.). More specifically, the increased availability of PHC as delivered by family practitioners (FPs) is associated with higher patient satisfaction, reduced aggregate spending on health care for a given outcome, better access and accessibility, and enhanced equity.

The case study of Estonia was presented, in order to confirm the cost–effectiveness of transferring some services from the secondary to the primary level. As the number of FPs and the ratio of FPs per 10 000 population have risen since 1997, the number of hospital admissions for “PHC-sensitive” conditions (ischaemic heart disease, asthma, diabetes, etc.) has fallen, while prescriptions for statins have increased. Patient satisfaction has been monitored annually since 1996, cost analyses have been carried out, and forecasts of the demographic and economic situation as well as of patients’ needs, have been made. Similar findings were reported from a case study from Kyrgyzstan.

In the traditional PHC model, first contact has been mainly with services led by acute demand, and there have been limited chronic disease management and coordination, and limited health promotion, disease prevention and diagnostic services. The new primary care model, on the other hand, entails a far more strategic role: first contact can be made through accident and emergency services, as well as community hospitals; chronic disease management and out-of-hours services are offered; there is engagement in needs assessment and strategic planning and purchasing, as well as assumption of budgetary responsibility; and a comprehensive range of services are delivered, including health promotion, disease prevention, community-based care, “hospital at home” and specialist nursing and medical services.

Turkey was cited as an example of a country that is implementing an explicit policy on PHC, aimed at improving people’s access to health services through the establishment of an FP system and the introduction of hospital autonomy in the context of a reform intended to generalize health insurance. A further objective is to improve the country’s health information system.

In the ensuing discussion, participants explored the definition of “primary care”, noting that some countries in economic transition have inherited arrangements that include specialists working at that level. They agreed that primary care should be specified in terms of functions, rather than of location or staffing. Risk management should be one of the underlying concepts, although PHC has a far more positive contribution to make to people’s lives, notably in promoting greater social cohesion. In those reforms, the proxy measurements of both process and outcome show that the quality of care delivered at the primary level is moving in the right direction; nonetheless, the responsiveness of the service could be further improved, and there are still organizational, legal and financial barriers to be overcome and a lack of coordination and stewardship to be remedied.

**Integrating vertical health programmes into mainstream health services**

Vertical health programmes were characterized as being disease- or population group-specific, with dedicated funding, management, experts and service delivery schemes. Taking tuberculosis (TB) as an example, it was questioned whether poor results in the fight against some diseases are linked to over-hierarchical, poor standards of care in vertically segmented institutions. It was noted in particular that the top 13 countries in the world in terms of the prevalence of multidrug-resistant (MDR) TB are in Europe, while population coverage for a short course of directly observed treatment (DOTS) is only 40%. Also, while the overall TB incidence in the WHO European Region in 2005 was 50 cases per 100 000

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5 Atun R. *What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services?* Copenhagen, WHO Regional Office for Europe, 2004 (Health Evidence Network report; [http://www.euro.who.int/document/e82997.pdf](http://www.euro.who.int/document/e82997.pdf), accessed 28 November 2007).
population, rates varied from 13 per 100 000 in the 15 western European EU countries to over 100 per 100 000 in Member States bordering the current 27 EU member countries. TB notification rates per 100 000 population showed a similar (and increasing) spread. A combination of vertical arrangements and external funding exists in the worst performing country examples.

After the collapse of the Soviet Union in the early 1990s, general health services were judged to be unable to deliver even priority interventions. Imbued with a campaign mentality and urged on by philanthropic bodies and nongovernmental organizations, bilateral organizations such as the United States Agency for International Development (USAID) the United Kingdom’s Department for International Development (DfID) and intergovernmental agencies (the World Bank, WHO, etc.) placed emphasis on fighting (mainly infectious) diseases using a vertical approach in terms of service delivery structures, funds and staff.

Recently, however, the preference for vertical programmes seems to be changing. It has been reconfirmed that vertical programmes respond to diseases, not individual clients, which is a major shortcoming when addressing the concerns of people with multiple conditions. Vertical campaigns also promote technologies brought in from outside, value the knowledge of foreign experts, and make little or no attempt to enlist the participation or cooperation of local populations in planning or implementation (thus reducing the potential impact of interventions). In addition, multiple parallel policy processes or reporting systems have led to unnecessarily high transaction costs, while narrowly focused support is drawing scarce personnel away from other essential services.

Also, despite the existence of effective interventions, falling prices and increasing funds, progress towards the health objectives within the Millennium Development Goals (MDGs, which are addressed with a rather vertical approach) remains slow. There is increasing consensus that stronger health systems are the key to achieving improved health outcomes; indeed, the WHO Director-General observed, at the fifty-seventh session of the WHO Regional Committee for Europe in September 2007, that “insufficient capacity in the area of health systems is an insurmountable barrier to achieving the health-related MDGs.”

Nonetheless, there is still a paucity of evidence about the circumstances under which either vertical or horizontal arrangements are likely to improve the efficiency and equity of service delivery in health system reforms. Few studies relate a given reform to health outcomes, and even evidence on intermediate outcome measures (such as costs and quality of service provision) is often lacking. There is virtually no information available about the costs of strengthening capacity or its effectiveness, and about what types of governance and institutional arrangements would support the achievement of widespread health improvements, especially for the poorest members of society.

Some participants in the ensuing discussion pointed to the value of vertical programmes in tackling single diseases such as poliomyelitis or malaria. Others noted, however, that a vertical approach is not favourable to health (it results in more deaths than a horizontal approach), wealth (it leads to more inequity and discrimination) or the health system (it encourages sub-specialization, restricting health workers’ ability to deal with a broad spectrum of health problems) and recommended that vertical programmes should be properly integrated into a country’s health system at all levels (national, regional and local).

**Empowering health system users: strategies and innovations**

The importance of clearly defining the terms employed to designate the different persons involved when discussing the health system was emphasized. The “public” at large is frequently seen primarily as voters, although also as “consumers”, which implies a contested, commodity-based view of health and health services. Individuals taking responsibility for their own health, self-care and lifestyles, or those involved

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in community action for health, by way of contrast, are commonly referred to as “citizens”. Recipients of care may be “patients”, “clients” – especially in the context of mental health services – or “users” (the generic term). People who are active as informal carers or engaged in other forms of volunteerism can be assimilated to health care “providers”. The needs of patients and citizens are not necessarily identical: patients want fast access to reliable health advice, effective treatment delivered by trusted professionals, participation in decisions and respect for preferences, clear and comprehensible information and support for self-care, emotional support, continuity of care, etc. Citizens, on the other hand, want affordable treatment and care free at the point of use, safety and quality of care, accessible local services and national centres of excellence, universal coverage, responsiveness, transparency and accountability.

There are three main “pathways” by which patients and citizens can participate in the health system: by exercising “choice” or becoming involved, on an individual level, in decisions that reflect their personal preferences, especially in the context of clinical care; by having a “voice”, i.e. collective involvement in shaping health policy and influencing service design; and through “representation” or formalized participation in steering health organizations.

Choice can be exercised – depending on the country – in terms not only of treatment (whether, when and how to be treated) but also of health care provider (general practitioner, specialist, hospital doctor, etc.) and of insurance (to be insured or not, with a public or private insurer, at different levels of benefits and contributions). So far as trends are concerned, it is envisaged that general practitioners will increasingly give patients specific options for their choice of specialist (following the model adopted in the United Kingdom). In addition, patients who pay health insurance premiums increasingly expect health insurers to guarantee quick access and clinical quality, thereby transforming those bodies into patient advocates. Chronic patients, in particular, are becoming experts in their own care and demand a good flow of information between providers and integrated care in the home or community.

The citizen’s voice can be enhanced through feedback, consultation and advocacy, while representation can be fostered in patients’ committees, governance boards of hospital or public health bodies, and citizens’ forums. Examples of “voice mechanisms” in the European Region include citizens’ “juries” and consensus conferences in France and Denmark, a national health forum in Portugal, and a parliamentary commission in charge of priority-setting in Sweden. Representation is being fostered at local, regional and national levels through mechanisms such a national patient consumer federation in the Netherlands and health systems quality councils in a number of countries.

People’s participation in decisions that affect their health is rights-based and does not therefore have to be justified through evidence; on the other hand, more research needs to be done into the impact of user empowerment on health system performance. WHO has commissioned a policy brief publication for the Ministerial Conference on the place of patients in making decisions about their care, looking at the involvement of patients in the management of their conditions and the effects of that involvement in terms of health outcomes, satisfaction and quality of life. It is already apparent that worthwhile policy options include informing patients about their role in decision-making, giving health care providers incentives to employ patient decision aids in clinical practice, and providing support to patient and consumer groups.

Following a survey of patient preferences, Denmark has implemented a national strategy of support for patient self-management, which includes free choice of hospital, free access to medical records, and patient education and involvement in monitoring. There is good evidence for the value of these interventions. In other countries, however, user involvement and consumer choice seems to have had negative repercussions: high proportions of elective admissions for inpatient care have not been referred from lower-level facilities; competition among public payers, as a result of offering consumers the choice of insurance bodies, has proved to be counter-productive; patients’ associations have encouraged the use of proprietary drugs, rather than generic preparations, and unnecessary laboratory investigations have been common. Standard treatment guidelines were advocated as one solution to the latter problem.

More generally, there is a challenge in ensuring genuinely equitable representation through patients’ associations. Governments have a role to play in encouraging them to come together in an umbrella
organization and to engage in collective costing of their demands (as has been done in the Netherlands), although it was recognized that this could be a lengthy process.

Conclusions

While the session was focused on service delivery, that is only one aspect of improving people’s health. Within those limitations, however, it is important to align all the health system “building blocks” (human resources, financial mechanisms, organizational structure, etc.) on the same set of values and objectives, retaining and integrating any vertical systems that are already in place and performing well. Further evidence needs to be gathered to inform priority-setting (although lack of evidence should not prevent policy-makers from taking some decisions). To that end, delivery innovations and subsequent analysis and evaluation (i.e. clinical trials as applied to the health system) should be embedded in proper health information systems.

In this context, intergovernmental organizations have an important role to play in promulgating international standards, conducting health technology assessment, encouraging the sharing of evidence and experience, and providing support to countries in economic transition.

It is clear that health systems need to be imbued with and give effect to values such as equity and responsiveness. Societies will need to prioritize their actions in the light of the severity of the problem being tackled and the usefulness and, most importantly, the cost–effectiveness of the intervention envisaged.

Many of the current inequities in terms of health outcomes have in fact not been corrected by measures attempted over 30 or 40 years. What is currently required is to shift the research agenda, in order to focus on inequalities in terms of health determinants and, more particularly, of access to health care. In the case of the former, one finding is that the social gradient in mortality is constant, with higher income levels matched by corresponding increases in life expectancy. With regard to the latter, once a chronic disease has been contracted, the main need will be for good-quality and continuing health care.

On a more practical level, it will be important to search for mechanisms or incentives that contribute directly to those values. The world health report 2008 will be on the theme of primary health care, looking at how to operationalize values and principles such as equity, comprehensiveness, continuity and closeness to the community.

As already explained, the meeting in Bled addressed service provision issues (after the first preparatory meeting in Brussels dealt with health system performance and the discussion during the fifty-seventh session of the WHO Regional Committee for Europe in Belgrade had addressed the need to ensure the right numbers and mix of health workers; a third preparatory meeting in the spring of 2008 would address health system governance). A number of driving forces behind health system reform will not be specifically covered in single-topic meetings. They include demographic changes, ways of managing the very large flows of information generated by the system, health technologies, and relations with the pharmaceutical industry.

Session 3: The Health Systems Charter

Introduction

The Charter will be the main political outcome of the Ministerial Conference, aimed at providing guidance and a strategic framework for strengthening health systems throughout the WHO European Region. It will also reflect where Member States feel priority action should be taken and set out areas for WHO support to countries in the coming years.
The diversity of health systems, policy contexts and development conditions across the WHO European Region was acknowledged, so the Charter is not intended as a “one size fits all” standard for health systems in the future. Rather, it should offer a framework of the common factors and areas where national and collective action across the Region could strengthen the impact of health systems on health outcomes and contribute to wealth generation and development.

Issues to be addressed in the Charter include:

- the relationship between health systems, health and wealth
- the values and principles underlying health systems
- definition of the boundaries of health systems
- intermediate and final objectives
- functions and inputs (“building blocks”).

Discussion

A Charter drafting group has been formed with nominated representatives of 26 Member States including Chairs, and the Organisation for Economic Co-operation and Development (OECD), the European Commission (EC) and the World Bank. The importance of Member States driving the development of the Charter was stressed, and to that end the Charter Drafting Group is chaired by the representative of the United Kingdom, with co-chairs from Kyrgyzstan and Belgium, backed up by WHO technical and secretariat teams.

The Charter Drafting Group held its first meeting in Gastein, Austria on 6 October 2007, following which an initial draft of the Charter was elaborated and sent out to Member States for comments. Fourteen responses received before the present meeting were incorporated in the draft under consideration (Annex 2). That document should be seen as setting out the key ingredients and thinking to date on what the Charter should focus on.

Seven key questions have emerged following the first meeting of the Charter Drafting Group:

- Should the terms “health systems”, “health” and “wealth” be explicitly defined?
- Are health systems driven by values or incentives?
- How can health promotion be incorporated as a way of reducing health systems expenditure?
- What does it mean in practice and for health systems that “health is a human right”?
- To what extent is health an individual responsibility?
- How can equity and efficiency be balanced?
- How can effective mechanisms be developed to share experiences among countries?

The current definition of a health system in the Charter has been taken from *The world health report 2000*. That report identified four functions of health systems but discussions within WHO since that time have led to the identification of six “building blocks”. Participants were of the opinion that the Charter should focus on the impact that health systems achieve through their four functions. It would be desirable to have clear and concise definitions of health systems, health and wealth at the beginning of the document and to include other definitions as a glossary or with detailed explanations in a technical annex.

The Charter should be a tool to foster political commitment and action, and it should therefore be written in a way that gives ministries of health the arguments they need to make the case (with other sectors of government) for action on and investment in health. The current version was felt to be “on the right track”. The impact of health systems on health and wealth should be further clarified, the links with the Millennium Development Goals (MDGs) should be made explicit, and whenever necessary sharper
arguments should be advanced in favour of broader intersectoral action and, in some cases, even of integrated planning and delivery with other sectors.

The Charter, it was argued, should recognize that issues related to health systems, health and wealth vary between higher-income countries and those in economic transition, specifically with regard to the goals of their respective health systems. The focus in the former was said to be on cost containment, while in the latter emphasis is placed on attracting additional investment and on prioritization.

Future drafts of the Charter could articulate more clearly what types of investment (and in which parts of the system) would produce the best possible health outcomes and contribute to economic development. As the document will be aimed not only at ministers of health but also at those responsible for finance and economic development, the policy implications of those arguments and actions should be explained in detail. References were made to the discussions earlier in the meeting, which showed the positive health impacts of prioritizing and strengthening PHC, particularly as many countries are currently focusing investment on specialized care.

In view of its target audience, the Charter should refer for example to the employment potential of the health sector (which will appeal to ministers of finance and labour) and to health systems’ contribution to strengthening social cohesion through fair financing and equitable access to services (which will be attractive to ministers of social affairs). More generally, the Charter could highlight the “trade-offs” in the economy from investing in health and the ethical dimension of not being cost–effective.

Participants also suggested that the Charter might make reference to the need for indicators and ways of measuring the health system’s contribution to wealth, and at a political level, some means of verifying its impact by committing ministers of health to report on progress and impact.

There was general consensus that health systems actions are not only underpinned by values but also driven by incentives. That area could be further elaborated in the final Charter, exploring the relative weight of values and incentives, and outlining ways of placing emphasis on values. The Ministerial Conference will provide an excellent opportunity for countries to gain a better understanding of their health systems and of the values that are integral to them, such as solidarity. Raising awareness of those values across the Region will be a key factor in the success of the Conference and the Charter.

With reference to the previous day’s discussion on a patient-centred approach to health care, the issues of empowerment and participation were raised by several participants, who asked for further clarification of how those values could be translated into the practice of health systems, and specifically of which organizations are involved and how.

Reference was also made to the importance of health systems in promoting health and the need for a sharper focus on combating risk factors through partnerships with other ministries. Health promotion, it was said, should be emphasized in the Charter. Health is currently understood in much broader terms than before, which makes it difficult to define the borders of health systems. Other sectors need to be involved, and that is why the Charter considers all measures, actions and institutions, not just those related to health care.
Member States in economic transition are going through a crucial period, with new social and political relations being forged. As the Charter is also addressed at decision-makers who are far from the health system and who may only understand the concept of health care, a request was made to include key passages on disease prevention and health promotion, so that work in those areas could be taken forward in such countries. On the same theme, the Charter should further highlight arguments for multisectoral action for health and ways of establishing such partnerships, especially as there are other strong stakeholder interests to be managed within government.

Despite the strong arguments for intersectorality, the Charter should strike a balance between “selling” public health to other sectors and recognizing those actions that ministries of health can take themselves; the focus should be on improving performance in areas for which ministries of health are directly accountable, especially since by doing so they could not only improve health but also enhance their credibility with other sectors. The constituent parts of a health system were repeated to be the organizations, institutions and resources devoted to producing health actions, that is “efforts, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health”.

A number of participants indicated the benefits to be gained from sharing experiences and pooling learning, particularly in the form of health information and intelligence.

The issue was raised of countries exporting health professionals and effects that has on the human resources capacity of domestic health systems. It was recalled that an in-depth discussion of health workforce policies had been held at the fifty-seventh session of the WHO Regional Committee for Europe in September 2007. A number of commitments had already been made in the resolution adopted on that occasion (resolution EUR/RC57/R1), and for that reason the issue has not been included in further depth in the current draft of the Charter. A small group has been established to develop an ethical framework on health migration policies. The topic will be again discussed at the next pre-Conference meeting in April 2008 and a reference to the issue might then be included in the Charter, with Member States having the possibility of endorsing the framework at the Ministerial Conference.

The current draft of the Charter was seen as a good analysis of the situation with regard to health systems, but it needs to be supported by a description of practical ways to move forward. One option could be to use specific examples, such as chronic diseases, and identify which actions could be taken and which organizations needed to be involved.

With regard to the format of the Charter, there was general agreement that a short document focused on action statements is preferred, although suggestions as to acceptable length ranged from one to five pages and there was some debate about the amount of detail that should be included. Several practical suggestions were made for restructuring the Charter in the form of action statements, setting out the ideal situation or goals to be attained in 25 years’ time, with a menu of the elements required to reach those goals at national and regional levels and the critical factors for their successful attainment. In doing so, the Charter would focus explicitly on regional solidarity, or in other words solidarity within and between countries.

The possible need for a technical annex was discussed, and some participants indicated how important it would be to have the background documents for the Conference (policy briefs, evidence reviews and case studies) finalized and available to inform the process of consultation on the Charter within countries. It was recognized that the Charter would not be a comprehensive list but rather a “decoder” of the background documents, which in turn would offer Member States a review of the best available evidence that they could use to “customize” actions to the conditions in their countries.

It was agreed that all countries’ comments on successive drafts of the Charter would be made available on the password-protected website for the Conference.
All Member States have nominated a national focal point for the Charter within the ministry of health, to coordinate the process of consultation at country level. The WHO Secretariat was asked to provide guidance for focal points on how best to organize the in-country consultation process. Conversely, WHO would appreciate reflections from Member States as to which ministers should be invited to participate in the Conference.

It was clarified that any declaration by a ministerial conference has to be endorsed by the WHO Regional Committee for Europe. That would normally take the form of a resolution in which it calls on Member States and the Regional Director to take follow-up action.

The next version of the Charter will probably be around five pages long, to allow for incorporation of all the points raised to date and to serve as a basis for meaningful in-country consultations. It was envisaged that the document will then be reduced to two pages in February 2008, in time for the final meeting of the Charter Drafting Group and the last pre-Conference meeting to be held in April 2008.

**Closure of the meeting**

Closing statements were made by the WHO Regional Director for Europe and the Deputy Regional Director, WHO Regional Office for Europe.
Monday 19 November 2007

Welcome and opening. Objectives of the meeting
Ms Zofija Mazej Kukovič, Minister of Health, Slovenia
Dr Marc Danzon, WHO Regional Director for Europe

Session 1. The 2008 WHO European Ministerial Conference: “Health systems, health and wealth”
Conference preparations: a briefing – Dr Nata Menabde, WHO Deputy Regional Director for Europe

Questions and debate

Session 2. Improving the performance of health service delivery
Chair: Dr Josep Figueras, Director, European Observatory on Health Systems and Policies
Panel: Chair, presenters and Member States’ representatives (Professor Jose Maria Albuquerque, Portugal and Dr Snezana Simic, Serbia)

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

Innovations in service delivery: assessing performance – Professor Peter Smith, Director, Centre for Health Economics, University of York, United Kingdom

Questions and contributions

A case for coordinated delivery: approaches and models and financial incentives – Dr Ellen Nolte, Senior Lecturer, European Centre on Health of Societies in Transition, London School of Hygiene and Tropical Medicine, United Kingdom

Questions and contributions

Panel discussion and debate with participants

Session 2. Improving the performance of health service delivery (cont’d)
Chair: Dr David Evans, Director, Department of Health Systems Financing, WHO headquarters
Panel: Chair, presenters and Member States’ representatives (Dr Ivi Normet, Estonia, Professor Bjorn Guldvog, Norway and Dr Fehmi Aydinli, Turkey)

Responding to the challenge of cancer control in Europe. The Slovenian presidency – Dr Marija Seljak, Director-General, Public Health Directorate, Ministry of Health, Slovenia

Integrating preventive, curative and rehabilitative interventions in cancer control – Dr Tit Albreht, Adviser to the Director, Institute of Public Health, Slovenia

Questions and contributions
Monday 19 November 2007 (cont’d)

Session 2. Improving the performance of health service delivery (cont’d)

*Primary care in the driving seat: the evidence* – Professor Rifat Atun, Director, Centre for Health Management, Imperial College, London, United Kingdom

*Integrating vertical health programmes into primary health care services* – Dr Antonio Duran, Adviser, WHO Regional Office for Europe

*Questions and contributions*

*Empowering health system users: strategies and innovations* – Dr Pim de Graaf, Adviser, Primary Health Care, WHO Regional Office for Europe

*Questions and contributions*

*Panel discussion and debate with participants*

*Conclusions* – Professor Peter Smith, Director of Centre for Health Economics University of York

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Tuesday 20 November 2007

Session 3. The Health Systems Charter

**Chair:** Dr Fiona Adshead, Deputy Chief Medical Officer, Department of Health, United Kingdom

**Co-chairs:** Dr Ainura Ibraimova, Deputy Minister of Health and Director, Statutory Health Insurance Fund under the Ministry of Health, Kyrgyzstan
Dr Leen Meulenbergs, Head of Service, International Relations Department, FPS Health, Food Chain Safety and Environment, Belgium

**Panel:** Chair, Co-chairs, Dr Nata Menabde, WHO Deputy Regional Director for Europe and Dr Antonio Duran, Adviser, WHO Regional Office for Europe

*Introduction* – Dr Fiona Adshead, Deputy Chief Medical Officer, Department of Health, United Kingdom

*Context* – Dr Nata Menabde, WHO Deputy Regional Director for Europe

*The Health System Charter: objective of the Charter; outputs of the Charter Drafting Group and the Gastein meeting, and presentation of the first draft for discussion* – Dr Fiona Adshead, Deputy Chief Medical Officer, Department of Health, United Kingdom

*Questions and contributions*

*Conclusions and next steps* – Dr Fiona Adshead, Deputy Chief Medical Officer, Department of Health, United Kingdom

*Final remarks and closure*

Dr Marc Danzon, WHO Regional Director for Europe
Annex 2

FIRST DRAFT OF THE CHARTER OF THE WHO EUROPEAN MINISTERIAL CONFERENCE ON HEALTH SYSTEMS: “HEALTH SYSTEMS, HEALTH AND WEALTH”

I. Introduction

1. Background

The mission of the WHO Regional Office for Europe is “To support Member States in: developing their own health policies, health systems and public health programmes; preventing and overcoming threats to health; anticipating future challenges; and advocating public health”. The Ministerial Conference has thus been part of a long-term process that started at the fifty-fifth session of the WHO Regional Committee in September 2005. Member States endorsed there a resolution on the next phase of the WHO Regional Office for Europe’s Country Strategy: Strengthening health systems under the slogan “Strengthened health systems save more lives”. Understanding that “Investing in health is investing in the future”, the Conference has now analysed the rapid changes in health systems in the last few years. It has explored ways to make health systems more effective and coherent, so that they can contribute to economic growth and social development – in other words, the Conference has gone “Beyond healthcare, towards health and wealth”. Old and new stakeholders across the health, economic and development spheres of governance have been active in this process.

The Conference has taken stock of progress to date, identified new approaches and offered guidance on implementation, while providing a forum to debate challenges and priorities for action. It has aimed at putting health systems and investment in health high on the political agenda with ministries not only of health but also of finance and of economic development, as well as treasury departments. Emphasis has been placed on both subnational and national levels, bearing in mind the fact that many countries have highly decentralized governance systems.

2. Definition and aim of the Conference Charter

We, representatives of the Member States of WHO in the European Region, have agreed that a crucial outcome of the Conference should be a statement developed by us, drawing on the political and technical experience of WHO, that will be relevant to all countries, not prescriptive and signalling how we can collaborate with each other and with WHO and other relevant stakeholders in improving our own health systems in a continuous way. Representatives of 26 Member States, as well as of the European Union (EU), the World Bank (WB) and the Organisation for Economic Co-operation and Development (OECD), supported by a WHO secretariat, have participated in the Charter drafting process. For us, this Charter is understood to be more binding than a simple Declaration.

II. Signatories Recognize

1. The definition and boundaries of health systems

Health is the outcome of a number of determinants, some biological (e.g. genetics) and some man-made (personal behaviour and social factors, health care, etc.). Perhaps for this reason, the words “health system” are sometimes used to designate everything and anything globally related to the social production of health and disease (from education to agriculture, urban life, etc.). Being more specific, a system needs to be understood as “an arrangement of parts and their interconnections that come together for a purpose”.¹ The Conference defines a health system as “the ensemble of all organizations, institutions and resources devoted to producing health actions, i.e. all efforts, whether in personal health care, public

health services or through intersectoral initiatives, whose primary purpose is to improve, maintain or restore health”. This is the definition proposed by the World Health Organization,² the World Bank³ and the European Union.⁴ It is also the explicit definition included in the “Next phase of the WHO Regional Office for Europe’s Country Strategy: Strengthening health systems”.⁵

A distinction is thus made between (i) health services as the “machinery” strictly related to the delivery of personal care and public health services; (ii) health systems as per the proposed definition, and (iii) any other sets of factors related to health – sometimes referred to as the “health field”, “health sector”⁶ or as the “broad determinants of health”. Indeed, effective linkages need to be nurtured between the health system and any social sector with the potential to contribute to health. A multiplicity of names are also used to refer to the constituent parts of an effective health system, sometimes including the word “system” (as in health information systems, health management systems, health financing systems, health monitoring systems, health policy systems, etc.) – the word “subsystem” would probably be more appropriate.

2. The relationships between health systems, health and wealth

Substantial progress has been made in recent years, as described in the Report of the Commission on Macroeconomics and Health, and as evidenced in the work of the Commission on the Social Determinants of Health and other research from across Member States, on clarifying the relationship between health systems, health and wealth. The Conference has reviewed the extensive evidence on how effective personal and non-personal health services generate health. A well-functioning health system will reduce the burden of illness, impairment and disabilities among individuals and contribute to economic growth and welfare in society. Combined with investment in public policies, social protection measures and equitable development, health systems lead to wealth in more than one dimension, namely: (i) gains in personal wealth in terms of social protection in case of catastrophic illness; (ii) economic growth of the country through human capital, labour force productivity, savings, and overall economic development due to improved population health status; and (iii) exploitation of the commodity elements of the health sector, such as investment in and consumption of wellness products – which may in turn contribute to (regional) economic growth.

In short, health is a vital investment for growth throughout the WHO European Region. In high-income countries this takes the form of (i) higher productivity, (ii) higher labour supply, (iii) improved skills as a result of more education and training; and (iv) increased savings available for investment in physical and intellectual capital. In eastern Europe and central Asia, effective health systems can contribute to the attainment of broader country development goals. Children and young people constitute both the future workforce and the potential future health burden. Health systems should thus be specifically designed to respond promptly to the needs of children and youth, with specific attention paid to how poor health status (drug abuse, mental ill health, etc.) may limit the possibility for education and entrance to the workforce. However, additional efforts need to be made in order to further analyse those linkages: clarifying what combination of health actions and efforts gives comparatively the best return on investment in terms of health and wealth production is an increasing demand from policy-makers and society.

⁶ Economists use ‘sector’ rather differently to refer the provision of personal health goods and services.
3. Health systems’ values and principles in practice

As key social institutions, modern health systems are driven by values and incentives (interrelated with each other in different ways; countries remain autonomous in their application in different national contexts). European health systems’ values include health as a human right (as acknowledged in international agreements – this does not mean either that health care should be provided only by the State or that health care use could not be linked to co-payments, if so decided for the sake of sustainability); solidarity; equity and participation; and an ethical approach to health systems development that puts social welfare at the centre. While it is acknowledged that individuals bear responsibility for their own health, ample indirect evidence (such as support for electoral programmes, participation in institutions, payment of taxes) points to the fact that European men and women of different political orientations are willing to share for reasons of solidarity. European Union members recently adhered to a very similar set of common values and principles.7

The same applies to the belief that people’s participation improves health services and health outcomes, community participation, family responsibility and personal decision-making. A person’s health status is strongly linked to his or her ability to participate meaningfully in societal activities, including work, so loss of health contributes to a capacity shortage and constitutes a threat to economic growth. Citizen are thus coproducers of health and wealth with the health system – health outcomes improve as a result of citizens being active agents in their own health and properly using health services. The recently proposed concept of “health literacy”8 is related to the position of patients at the centre of the system, in terms of a choice- and voice-enhancing, patient-empowering, population-based approach.

There is a desire to achieve better results with the resources available and to see health systems’ performance measured more accurately. The dimensions and techniques for improving health system performance with existing and (if necessary) new tools have to be refined and broadly shared. Special attention must be paid to operationalizing patient safety and health services’ responsiveness to patient demands, as part of health system performance.

4. Final and intermediate objectives of health systems

Health gain, financial protection/fairness in financial contribution and responsiveness are identified as genuine final objectives of all health systems. They are important in terms both of average levels and of their distribution through populations. One inherent target of European health systems is, through their interventions, to combat and reduce inequalities in health between geographical regions and social or gender-based groups and subgroups. Equity of access to adequate treatment for equal need and other equity-related objectives (e.g. protecting vulnerable individuals from the catastrophic impact of ill-health, addressing poverty as a health risk factor) are thus important performance goals for the health and wealth of each nation. However frequently it is mentioned as an objective, the Conference acknowledges that not enough progress has been made towards equity in health in Europe – and given their political experiences, the concept of “equity” may even be received with reluctance in some Member States. Equity and efficiency are legitimate objectives which every health system should do its best to attain at the same time. Countries are confronted with difficult choices of rationing scarce resources in complex trade-offs; more work is needed in order to gain a better understanding of such trade-offs and to build the case for equity on grounds of efficiency (“is equity intrinsically efficient?”).

The final objectives mentioned above are mediated by other results (e.g. quality, safety, access, choice) that make it possible for the final objectives to be achieved. The values and incentives that make each system pursue its objectives need to be transparent and well understood by society through robust health system governance (see section 5.6 below).

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8 “The capacity of an individual to obtain, interpret and understand basic health information and services in ways that are health enhancing”.
5. Health systems inputs and functions (“building blocks”)9

Health system analysis as a discipline has gone beyond the traditional structural and managerial approaches to incorporate a functional point of view. In the context of this Charter, the word “function” is used to designate the groups of similar, interdependent activities that need to be done for the overall health system to achieve its goals (e.g. services need to be provided, funding has to be ensured, inputs have to be created and the whole system has to be governed). From this point of view, this Charter includes the functions of service provision, financing, resource generation, and governance (named in The world health report 2000 as “stewardship”). If the functional perspective is adapted in order to focus attention on human resources, technologies and information systems, the concepts and issues related to the following “health system building blocks” need to be examined.

5.1. The provision of health services

Effective, high-quality personal/individual and non-personal/population-based services make a substantial contribution to the health of the population. There is ample international evidence to show that the way in which health systems produce and manage cost-effective services that are available, accessible, affordable and acceptable has a crucial impact on sustainability and wealth. Poor coordination between service subunits leads both to individual distress and dissatisfaction among patients, and to system inefficiency, hence the importance of designing efficient pathways to meet the needs of the individual. Few would challenge the importance today of reassessing strategies to deliver proper care to all groups of society in the new demographic and sociopolitical context. Also, access to health care has a substantial role to play in reducing health inequalities – although lifestyles and self-responsibility are also part of that broad problem.

5.2. Human resources for health

The impact of globalization means that national health systems are not impervious to the increased movement of professionals and patients across borders. Properly planning the training, deployment and retention of human resources for health in that context has become critical for all health systems in Europe in order to avoid causing a “brain drain” from poorer countries. Also in times of migration and rapid technological innovation, assessing what balance of services should be provided by which group of health professionals (the best skill-mix for those health services) is a crucial challenge. Many countries have serious problems in determining the competencies needed for health system management and the corresponding training.

5.3. Health information systems

Health information has acquired renewed importance in modern society (i) as a component of efficient service and facility management, (ii) as part of participatory policy-making, and (iii) as the vehicle of knowledge management in the development and sharing of evidence and experiences; all the above has to be made compatible with the individual’s right to confidentiality related to information about her or his health status. Making information available in a timely way is therefore one of the key challenges for health systems in their efforts to achieve the objectives of effectiveness, efficiency, responsiveness, quality and transparency. This challenge has to be balanced against the cost of obtaining, processing and disseminating such information. As with other technologies and inputs, health systems need to set priorities in order to ensure that very expensive and less cost-effective measures do not displace less expensive and more cost-effective ones.

5.4. Health technologies, including pharmaceuticals

A substantial part of the effectiveness of modern health care depends on the availability of modern equipments and technologies, consumable medical goods and drugs, most of them provided by the private

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9 The world health report 2000 was based on a rather restrictive definition of “functions” from a managerial perspective; however, the 2007 WHO paper Everybody’s business: strengthening health systems to improve health outcomes speaks of “building blocks”. This title is mostly intended to make the reader aware of such difference.
sector in many countries. Health technologies in general and pharmaceuticals in particular consume enormous amounts of often scarce health system resources. Ensuring the availability of efficient equipment, technologies and consumables in a sustainable manner is a critical challenge. Assessing the safety, utility and efficiency of new technologies and drugs through proper health technology assessment is crucial in the WHO European Region, especially in resource-poor countries.

5.5. Health system financing

Health systems should fund cost-effective personal care and broad public health measures that contribute to health improvements for individuals and health gains for populations. In addition to their role in promoting, restoring and maintaining health, health systems are also economic entities in their own right, which directly and indirectly support economic activity at many levels (e.g. employers, procurers of services and goods). Also, they may – or may not – prevent the impact of catastrophic payments, etc. In short, health systems may be part of either a virtuous or a vicious circle in economic terms. Member States are learning lessons and choosing a blend of different options with implications in terms of fairness, sufficiency, pluralism, etc. Critical areas are to ensure the availability of funds for all by pooling risks and resources, mostly by pre-payment (insurance), to decide on a proper role for government and the private sector and to design effective payment methods that are able to provide the right incentives to professionals.

5.6. Health system stewardship and governance

Health systems are complex social “machineries” that need to combine robust leadership with sensitive checks and balances. Such stewardship role must be guided by values and be evidence-based, with clear monitoring and audit functions available to inform it. Its importance in a democratic context (providing strategic direction and advocating health, regulating wisely, ensuring transparency and accountability) cannot be over-emphasized. Stewardship should be concerned with the ability of structural micro-systems to respond to individual needs, ensuring access to effective interventions on the basis of severity (loss of life and of quality of life), potential effectiveness of the intervention, and a reasonable balance between effectiveness and costs. Member States should also recognize that policies in other areas impact on health systems and their sustainability, as well as on population health. Thus they should seek to address these impacts as part of the policy-making process, by increasing the political “connectivity” between health systems and other policy areas (intersectoral action, “Health in All Policies”). This is important in times when health emergencies due to natural and man-made disasters potentially devastating for health and wealth call for enforcement of the WHO-led International Health Regulations (health systems should also be designed to meet crises and catastrophes, and measures should be taken to ensure collaboration between countries whenever needed).

In summary, prioritizing investment in the functions that would provide the best results is a major concern for Member States. Linking production of the necessary inputs (e.g. human resources, knowledge, technologies, buildings) with the choice of cost-effective, appropriate services and the management of their production and delivery in a climate of efficiency is a crucial objective. The same can be said of the governance and financing functions led by ministries of health.

A significant problem is that the tools and mechanisms to share experiences of what has and has not worked in other countries currently seem to be insufficient. The documentation supporting this Charter (books, policy briefs, case studies) offers evidence and examples that will help Member States build and/or refine mechanisms to identify and discuss what to prioritize and where better to invest, in order to produce health and contribute to wealth generation in each country.
III. Signatories Agree

We, representatives of Member States and international agencies signatories to this Charter, have reached the following agreement by consensus, emphasizing international cooperation on actions and commitments.

Member States will:
- continue to promote European values in the development of health system strategies while taking account of their own national specificities. Particular attention will be paid to helping the process of making health systems more patient-focused;
- explore in more detail how the health system can contribute to the greatest extent possible to creating health and wealth and achieving equity in outcomes;
- commit themselves to better measuring the impact of investment in health systems, so as to identify with greater precision the likelihood that a particular set of actions/investments will contribute to health, wealth and equity in specific country contexts. The work of the Commission on the Social Determinants of Health will be taken into account;
- specifically target the production of a robust evidence base, to be shared by all, on improving the performance of health systems;
- commit themselves to taking the interests, opinions and expectations of stakeholders properly into account, in view of experiences demonstrating the limitations of technocratic approaches to health systems improvement.

WHO will continue to support Member States, though its normative and technical roles, in developing their own health systems and institutions, working in partnership with other international agencies towards the objectives included in this Charter.

Intersectoral action will be built on ongoing work within the European Union on “Health in All Policy Areas”. The European Union’s work on free movement of patients and professionals within its boundaries, as well as the health care quality indicators under development by the European Commission, will also be considered with a view to transferring the lessons learned to the rest of the WHO European Region.

The World Bank is prepared to support the objectives of the Charter through its technical advisory and lending work in the health sector in its Europe and Central Asia (ECA) region and to further deploy its comparative advantage of cross-sectoral engagements to leverage health determinants that are outside the traditional purview of the health sector

In coordination with WHO, the Organisation for Economic Co-operation and Development can contribute in assisting European Member States, particularly on sustainable financing.

Finally, Member States and international agencies also commit themselves to producing and/or refining tools and resources linked to a process of intercountry exchange of lessons learned in the development (and implementation) of this Charter.
Annex 3

LIST OF PARTICIPANTS

(IN ALFABETIC ORDER)

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Albania
Mrs Ehadu Mersini – CFP
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<td>CTE</td>
<td>Country Technical Expert</td>
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<td>CDG</td>
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