World Health Organization
REGIONAL OFFICE FOR Europe

DRAFT REPORT – PLEASE DO NOT CITE

WHO European Regional Office 'Health Systems Foresight Group' – launch and first meeting*

Bruxelles, Belgium, 07 July 2017

***This meeting report represents an overall summary of the discussions and directions from the meeting. It is not a full transcript and does not involve individual attribution of statements.**

Contents

On behalf of the WHO European Regional Office, the Division of Health Systems and Public Health who convened the meeting, expresses its sincere appreciation to the Institut national d'assurance maladie-invalidité (the Belgian National Institute for Health and Disability Insurance, INAMI-RIZIV) for generously hosting this meeting at their premises.

Introduction

Hosted by the Institut national d'assurance maladie-invalidité (the Belgian National Institute for Health and Disability Insurance, INAMI-RIZIV), a WHO European Regional Office (WHO/Europe) expert meeting on the future of European health systems was held on July 07, 2017 in Bruxelles, Belgium (See Appendix 1 for the Meeting Provisional Programme). The meeting was attended by a number of Member State representatives, alongside researchers, academics, independent experts and WHO/Europe staff. The meeting represented the establishment, and first convening, of the *WHO Europe Health Systems Foresight Group* (EHSFG), set up by the Division of Health Systems and Public Health (DSP). The EHSFG has been established to help WHO/Europe understand potential future health system directions in the WHO European Region, and how to support Member State health policy- and decision-makers in planning for them.

Background: Health Systems Strengthening from the Tallinn Charter onwards

The establishment of the EHSFG and its work falls under the Regional Office's mandate in providing guidance and technical assistance to its Member States on strengthening and improving the performance of their health systems. This work is in turn grounded in the *Tallinn Charter 'Health systems for health and wealth'*, which established a set of shared values and commitments on behalf of all Member States of the Region[1]. Calling for health systems which have solidarity, equity, participation and accountability at their core, the Tallinn Charter anticipated future pressures and demands on health systems – even if not the immediacy of the financial crisis which took hold the following year – and the need to ensure that health systems are seen as promoters of health, wealth and societal well-being while adhering to those values even in times of crisis. These directions were inspired by the 1996 *'Ljubljana Charter on Reforming Healthcare'* which stipulated that health care systems need to be driven by values[2], and the Tallinn Charter has proven important in helping countries design and strengthen their health systems and policies[3]. Indeed, its values are reflected in the commitment to people-centred health systems as one of four core pillars in *Health 2020*, the regional health policy and framework for the WHO European Region since 2012[4].

In 2013 a WHO technical meeting marking the 5 year anniversary of the Tallinn Charter, *'Health systems for health and wealth in the context of Health 2020: Follow-up to the 2008 Tallinn Charter'*[5], was held in Tallinn, Estonia. One result from the meeting was a request to the WHO/Europe for a strategic document on health systems strengthening (HSS) in the European Region. DSP had already developed an outcome-focused operational

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[1] The seven commitments outlined in the Tallinn Charter are to: (1) promote shared values of solidarity, equity and participation; (2) invest in health systems and foster investment across sectors that influence health; (3) promote transparency and accountability; (4) make health systems more responsive; (5) engage stakeholders in policy development and implementation; (6) foster cross-country learning and cooperation; and (7) ensure that health systems are prepared and able to respond to crises.

[2] http://www.euro.who.int/__data/assets/pdf_file/0010/113302/E55363.pdf

[3] http://www.euro.who.int/__data/assets/pdf_file/0008/287360/Implementation-of-Tallinn-Charter-Final-Report.pdf?ua=1

[4] The European policy *Health 2020* has two strategic objectives: to improve health for all and reduce health inequalities, and to improve leadership and participatory governance for health. The policy delineates four pillars for action to achieve these objectives: 1) investing in health through the "life course" approach; 2) tackling Europe's major disease burdens of NCD and communicable diseases; 3) strengthening people-centred health systems and public health capacity; and 4) creating supportive environments and resilient communities. The DSP works primarily under pillar three to revitalize public health services and to transform health systems in the region towards a more people-centred focus.

[5] http://www.euro.who.int/__data/assets/pdf_file/0008/249731/HEALTH-SYSTEMS-FOR-HEALTH-AND-WEALTH-IN-THE-CONTEXT-OF-HEALTH-2020-FOLLOW-UP-MEETING-ON-THE-2008-TALLINN-CHARTER,-Tallinn,-Estonia,-1718-October-2013-Eng.pdf

approach to providing technical support on HSS to Member States, and which was put into practice for a number of tracer diseases including the control and prevention of non-communicable diseases and for multi-drug resistant tuberculosis and anti-microbial resistance[6]. Building on that approach, and following a number of information consultations and discussions, an expert meeting on HSS in the context of *Health 2020* was convened in Barcelona, Spain, 03-04 November 2014, in order to help identify HSS priorities for the future. The focus of the meeting was on the role of health systems in improving health and well-being, with particular attention on tackling inequities[7], and had four key components:

- To identify the key constraints and challenges health systems are likely to face in the next five to ten years, taking into account the diversity of countries in the European Region.
- To identify priority areas for health systems strengthening building upon the Division's current and planned work on health systems strengthening.
- To identify ways in which WHO can best support Member States (at country and regional level) to make progress in the priority areas.
- To identify priorities for generating the evidence needed to support Member States in health systems strengthening.

The meeting in turn lead to the drafting of a forward-looking document, *Priorities for health systems strengthening in the WHO European Region 2015-2020: walking the talk on people centredness*, which was approved by all Member States during Regional Committee 65 in 2015[8]. This has since served as the guiding framework for DSP's HSS streams of work.

As the Tallinn Charter approaches its 10 year anniversary – for which a high-level meeting, again hosted by the Estonian Government, will be convened in Tallinn, Estonia, 13-14 June 2018[9] – there is a need to look at the future of health systems in Europe beyond 2018, beyond the DSP priorities framework document, and beyond Health 2020. The European environment is currently in flux, having changed drastically since the Tallinn Charter was signed, particularly in terms of the political, economic and social context. One result for the health sector being that some of the attributes that we assign to European health systems – that they are based on solidarity, equity and universalism – are under threat. Yet, at the same time, we see broader global directions, such as the Sustainable Development Agenda with the 17 Sustainable Development Goals (SDGs)[10], and the push towards Universal Health Coverage (UHC) as a partnership endeavour[11], which show us that the underlying values of the Tallinn Charter still carry relevance today. Reviewing the Charter in the new European environment is, therefore, important to help ensure that all Europe's citizens are able to benefit from effective, equitable, and appropriate care delivered by well-functioning health systems.

[6] http://www.euro.who.int/__data/assets/pdf_file/0006/186756/Towards-people-centred-health-systems-an-innovative-approach-for-better-health-outcomes.pdf

[7] http://www.euro.who.int/__data/assets/pdf_file/0005/278726/Barcelona-Health-systems-strengthening-Health2020-challenges-priorities-en.pdf

[8] http://www.euro.who.int/__data/assets/pdf_file/0003/282963/65wd13e_HealthSystemsStrengthening_150494.pdf

[9] To mark the tenth anniversary of the Tallinn Charter, a high level technical meeting entitled "Health Systems for Prosperity and Solidarity: Leaving no one behind" will be held in Tallinn, Estonia (13-14 June 2018). The meeting will be supported by the European Observatory on Health Systems and Policies, which is marking its own twentieth anniversary. The meeting will celebrate the Charter, reflect on progress and priorities in health system strengthening within the Region, and will also look ahead toward what we can expect in an increasingly changing European landscape. It will be oriented around three overarching themes: Include – improve coverage, access and financial protection for everyone; Invest – make the case for investing in health systems; and Innovate – harness innovations and systems to meet people's needs, all of which espouse a strong value base. The Foresight Group will report its initial findings at the Tallinn meeting in order to inform and sensitise policy-makers to the main issues at stake and what future scenarios exist.

[10] http://www.un.org/sustainabledevelopment/

[11] https://www.uhc2030.org/

A WHO European Regional Office 'European Health Systems Foresight Group'

It is against this backdrop that the European Health Systems Foresight Group has been established. Taking as it starting-point that health decision-makers in Europe face a number of common challenges – including the increasing costs of health care, demographic change and population ageing, changing profiles and burden of disease, concerns about health workforce sustainability, and growing patient demand – which, in turn, raise broader health system issues around affordability and sustainable financing, adequate human resources for health, and systems' ability to adapt to meet such challenges while still providing quality care, the EHSFG will consider potential future scenarios and develop pragmatic and policy-oriented advice for policy-makers. Its work is firmly grounded within the overall aim of ensuring that European health systems remain oriented around their shared values in order to promote equity and serve everyone.

The members of the new European Health Systems Foresight Group reflect the necessary diversity in discipline and expertise required to consider questions regarding the future of health and health systems in Europe. Moreover, the EHSFG comprises individuals from within and beyond the European Region. It was important to include not just representatives of Member States (from across the WHO European Region) and health system experts and researchers, but so too experts in (health) technologies and digitization, representatives of patients, payers and hospitals (See Annex 2 for List of Participants).

In establishing the EHSFG, a review of other approaches which are looking at the longer term future for European health systems was undertaken. Three cognate groups were noted: the Calouste Gulbenkian Foundation – which supported a report on the future of the Portuguese health system[12]; the World Economic Forum – which has set up a 'System Initiative on Shaping the Future of Health and Healthcare', aiming to provide a "unifying framework for health preservation and improved health care delivery"[13]; and the European Health Forum Gastein – which in 2017 set up a 'Health Futures Project' to look at how the various factors that influence health might evolve over the next twenty years[14]. The EHSFG will work with and alongside these initiatives as appropriate, but through the specific lens of WHO/Europe's value-oriented approach and its focus on HSS.

While not exhaustive, the questions which will guide the work of EHSFG, and which were set out to kick off this first meeting, were:

- What does the future hold for European health systems, both broadly and specifically, and can we make any long-term predictions? (e.g., can we develop scenarios around disease burden, spending on health, patient expectations, models of care?)
- What do current health system challenges tell us about future directions? (e.g., will growing financial pressures result in tiered systems, undermining principles around solidarity and equity?)
- Are there any likely scenarios that we can predict and prepare for? (e.g., does the automation of routine, or even specialist, surgical interventions seem likely and what implications does this have on quality of care or the health workforce?)
- Can we account for pressures from outside the health system? (e.g., does a trend towards adversarial rather than consensus-based politics pose challenges for health system planners?)

[12] Crisp LN, Berwick D, Kickbusch I, et al. The Future for Health. Lisbon, Portugal: Calouste Gulbenkian Foundation, 2014.
[13] World Economic Forum. Sustainable Health Systems Visions, Strategies, Critical Uncertainties and Scenarios. Geneva: World Economic Forum, 2013.
[14] https://www.ehfg.org/fileadmin/downloads/13-0-health-futures/EHFG_Health_Futures_Project_Report.pdf

- What are the key issues to be addressed or overcome in the short- medium- and long-term, and can health systems remain value-oriented? (e.g., what might an expanded role for the private sector in providing care, given financial constraints on health systems, mean in the next 10 years?)
- How can national policy- and decision-makers take informed directions to prepare for the future? (e.g., what sort of advice and practical guidance do they need and can WHO/Europe provide this?)

Trends and challenges for initial consideration

It is clear that policy-makers across the region are in need of pragmatic and policy-oriented advice in respect of such questions, and the EHSFG aims to provide perspectives on the long-term future of health systems in Europe, their priorities and orientation. Thus, in preparation for the first meeting of the group, of the many challenges and trends that we see in Europe, participants were invited to reflect on a number of key ones which are shared across the Region.

- Different models and structure of health systems. While European health policy-makers are committed to shared values, and their systems may to varying degrees reflect them, the region's health systems remain very different. The three traditional models of Beveridge, Bismarck and Semashko have all been adapted in different national contexts and have evolved over time. Even if these categorisations no longer apply in practice, each has left its own historical legacy in terms of health system structure and design, resources, infrastructure (buildings), and expectations about how the health system should work; all with specific country adaptations. Indeed, existing health system infrastructure is an issue for the future in all countries as it reflects past needs and approaches. This covers both the traditional 'hard' physical infrastructure such as hospitals and facilities, and the 'soft' infrastructure such as mechanisms of administration, financing, monitoring, recording and providing health care, and the training and distribution of health professionals. Bringing these, and the associated professional and institutional mindset, into the future is not an easy proposition. And while all countries may have acute resource and hospital infrastructure issues, for example, they have different starting-points and potential trajectories when planning to address these for the future; in some cases vastly so.

- Financial pressures. Another challenge participants were asked to consider relates to the financial pressure on health systems, now exacerbated by the global economic crisis. The period 2009-2013 saw a general drop in health spending in many countries, but since then expenditure on health systems has been rising again across the region. Also, because health systems in Europe are mostly publicly financed, this financial pressure is typically expressed as a challenge for public budgets. Responses to it are thus not only about private choices regarding insurance or saving, but rather are understood as a matter for society as a whole. Recalling the importance of solidarity to European health systems, not only are questions being asked about the economic and financial sustainability of current health system expenditure, but now whether it is politically and socially sustainable as well; how much money is the population going to accept being spent on their health system, and for what services?

- Technological advances. Advances and improvements in medical technology, techniques and medicines are key to delivering quality care, but they are increasingly expensive. With a focus on high-cost products, medicines and technologies are a major factor in driving health system expenditure (and out-of-pocket payments in some contexts). It is also unclear whether the prices of many of these improvements reflect their comparative value-added to health and health systems. Cancer treatments is a current example, where spending more on cancer care does not correlate directly with improved outcomes as prices for new drugs

(and existing off-patent medicines) continue to rise at an alarming rate. Moreover, many innovations do not necessarily align well with the needs of the health system, or with those of patients. Mental health stands out as an under-served area, as does the increasing threat posed by antimicrobial resistance where innovations and new drugs are not readily forthcoming.

- Insufficient long-term planning. A final challenge participants were asked to reflect on in preparation for this first meeting was the continuing poor capacity for long-term policy-making and implementation within countries. The combination of sustained financial pressure and the relatively short terms for health ministers (with health also often being an 'easy' budget cut), has led to a focus on short-term policies and structures. Additionally, as health systems and their challenges become more complex, the process of change within them has become more difficult and time-consuming. This risks creating a structural incapacity for strategic, long-term reform of health systems, and difficulties in meeting global aspirations and targets such as under the SDGs.

These four areas in no way constitute an exhaustive list of all (current) challenges for the future – indeed one task of the foresight group is to identify others – but they are important ones for policy-makers to consider going forwards. In asking participants to reflect on these areas in advance of the meeting, the objective was to ensure that all were "on the same page" and with enough background to prepare for an interactive and particpatory meeting. It is to be noted that the aim of the group and the foresight work is not to be predictive. Rather, it is to help develop proposals for health policy- and decision-makers which can support their systems' adaptation to the main and emrgent challenges and trends going forward.

Meeting synopsis

Opening and introductions

The meeting opened with Jo De Cock (Chief Executive Officer, INAMI-RIZIV) and Hans Kluge (Director, Division of Health Systems and Public Health, WHO/Europe) issuing a joint welcome. A 'tour de table' followed, along with the introduction of Nick Fahy (University of Oxford) as the facilitator. The origins of and rationale for the group were explained – that as part of preparations for the Tallinn 2018 health systems meeting, DSP was interested in looking forwards and working with Member States after Health 2020. A longer-term perspective was deemed necessary and Belgium (through INAMI) in particular was interested in going beyond the usual 10-25 year forecasts. The intent was to be as open to future unknowns as possible and, as such, the EHSFG will look at the future of health systems in Europe to 2070. The aims of the meeting were outlined as to:

- have a first brainstorming on the issues and challenges facing health systems in Europe in order to consider how best to advise Member States.
- consider what outcome the group should produce and what input the group should have in the Tallinn 2018 high-level meeting.
- plan the work of the EHSFG and discuss its potential future.

During the opening round of participant remarks, it was stressed that there is a need, when looking towards the future, to attempt to be concrete. Rather than predicting the usual or obvious directions, the need for more action-oriented planning and being pro-active in system design, was seen as key to making the exercise useful to policy-makers in countries. Participants felt that we cannot simply keep restating what we think may happen in areas around e.g., ageing populations, health workforce retirements, migration flows, the rise of non-communicable diseases and changes in disease profiles etc., as enough such predictions are being made by

researchers and academics and through other exercises. Instead, the challenge for this group, and where the real need lies, is in helping to prepare policy-makers and guide Member States in concrete terms.

Understanding a foresight exercise

The format and approach to the meeting itself were also set out, including the use of targeted working groups in line with the four central principles of a foresight exercise:

- action-focused – the aim of the process is to guide action by Member States and WHO/Europe.
- explore alternative futures – consider different issues, trends and challenges, and potentially raise different scenarios.
- participatory – process will be driven by stakeholders from across European health systems, and related areas / sectors, also reflecting diversity of context and culture.
- multidisciplinary – involving a variety of expertise and stakeholders.

In following these principles, the EHSFG will work through three stages: *diagnosis* (understanding where we are), *prognosis* (exploring future and different scenarios), and potential *prescription* (recommending ways forward). The process is iterative rather than sequential and the group is not time-bound. It was explained to participants that as discussion on the future and potential actions develops, the group may be asked to go back and refine the initial diagnosis, for example. The intent of having a structured but open and fluid approach to the meeting and programme was to benefit as much as possible from the expertise and thoughtfulness of the participants.

Further, it was explained that the work of this group, in keeping with a foresight approach, was not about following the usual process of asking: Where am I? Where do I want to be? How do I get there? Rather, the approach is to start with: Where do I want to get to? Then ask: Where am I in relation to that goal? And only then ask. How do I get there? In this context, as we cannot really predict health needs in 2050, far less 2070, the group debated whether putting such a long timeframe was in fact useful. Participants concluded that the end-date itself was not the important element. The long-term timeframe was instead symbolic as it forced the group to consider uncertainties, disruptions and potential changes around not just health systems, but so too in political and social spheres, and the impact of economic trends and scenarios (including influences from outside Europe), environmental issues etc. In other words, for the group to do its work effectively, and especially in view of the long-term timeframe, there is a need to look outside the health system and beyond the health sector.

A related question was asked about focusing and aligning the group's work on / towards 2030 given the SDGs and UHC timeframe. Overall, the group saw the need to be relevant to such agendas, particularly as they are Member State driven, but there was consensus that we needed to look past these (and their short timeframe) in order to be useful and, indeed, different from other exercises; especially in offering health system advice which is shaped by outside factors as well as those from within 'health' broadly construed.

Other opening thoughts from participants related to whether the group would work towards quantification of trends or scenarios in any way. Modelling was deemed a useful exercise in such future-looking exercises but beyond the scope and remit of this group. It was noted that linkages could be made later as the group and its work developed. Further, it was felt that while prognoses and predictions are helpful, what of 'black swan events' – was this something that group could realistically think about or assess? For with a timeframe running until 2070, the chances of such an event(s) were likely. Ensuring awareness of the issues and areas around which such big impact changes – even if unforeseen – could occur was seen as the best the group could do here. The important point was the degree to which health systems and policy-makers would be able to adapt / react to any

such events rather than trying to predict them. Indeed, this was seen as the thrust of the foresight exercise overall.

It was stressed that the EHSFG at this meeting needed to spend time on diagnosis as the first stage of foresight in order to then analyse how systems can respond. The example of demographic change was given. For while it is often cited as challenge to health systems in that individuals are living longer, but potentially doing so in ill health with a consequent impact on health budgets, a closer look reveals nuances about prospective good health, compression of morbidity, economic contribution from a healthy workforce etc.
We will start with diagnosis as the first stage of foresight.

Working groups

As noted earlier, this first meeting of the EHSFG looked at a number of specific trends that national health policy-makers will face in future, and participants were equally divided into four working groups according to expertise and interest, and invited to look at a number of leading current trends with short- medium- and long-term implications on European health systems. Working groups were also asked to identify other issues or questions they felt ought to be discussed within their topic area as well as with the wider group when reporting back. The working groups convened twice, once regarding key issues in their area before the break, and once to discuss challenges and trends after the break; and the group work in fact continued after lunch.

Chaired by Nicola Bedlington (European Patients' Federation, BEL), the first group looked at:

- *changing health needs*: not just demographic ageing, but changing disease patterns and patients increasingly presenting multiple chronic conditions – what does this mean for the structure of health care provision, and what social structures and expectations does this require in terms of the responsibilities of the individual, the family, civil society and public services?

The second group, chaired by Nigel Edwards (Nuffield Trust, UK) considered:

- *continuing and growing inequalities* in needs, interventions and provision: there are uneven patterns of need, with only a small proportion of patients accounting for the bulk of expenditure, and the spread of new treatments – where they exist – is unevenly distributed even within countries.
- challenges in relation to understanding and incorporating the *social determinants of health*: socioeconomic inequalities in society and across the region impact on health systems, in turn affecting the wider economic and political sustainability of health systems, also in terms of maintaining a strong value orientation.

Charing the third group, Reinhard Busse (Berlin University of Technology, GER) was asked to reflect on:

- *information and efficiency*: we know the general benefits of information technology in health care, but one of the long-standing challenges around health systems remains the need to measure what matters; our current health information systems are heavily skewed towards inputs and processes and we crucially need more on outcomes.
- *health system resilience*: the challenges to health systems are set to continue, and a crucial issue for all policy-makers is to improve their capacity to identify challenges at an early stage in order to be able to adapt their systems to them.

Rifat Atun (Harvard University, USA) chaired the fourth group on:

- *innovation and implementation*: this relates to issues around the link between research, development, evaluation and implementation processes, where current systems linking research to need and the use of evidence in developing good practice are far from perfect.
- *a changing health workforce*: technology is already changing the nature of health professionals' roles, as is changing patterns of disease, and calls for the development of new functions or professions entirely; and difficulties associated with an ageing health workforce, and the retention and distribution of health workers will continue.

Reporting back, rapporteurs from each of the working groups summed up their deliberations and delivered some key points and findings for the whole group to reflect on via discussion in plenary.

[Note that the summaries of the working groups' deliberations in following reflect some of the main points of discussion, but are not a complete record. The nature of the exercise was to brainstorm in a highly interactive manner rather than to produce coherent topic reports.]

Brainstorming and feedback

Before breaking into the four working groups, participants asked about the use of "scenarios" in responding to the different areas of challenges to Member States, for this too is part of a foresight exercise. Ultimately, the consensus was that it was too early for the group to develop scenarios in this meeting – this required dedicated time and expertise – and that it perhaps might not be helpful in the longer-term either; particularly not given the diversity between Member States in the region. But as it was noted that the group's potential longer-term profile was to be demand-side driven (e.g., Member State requests), it will necessarily mix generic with specific advice and scenario-development may thus be a future area of work for the group.

<u>Working Group 1: Changing health needs</u>

Group 1 found themselves asking a number of important questions to provoke debate in plenary, rather than trying to provide specific views of the future. The group's raising of these questions reflects the type of issue and challenge policy-makers can expect – particularly from patients – in the future. For example, the group's first concern was how individuals would understand and value health – their own and as a concept more generally – in the future? Will this be defined by technology or will it be the other way around? What does (good or bad) health mean now versus in the future? And as a corollary what does (a good or bad) death mean now versus in the future? Obviously we cannot answer these questions as they stand, but it was asked whether individuals' health (and their understanding thereof) might affect their political choices, and the way people choose to live? For the group noted that changing societal preferences and directions will have a consequent impact on values and beliefs. How people choose to live will lead them to define their health accordingly.

Reflecting on this questions of how people will define their health in future, the group noted the importance of decision-makers making an active attempt to understand what patients (will) want. An example was provided around efforts to improve patient literacy, where this is based on the assumption that the information provided is what people actually need, and that they are interested in understanding it. As we see, this is not a given. Further, commenting on the experience of a highly digitalised country, the group noted that good information systems and data are not necessarily useful. That is, in this case the country has considerable data on individuals' health and use of services, but doctors and the patients themselves do not really know what to do with it. This raised the issue of how health systems adapt or incorporate new technology and innovations. And whether there

is a danger of technology hijacking the patient i.e., that technologies and services are at the centre of the health system rather than individuals? For it was noted that greater reliance on technology could lead to a situation where an automated system identifies risk factors for individual patients, and then triggers the need for emergency action even before diagnosis of a condition. What does this mean about patient decision or choice, and the human factor in wanting to perhaps live in an unhealthy or risky manner? And while previously we could screen for 10 diseases, now we can screen for 100. What does this mean for individuals and the way they may wish to live?

The group discussed the implications of changing societal definitions of health, and the impact of technology, on the health workforce and the provision of care as well. It was seen as likely that health professionals' roles would change considerably, perhaps to become more of a "coach" rather than "decider" as individuals take more responsibility and have more say. Health professionals already report difficulties in getting patients to understand that the advice they provide is done so on the basis of this being best for the patient rather than for themselves. With health professionals' roles changing, might this also lead to an emphasis on 'taking care' rather than healing, and the development of a more mature understanding of "social health" which involves the community, religious groups etc. What are the implications here? From whom will patients want or expect care in the future? For this too carries concerns, as declining immunisation rates in children point to.

Relatedly, the group reflected on the so-called 'commercial determinants of health'. The benefits of greater private sector involvement might be clear, if sometimes overstated. And 'fads' around self-monitoring were seen as distracting from the real health issues. But the dangers of relying too much on for-profit providers were seen as the tip of the iceberg. We are being pushed to 'lose' what we already know e.g., vaccines. Why?

As for future disease burden / profiles, the group concluded that while expectations of premature mortality from NCDs will no doubt drop overall, cancer for example will only get worse. And this brings us back to definitions of health and death. For cancer patients generally want a cure, or else the best available treatment and eventually a 'good' death. It is clear, the group concluded, that some people will get left behind.

<u>Working Group 2: Inequalities and social determinants of health</u>

Working Group 2 reported back to plenary that their discussions on inequalities and social determinants of health, while animated and considered, had on balance been "depressing". The overall conclusion from their deliberations was that in future we cannot assume that social solidarity-based health systems will still be supported. Increasing wealth concentration was identified as driving this, and it will most likely spread across Europe (the group pointed to the worsening situation in the United States of America). The end-result of this being that different groups will increasingly demand different things from their health system, with some able to pay for whatever service they want. In turn, this implies that the service-offer from health systems in future will need to be adjusted and, potentially, tiered according to ability and willingness to pay. We will not be able to force people to have the same services in the same way.

In terms of specific examples which we already see as emergent, the group pointed to the impact of migration (differing health needs resulting in differing health services and, in some cases, migrants being kept outside the formal health system) and as well as mental health (where the provision and quality of care is already very diverse within the region, and where some contexts see the involvement of the judicial and criminal system in providing care; again outside the formal health system).

And as with the first working group, it was noted that such changes will impact the health workforce: roles will change and traditional classifications may become even more 'judged'. A physician who provides care to the more vulnerable members in society may come to be (even) less regarded than one who serves the political class, or another who serves the extremely wealthy.

Overall, the group reflected on the interrelationships between different 'blocks'. For example, how (a) wider economic changes may drive (b) the greater automation of jobs, with consequent results for (c) the provision of long-term care. Or how (a) greater income inequality will lead to (b) technology inequality and a (c) decreased commitment to solidarity, in turn demanding (d) greater diversity in system and service, contributing to (e) greater variance between people, (f) increased poverty and (g) further income equality – this will have an impact on (h) NCDs and (i) mental health for example. The group's focus was on making these links, and writing these up in a coherent format was seen a potentially interesting contribution for the future. As a final remark, the group felt that we are making assumptions around a social consensus that may be, if not already has, changed.

Working Group 3: Innovation and implementation

Taking as its starting point that "the future is here (now)", Working Group 3 engaged with innovation as an ecosystem which is coming. The leading questions were thus around outside-in versus inside-out approaches, how to harness useful innovations (who to define a useful innovation), how to manage useful innovations, and how to steer clear of less useful ones. The group stressed that important in this context was the need to have an understanding that covered both 'soft' innovations such as in policy (e.g., the introduction of a new primary care approach) and intervention 'hard' innovations such as technologies or medicines. With regard to the former, it was noted that policy innovations in particular need to be sustained, and that health systems have a responsibility to steer and not just to row.

For both hard and soft innovation, an assessment framework and an evaluation framework were seen as separate but equally crucial. The group felt that future innovations, insofar as we can prepare for them, need to be measured against quality, sustainability, and the degree to which they enhance or promote equity and solidarity (assessment). Evaluating them over time is equally important, and any framework needs to cover impact (though how to measure this remains a challenge), timeframe, magnitude, certainty. For it was clear that there are policy implications across the health system and that alignment between needed and emerging innovations (to benefit patients, to be affordable to health systems and payers, etc) was an important balancing-act that policy-makers should not just pay attention to but influence. It was agreed that this work could be developed by the EHSFG in general, and that a proposal could be put to the next meeting.

In this regard, the group reflected on the balance between push and pull mechanisms for driving innovation, and agreed on a traditional linear 'model' which covered the emergence, adoption, diffusion, uptake and harnessing of innovations, coupled by an assessment framework which grew in complexity over time (as the evidence grew). It was noted that disruptive technologies, major medical breakthroughs or even the sudden introduction of a major reform were likely to challenge the way care is organised and delivered, but predicting how and when is not realistic. By contrast, being able to anticipate the sudden impact of a new innovation was what policy-makers and planners should be focusing on, and the group's innovation diffusion model was one way to help them do so. The group concluded that a Schumpeterian approach to 'creative destruction' was seen as a possible and useful way to look at the future of health system innovations.

Working Group 4: Information, efficiency and resilience

The fourth Working Group felt that while their contribution was best served by thinking about their topics individually, they began by reflecting on what the future would look like for health systems as defined by people's potentially changed value systems. While not directly part of their assigned topic area, the group felt that as this had implications on the structure of future health systems (so, health information, efficiency and resilience) it was an important starting-point. Here they foresaw two scenarios: one characterised by polarised values and social structure, resulting in a patchwork of 'health systems'; and other reflecting a set of uniform societal values developed out of the 'facebook generation' which led either to agreement on "uniform individualism" or "uniform solidarity" – one-size-does-not-fit-all versus one-size-fits all. The former sees no government role in the health system, with the possibility for catastrophic events taking a huge toll, while the latter sees a push towards universal health coverage and greater resilience.

In discussing resilience, therefore, the group reflected on the importance of macro-level inter-country collaboration and dependence in the facing of growing global threats and epidemics. This in turn meant interdependencies at the meso-level, such as between different sectors of society and the economy e.g., agriculture, education, health etc. And at the micro-level, inter-community resilience was identified as a way forwards. This in turn offered a more holistic view of the health system and the impacts of other factors on individuals' health. In this regard, the group concluded that there was a need to move from a 'health system model' to a 'health model'.

Considering health system information and efficiency, the group focused on why the health sector feels the need to constantly define itself in relation waste. In some respects waste, however defined, may be higher in health but this is certainly not the defining element. As such, a more positive spin and rebranding was deemed important – to highlight how well the sector spends the (limited) resources it has, the positive impact it has individuals and populations regarding improved health and well-being (and social cohesion), and the contribution this has for the economy. It was argued that our own focusing on waste, result in further 'discrimination' against the health sector in terms of funding, and we do not need to be so defensive participants concluded. What is clear, however, is that an improved ability to generate comparable data (measures) is key, as is a more uniformly-accepted definition or understanding of the health system and health sector on economic well-being. We need to create better structures for the measurement of impact / outcome also vis-à-vis other sectors, and improved health information systems are crucial in generating the relevant data.

An important overall reflection from group 4 was that individuals wear three hats, all which generate different profiles in respect of their engagement with a single health system: as a patient (needs), as a consumer (wants), as a citizen (expectations). Accounting and planning for these was clearly a challenge. Health professionals too wear different hats as they have expectations and needs from the health system, and yet are providers of health within it. Coming full circle, this brought us back to the question of how do we address this going forward, especially in view of changing societal preferences and values?

Final remarks

The facilitator's closing remarks were an attempt to capture some of the main themes from the discussions, while noting that not everything would be covered. Issues around changing societal preferences and understandings of health (individual and in general) were seen as a concern. The definition of health and what is healthy will most likely change, involving a greater understanding and embedding with well-being; social

interactions may need to part of a new formal definition of (good) health, and is there any scope for an increased use of the assets for health concept? The question this leads to is what is society willing to adhere to, or to believe, around health in the future and can we plan for this?

Technology and innovation are key drivers of improved health, but direction is required. The trend towards preventive medicine may not be desirable if it comes at the expense of curative medicine. At the same time, a future scenario for greater innovation and high technology will need to include an increased role for the private sector – we must acknowledge that it has already (in part unexpectedly) driven much advance in health care; the role of the internet also being an important example.

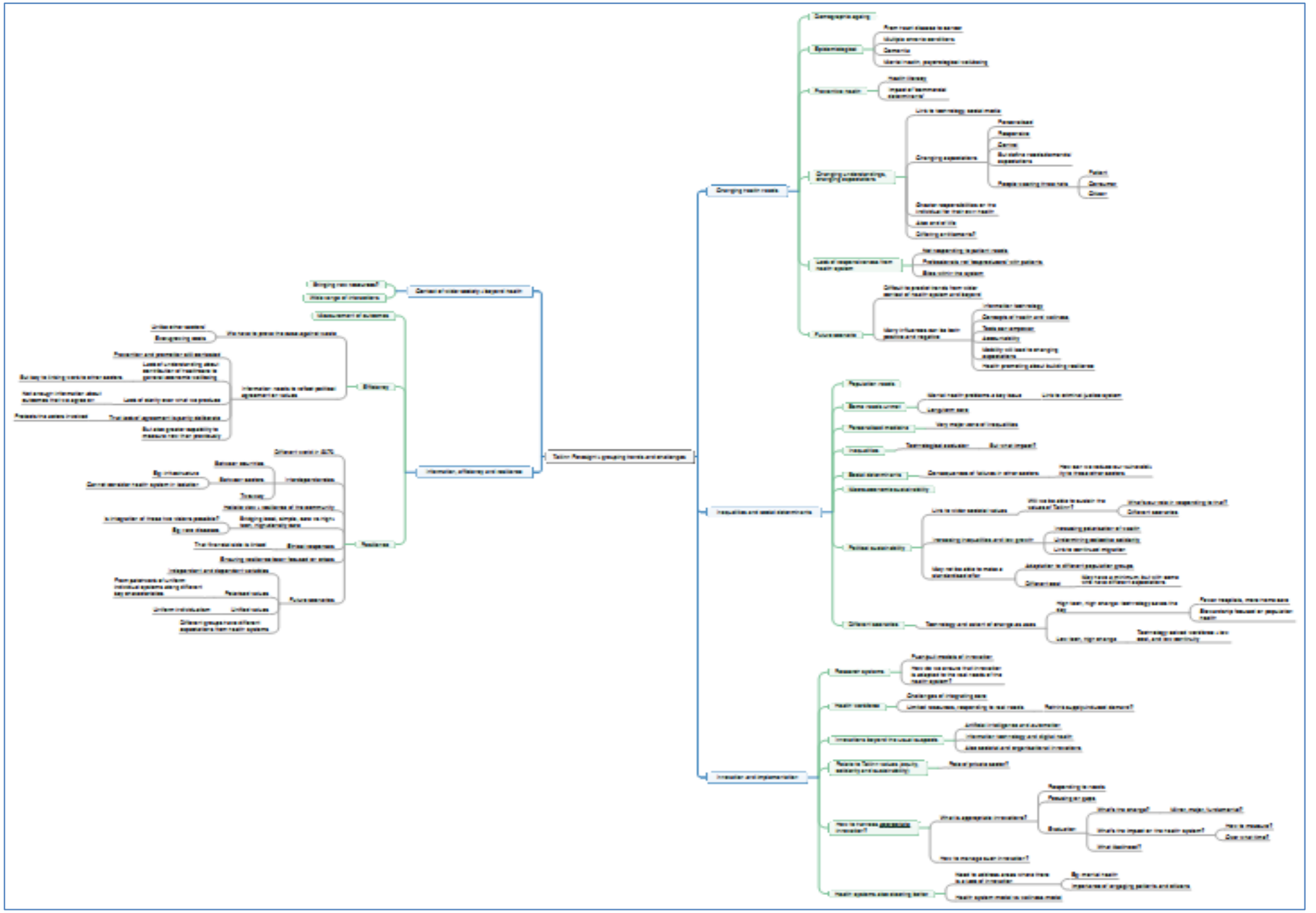
It is also clear that the future, no matter the scenario, carries considerable implications for the health workforce. Currently, while the work on predicting and planning needs for specific roles, adjusting academic curricula, considering distribution of specialisation and patterns of need etc is important, it is not likely to be enough to help planners ready themselves for 2070. Planning the impact of new technologies and ways of working is not easy, especially when there is the potential for breakthroughs in the delivery of care, but again readiness is key. We need to think this into our future health workforce scenarios.

A health-promoting environment is needed, whatever the future definition of health may be. But this will need to be context-specific and go outside health system. There is, however, a likelihood of different models. Social determinants and economic development will run in parallel, both raising concerns for health systems. The potential for a future defined by less solidarity has major knock-on effects, including in economic terms and thus as a driver of greater health inequalities and inequities from multiple sides. And while we may have some continuity in European health systems now, the future may be a patchwork of systems, even within countries.

Moreover, future health systems may be more targeted, tiered and with individual systems corresponding to categorisations of people e.g., gender, migrant, political leaning, income level etc. This has different, and not inconsequential, implications for financing, service delivery (basket of services) and system planning. What can policy-makers do to prepare for the emergence of such directions? Can they prevent it if they so choose; would they want to if it is driven by societal changes?

By way of concluding, the facilitator talked the group through a "mindmap" they had created on the basis of the days discussions (Figure 1 overleaf). This is not provided as a conclusion of the meeting, but it reflects the complexity and richness of the discussions and topics covered.

Figure 1: "Mindmap" of working group discussions (c/o Nick Fahy)



Conclusions

Following the afternoon coffee break, three linked but discrete sessions were planned: scoping potential outcomes from the EHSFG work discussing the suitability of the group and whether (and how) to involve others in the foresight process and, finally, a discussion on next steps for the group / working together. The richness of the working group discussions and plenary feedback saw these final three sessions merge into a single group brainstorming around the question of what next, or how do we go forwards with this exercise. It was agreed that a meeting report would help to set the stage for the further work of the group, and that the initial concept note provided to inspire this first meeting should be widened. Moreover, there was a clear view that, as per the next stage in the foresight process, the next meeting – and any work undertaken in the run-up – needed to reflect (or at least link closely with) a prognosis stage. This was deemed to be crucial in establishing the viability of the group and its work, particularly if any recommendations were to be possible in time for the Tallinn 2018 high-level meeting.

In so saying, the group acknowledged the difficulty in moving from prognosis to prescription in such a short timeframe (by June 2018). It was felt that this move needed to be captured in a potential third or fourth meeting, but even then that this might be premature and that more work on prognosis would be needed. The secretariat agreed, also noting that 'proof of concept' was important at this stage; further support and funding of the group could follow after the Tallinn 2018 meeting. In this regard, participants reflected on the possibility of collaboration with other networks to widen the group, but it was felt that this too was a bit early to consider. With the EHSFG delivering input to the Tallinn 2018 meeting, and depending on its reception by Member States, more formalisation of the group – including reaching out to others – was thus seen as a future consideration. It was agreed that the Tallinn 2018 meeting should, to the extent possible, be used as a platform to establish the EHSFG in a concrete capacity. Nonetheless, widening the expertise of the group beyond the current participants was deemed important in two specific areas. First, given the lengthy discussions around changing societal preferences, a values and ethics perspective was seen as imperative in understanding both diagnosis and prognosis. Second, a greater appreciation for future technologies and artificial intelligence was seen as necessary from both a health systems and a patient perspective. Additionally, and for a later stage, the need to potentially engage 'modellers' was expressed.

Additionally, the final session saw participants expressing their opinions on not just the topics discussed, and others for future meetings, but also on the process. It was agreed that the Tallinn 2018 meeting should be seen as a milestone in the work of the EHSFG, but should certainly not be an end. This resulted in a brief discussion around whether this foresight work could be about developing a structured learning system or mechanism for Member States (especially in view of the need to have their endorsement if the work is to be taken forward in a formalised workstream within DSP or the Regional Office more generally). It was suggested that a potential institutionalisation of a foresight function within the Regional Office – as a type of platform where Member States could come with specific concerns, questions and requests for support / work – would indeed represent an invaluable contribution to HSS in the European Region; and would help to fill an important gap. At the same time, participants understood the need to have an output from this group, in report form, for the Tallinn 2018 meeting. Here it was agreed that the initial concept note could be used as an initial template, but additional dimensions, stemming from the group work, need to be added to that analysis. Moreover, that the format and type of report should be discussed and agreed following the 'prognosis stage' of the foresight exercise at the second meeting. It was also stressed that document for the Tallinn 2018 meeting cannot be too academic and / or disease-focused. Again, the need to be relevant to planners and policy-makers was stressed.

Participants reflected on the fact that any type of forward-looking work, such as through this group, needs to be asking questions of policy-makers – understanding and serving their interests – not being prescriptive unless requested to be so. Here the issue of co-creation with countries was also raised as one way forwards. It was also noted that in looking at health systems for the future, any planning or foresight work needed to involve in-depth discussion with those directly affected or involved, for example the health workforce. Moreover, it was felt that there was a clear need to understand and think of potential non-linear directions of health systems' evolution.

Health system transformation

Although not part of participants' deliberations, in the closing session, Hans Kluge noted that the work of the EHSFG also ties into another important DSP workstream: the large-scale transformation of health systems ('the transformation agenda')[15]. This refers to a spectrum for change management and improvement in health systems, along which countries can move. For many countries in the European Region are currently grappling with extensive macro-level reforms, else are in need of undertaking them. And while designing appropriate and feasible large-scale health system reform is an acknowledged challenge, even greater is implementation (potentially at pace), and sustaining the transformation reform at policy-level. DSP is often requested to help with 'the how' of implementation.

Indeed, during the EHSFG discussion on future scenarios, help with policy implementation was identified by several Member State representatives as an area in which WHO's support is needed. Participants agreed that WHO has both a normative and interventionist function in this regard. So while the Regional Office is already using its convening power to create opportunities for Member States to exchange experiences in managing change in line with these directions, the work of the EHSFG can help prepare countries by offering longer-term scenarios and potential directions they need to be aware of. Such broader insights will then, as the group agreed, need to be applied to (and adapted accordingly) to the local context in deciding what areas and with what policies countries should focus their attentions. Moreover, being prepared also means understanding what is needed for implementation, and it was felt that the group also could be helpful in this regard.

Questions going forwards

This first meeting of the European Health Systems Foresight Group in Brussels was an initial attempt, on behalf of the WHO European Regional Office, to provoke discussion around key issues of concern to policy-makers in respect of planning for their health systems in future. This was in order to test the general appetite for a forward-looking process to provide key insights in support of the Tallinn 2018 meeting. Among the most notable outcomes of the EHSFG first meeting were:

- Identification of key constraints and challenges for health systems in Europe and, in turn, where Member States will need help from DSP and WHO/Europe more widely.
- Exploration of potential future health system directions, including structure, models of care, patient expectations and societal impacts.
- Agreement on the need for more detailed work in specific areas, but first around: (a) scenarios for health (burden of disease, disease profile) and health cost / spending; and (b) the impact and diffusion of innovation in health systems, also as areas of focus for the second meeting.

[15] http://www.euro.who.int/__data/assets/pdf_file/0014/318020/Madrid-Report-HST-making-it-happen.pdf?ua=1

- Acknowledgement of the need to widen the group's expertise – in light of the four working group discussions – to include both a social and ethics (ethicist, sociologist), and a technologies / artificial intelligence perspective.
- Agreement for a report from the group to be made available at the Tallinn 2018 meeting, but in acknowledgement that this will not be a concluding or final statement of the group's work, but a single deliverable as an input to the meeting and process; and that it should be pragmatic and informed but not academic either in content or format.
- Relatedly, the need for more detailed discussion on what the group could provide in terms of input into the Tallinn 2018 meeting 'outcome document'.
- Consensus on the importance of the foresight exercise and the need to develop a more formal mechanism, potentially a stream of work / function of the Regional Office through DSP as a direct service to Member States after the Tallinn 2018 meeting (depending on interest from the Regional Office and Member States, the specifics of any such mechanism would be developed later).

This first meeting was very much about the 'diagnosis' stage of the foresight process. And it is envisaged that the second meeting will look to 'prognosis' based on a select number of areas / issues.

Through policy dialogues and other fora for expert discussion, WHO/Europe offers opportunities where Member State policy- and decision-makers can be honest about the challenges their health systems face and share experience on how to improve them. The Regional Office's convening power enables peer-to-peer exchange of knowledge and experience, and also the involvement of stakeholders and actors from beyond ministry of health e.g., health professionals, patients, other ministries, researchers and experts. Relatedly, the Regional Office plays an important role in generating and disseminating evidence around issues important to countries. In the case of DSP this relates to health system issues – human resources for heath, service delivery, public health services, pharmaceuticals and medical devices, and health financing, along with the relevant targeted technical support. As forum for the open exchange of ideas and concerns, research, evidence and expertise, and with the goal of developing pragmatic advice to policy-makers, the European Health Systems Foresight Group reflects all these elements. Participants stated that its work will, therefore, be crucial not only in respect of being an input into the Tallinn 2018 meeting, but as a longer-term function for the Region's Member States thereafter.

Annex 1: Provisional Programme

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

European health systems foresight group **/1**

Brussels, Belgium
7 July 2017 **26 June 2017**

Provisional Programme

08:00-08:30	Registration
08:30-08:45	Welcome and introductions *Jo De Cock, Hans Kluge*
08:45-09:00	Aim of the workshop *Hans Kluge*
0900-10:30	Brainstorming challenges for the future ● Introduction to the brainstorming: *Nick Fahy* ● Breakout groups: trends, issues and challenges ● Report back from groups *(group rapporteurs)*
10:30-11:00	Coffee break
11:00-12:30	What will health systems look like in 2070? Visions and scenarios ● Values of the Tallinn Charter ● Grouping trends and challenges ● Breakout groups: visions for each scenario
12:30-14:00	Lunch
14:00-15:00	● Report back from groups ● Collective discussion of scenarios
15:00-15:30	Coffee break
15:30-16:00	Scoping the potential outcomes from this process ● Introduction: *Hans Kluge* ● Discussion
16:00-16:30	What other input will be useful for this process? Who else should we talk to? ● Introduction: *Nick Fahy* ● Breakout groups ● Report back
16:30-16:45	Next steps and how to work together ● Provisional timetable of meetings
16:45-17:00	Conclusions and close of meeting; *Hans Kluge, Jo De Cock*

Annex 2: Provisional List of participants

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ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

European health systems foresight group
- first meeting

Brussels, Belgium
7 July 2017

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