TRUST AND TRANSFORMATION
TALLINN CHARTER 15TH ANNIVERSARY HIGH-LEVEL CONFERENCE
Resilient and sustainable health systems for the future
12–13 December 2023, Tallinn, Estonia

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POLICY BRIEF 61

Financing for health system transformation

Spending more or spending better (or both)?

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CONFERENCE COPY

World Health Organization
European Region

European Observatory on Health Systems and Policies
a partnership hosted by WHO

Keywords:
Health financing
Health system transformation
Public funding
Health and economy
Health policy

This policy brief is one of a new series to meet the needs of policy-makers and health system managers. The aim is to develop key messages to support evidence-informed policy-making and the editors will continue to strengthen the series by working with authors to improve the consideration given to policy options and implementation.

What is a Policy Brief?

A policy brief is a short publication specifically designed to provide policy makers with evidence on a policy question or priority. Policy briefs

- Bring together existing evidence and present it in an accessible format
- Use systematic methods and make these transparent so that users can have confidence in the material
- Tailor the way evidence is identified and synthesised to reflect the nature of the policy question and the evidence available
- Are underpinned by a formal and rigorous open peer review process to ensure the independence of the evidence presented.

Each brief has a one page key messages section; a two page executive summary giving a succinct overview of the findings; and a 20 page review setting out the evidence. The idea is to provide instant access to key information and additional detail for those involved in drafting, informing or advising on the policy issue.

Policy briefs provide evidence for policy-makers not policy advice. They do not seek to explain or advocate a policy position but to set out clearly what is known about it. They may outline the evidence on different prospective policy options and on implementation issues, but they do not promote a particular option or act as a manual for implementation.

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The authors and editors are grateful to the reviewers who commented on this publication and contributed their expertise.

Print ISSN 1997-8065

Web ISSN 1997-8073

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Key messages

To transform health systems, countries will need to spend more public funds on health as well as to use those funds more efficiently and effectively.

- **Governments often have major concerns about the persistent growth of public spending on health and about the long-term sustainability of health financing.** Health policy-makers are finding it increasingly challenging to make the case for adequate health budgets as price growth, demographic shifts, and other factors put significant upwards pressure on health spending.
- **Health systems and services need to transform to meet their objectives and to become resilient to future challenges.**
- **Transformation requires a mix of more efficient (better) and increased (more) public spending on health.**
- **Health systems can spend their resources better by optimizing resource allocation and by focusing on priorities which provide value-for-money.** Some 'good' investments to consider include:
    - o primary health care and prevention which reduces the need for more expensive and intensive treatments;
    - o steps to strengthen and sustain the health care workforce to ensure there are enough staff in the appropriate geographic care areas to deliver high quality, accessible services;
    - o digital innovations which, if they are carefully selected and integrated, can enhance efficiency, access, and quality of care;
    - o improved access to mental health care to address population and societal needs;
    - o ongoing evaluation of pharmaceutical pricing and reimbursement models to make sure that prices paid reflect good value; and
    - o coverage policies that provide better financial protection and access to needed services.
- **Resources can be spent better in all countries, but additional public expenditure on health is also required now and over time.** Institutional rigidities and political economy factors mean efficiency gains and reallocation of funding from one priority area to another are not always possible. Even when they are, they are unlikely to be enough on their own to deliver on strategic goals such as high-quality, affordable, and accessible care.
- **Public sector budgeting has a strong political dimension and health policy-makers need the evidence, skills and willingness to negotiate effectively for resources.**
- There is no one-fits-all solution to negotiating for additional resources for health, but a strategic approach based on evidence-informed narratives and effective fiscal governance arrangements can help.

Acknowledgements

The Observatory and the authors would like to express their deep gratitude to Natasha Azzopardi Muscat, Tamás Evetovits, Josep Figueras, Triin Habicht, Ledia Lazeri, Suszy Lessof, Jason Maurer, David Novillo Ortiz, Cassie Redlich, Marge Reinap and Sarah Thomson for their assistance in providing information and for their invaluable comments and suggestions on previous drafts of the manuscript

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Executive summary

Health care is a significant part of the economy and government budgets in many countries of the WHO European Region, but the continuous growth in health spending has raised concerns about sustainability and efficiency. In particular, the COVID-19 pandemic drew renewed attention to health financing and the need for health spending growth to be on a sustainable trajectory. Countries had to increase health spending to bolster historically underinvested systems, leaving many policy-makers worried about escalating health care budgets. Even before the pandemic, various factors, including price growth within the health system, demographic shifts and climate-related issues, among others, have increased pressure on health care budgets and will continue to do so in the future.

To address these challenges, health systems and services must adapt and transform. This naturally leads to questions about the appropriate level and distribution of health spending in countries. This policy brief argues that achieving health system transformation objectives necessitates a re-think of public spending priorities within health systems; but additional public spending is also required to meet population health needs in most cases. To achieve health system objectives, health policy-makers must be prepared and able to advocate effectively for sufficient financial resources.

The brief begins by discussing health expenditure trends in the WHO European Region in the 15 years between the signing of the Tallinn Charter and the start of the COVID-19 pandemic. It highlights that while there has been significant variability across countries during this period, average government health spending as a share of gross domestic product has remained fairly consistent in the Region (even amidst declines in public budgets as a share of the economy during this time) and that priority of government spend has been given to health in many countries. It also discusses the increased public funding for health during the COVID-19 pandemic and its importance in managing the crisis and maintaining health care services. Although the role that health care already plays in the economy and government budgets is significant, the evidence presented also raises questions around sustainability, and hence how health systems can use their existing resources more effectively and how policy-makers can best argue for more funds.

To support health system transformation, priority areas for investing scarce financial resources include:

i) Focusing on prevention and primary care,

ii) Improving the health workforce's recruitment and retention,

iii) Embracing digital technologies,

iv) Prioritizing mental health with sufficient funding,

v) Re-evaluating pharmaceutical pricing and reimbursement models, and

vi) Designing effective coverage policies that ensure access to services and financial protection, especially for vulnerable populations.

In most health systems, however, increased public investment is required in addition to more effective allocation of existing resources, in part due to institutional rigidities that make it difficult to simply move money from one priority area to another without consequences. Cross-cutting lines of argumentation can be made to demonstrate how public funding for health is necessary and also highlight the broader value of good health outcomes to society which are linked to key public financial management objectives. These are explored and discussed before the brief concludes that in most places, health system and service transformation will hinge upon a combination of increased public spending on health and more efficient spending.

POLICY BRIEF

1. Introduction

Health care comprises a substantial share of the economy and is a large component of government budgets in most countries in the WHO European Region. There is considerable evidence that health spending is a key contributor to health and broader societal outcomes, but persistent growth in health spending raises concerns among some policy-makers and analysts, both because of worries related to the sustainability of ever-increasing expenditures and about whether the system is efficient enough. On the one hand, there are trade-offs when countries allocate greater resources to health care, which may mean that other important sectors will receive less. This could be optimal from a societal perspective, or it may not be, depending on the needs and context of the particular country. On the other hand, there are frequent criticisms and accusations regarding wasteful health spending, and arguments that resources could be put to better use – either within the health system itself, or better used in sectors other than health (for example, education).

For many countries, the COVID-19 pandemic drew attention to the sustainability of health systems financing

For many countries, COVID-19 brought renewed attention to the sustainability of health financing. In response to the pandemic, countries markedly increased their government health spending at the same time as their economies contracted and tax revenues declined. Much of this additional health spending aimed to build necessary surge capacity to compensate for underinvestment in health systems in previous years. However, in some countries, one consequence of rapidly increasing the budgetary space given to health has been that policy-makers have become newly concerned about inexorable growth in the level of resources allocated to health systems.

While the pandemic put a spotlight on health systems and their financial sustainability issues, several other relevant factors have been putting upwards pressure on public spending on health, and will continue to do so in the coming years. In particular, rising prices – for medicines, medical equipment and other types of advanced technologies – has been a major driver of health spending in many countries. Moreover, all countries in the Region are facing demographic shifts as people are living longer. Worldwide, the number of people aged 80 years and above is expected to rise to 426 million in 2050 – an increase of 300% since 2020 (WHO, 2022a). Although longer lifetimes come with increasing opportunities for individuals, communities and societies at large, older age is also typically accompanied by chronic health conditions, complex multi-morbidities and geriatric syndromes. Although population ageing is not a primary driver of health spending in most countries, contributing less than one percentage point of growth per person annually, older populations depend heavily on health systems and on average have higher levels of health spending (Greer et al., 2021; Watt et al., 2023).

There are many other factors affecting demand for health care and expenditures. Among them, the climate crisis is also having profound impacts on our health and making increasing demands on the health system. Natural disasters are becoming more frequent and are leading to premature death, lost work hours, food and water insecurity, higher incidence of infectious disease and other health consequences (Romanello et al., 2021). WHO estimates that by 2030, the direct costs of climate change to health will be between US$ 2 billion and US$4 billion annually (WHO, 2021). Other factors, including violent conflict, cost of living crises and gaps and shortages in the health care workforce, are pushing health systems from both the demand and supply sides.

Countries are at a critical juncture to consider how to transform health systems and how to pay for that transformation

As these pressures rise, health systems must evolve and transform to cope with these challenges. Rather than simply directing additional public funds towards old models of care, policy-makers need to give careful consideration to the ways to most effectively invest in health systems to ensure that they are equipped to provide high-quality, affordable and accessible care for all. For example, during the COVID-19 pandemic some countries demonstrated this shift in thinking by investing in areas such as telehealth and the establishment of multidisciplinary teams at primary health care level (Kumpunen et al., 2022).

If countries are to transform the way they finance their health systems to be more resilient and sustainable, answers to several questions have to be explored: how much do countries spend on health; what do they get for that money; what should they prioritize if they are to spend public monies more efficiently and effectively; and how can health policy-makers better argue their cases for public resources?

This policy brief demonstrates that in many countries a mix of better and more public spending on health is required to achieve health system objectives, including transformation

This policy brief begins by a presentation of evidence on government health spending levels and trends alongside data on health system goals to highlight what health systems in the WHO European Region achieved in the years between the signing of the Tallinn Charter (2008) and the start of the COVID-19 pandemic (in 2020). The next section considers some of the factors that are putting pressure on government health budgets currently and will continue to do so in the coming years, and how these will affect health spending and budgets in the future. Ideas around where countries can spend 'better' in health by reallocating their resources within the sector or through spending more effectively are explored. This is followed by discussion around how some countries may need to spend more public funds on health in addition to spending their existing resources better. To support this, evidence that can help inform health stakeholders on how they can best argue their cases for more financial resources for health is reviewed. The brief then concludes by arguing that most health systems in Europe need to spend more *and* spend better to transform their health systems.

2. How much do European countries spend on health and what has this spending achieved?

Before considering whether countries should spend more or spend better on health (or both), it is important to understand recent health expenditure trends and what that spending has achieved in terms of key health system objectives. In this section, the latest published data on health spending in the WHO European Region are reviewed, with efforts to relate these data to health system goals wherever possible (Papanicolas et al.,2022).

Before the COVID-19 pandemic, gross domestic product was one of the key determinants of variability in government health spending, but it was not the only factor

There is substantial variability in terms of how much governments in the WHO European Region spend on health care and how those spending levels have changed over time (WHO Regional Office for Europe, 2021). Much of this variability in the level of government spending on health can be explained by country wealth, with those countries that can afford to spend more generally doing so (WHO Regional Office for Europe, 2021). For example, in 2019, before the COVID-19 pandemic, domestic general government spending per person on health was highly correlated with per person gross domestic product (GDP) (correlation coefficient = 0.631) (WHO 2023a).

Nonetheless, a country's health spending choices do not just depend on what it can afford, they are also influenced by political choice and context. Health spending is determined by a range of factors, some of which are arguably within the control or influence of countries themselves. These include factors that affect the volume of care needed, such as the health status and age-mix of the population (Williams et al., 2019), as well as the availability of different types of health care goods, services and medical technology; and the prices paid for goods and services (including for medicines). Of course, although these factors affect health spending overall, political factors, the level of informality in the economy and societal preferences for redistributive policies also have an influence on how much government funding goes towards health.

Between 2008 and 2019, the share of health spending paid for by governments remained consistent across the WHO European Region on average, but there was large variability between countries

In 2008, the year the Tallinn Charter was signed, government spending on health care accounted for 64.6% of current health care spending in the average country in the WHO European Region (WHO, 2023a). Over the next decade, from 2009 to 2019, the average country in the WHO European Region continued to fund around 65% of health spending from government funds each year (WHO, 2023a).

This steady share overall masks considerable variation across countries during this period; the government's share of current health expenditure ranged from a low of only 12% to a high of 88%. Government funding accounted for over 80% of health spending in a range of countries including Croatia, Czechia, Denmark, Iceland, Luxembourg, Monaco, Norway, Sweden, Türkiye and the United Kingdom. Moreover, in fewer than half (21 out of 53) of WHO European Region Member States, the share of current health spending from domestic government funds increased from 2008 to 2019. The largest increase was in Georgia (22.6 percentage points) followed by Cyprus (13.6 percentage points), Bosnia and Herzegovina (13.0 percentage points) and Moldova (11.5 percentage points). The largest declines in domestic government spending as a share of current health expenditure occurred in Greece (–16.6 percentage points), Kazakhstan (–14.4 percentage points) and Ukraine (–13.3 percentage points). In countries where the percentage of health spending coming from domestic general government funds fell, most often the share paid out of pocket at the point of use increased.

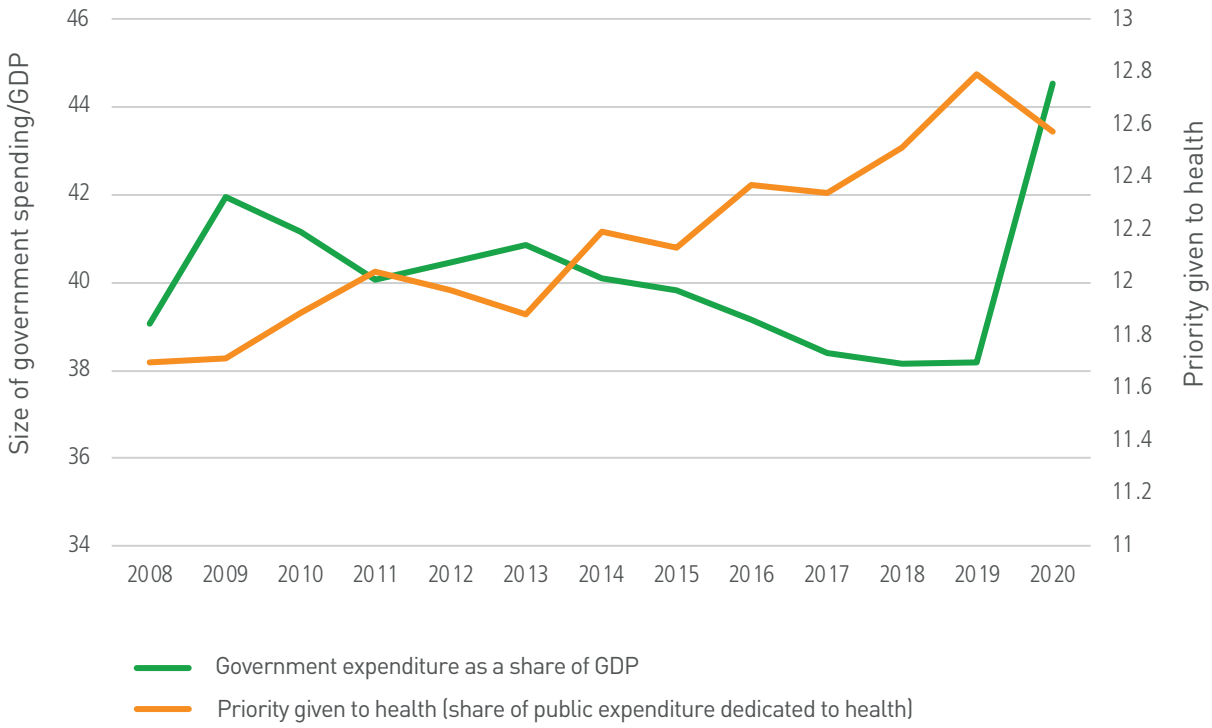
These patterns in how much of health spending comes from government funds reflect differences across countries and time in terms of the size of government budgets overall, the degree of private care provision, as well as the priority given to health within the government budget.

Between 2009 and 2019, the size of the overall public sector decreased in many countries, but the portion dedicated to health by governments increased

In the average Member State in the WHO European Region, the size of the public sector as measured by government expenditure as a share of GDP has generally fallen over time. In 2008, 39.1% of GDP in the average WHO European Region country was spent by government. As the financial crisis took hold in 2009 and GDP declined, government spending as a share of GDP increased to 42.0% in the average country. However, since that time, the size of government relative to the economy declined fairly steadily to 38.2% in 2019. Some of this decline in the size of the public sector reflects economic growth following the financial crisis, but many countries also experienced a retrenchment of the welfare state. In 29 of 52 countries with data available, government spending as a share of GDP was lower in 2019 than it was in 2008. If we consider 2009 as the starting point, in most countries, government budgets as a share of GDP shrank between 2009 and 2019. Only eight WHO European Region Member States had more government spending as a share of the economy in 2019 than in 2009.

However, this overall pattern of smaller government budgets contrasts with the priority given to health by governments (as defined as the proportion of public expenditure dedicated to health) (Fig. 1). Looking at this indicator, 38 countries in the WHO European Region have increased the priority given to health between 2008 and 2019. The largest increases between these two years have been in San Marino (13.2 percentage points), Iceland (5.4 percentage points),

Figure 1: Trends in government budgets and priority for health in the WHO European Region, 2008–2020



Source: Authors' own compilation.

Belarus (5.2 percentage points), Sweden (5.2 percentage points) and Georgia (4.6 percentage points). On average, the increase in priority given to health was fairly small: rising from 11.7% of government spending in 2009 to 12.8% in 2019.

Although this pattern of somewhat greater priority for health coinciding with smaller government budgets is strongest among high-income countries, it is also noticeable among middle-income countries (Fig. 2). For example, in the average high-income country in the WHO European Region, government spending as a share of GDP fell from 45.6% in 2009 to 41.6% in 2019, whereas the priority for health over the same time period increased from 13.2% to 14.6%. In the average middle-income country, government expenditure as a share of GDP fell from 35.1% in 2009 to 32.1% in 2019, but the priority for health increased from 8.9% to 9.6%. However, it should be stressed that these averages still mask important country differences within income groups.

We also observe that, in general, countries with larger government budgets have a higher priority for health spending within those budgets, meaning that countries with large public sectors – mostly wealthier countries – typically spend more of their resources on health.

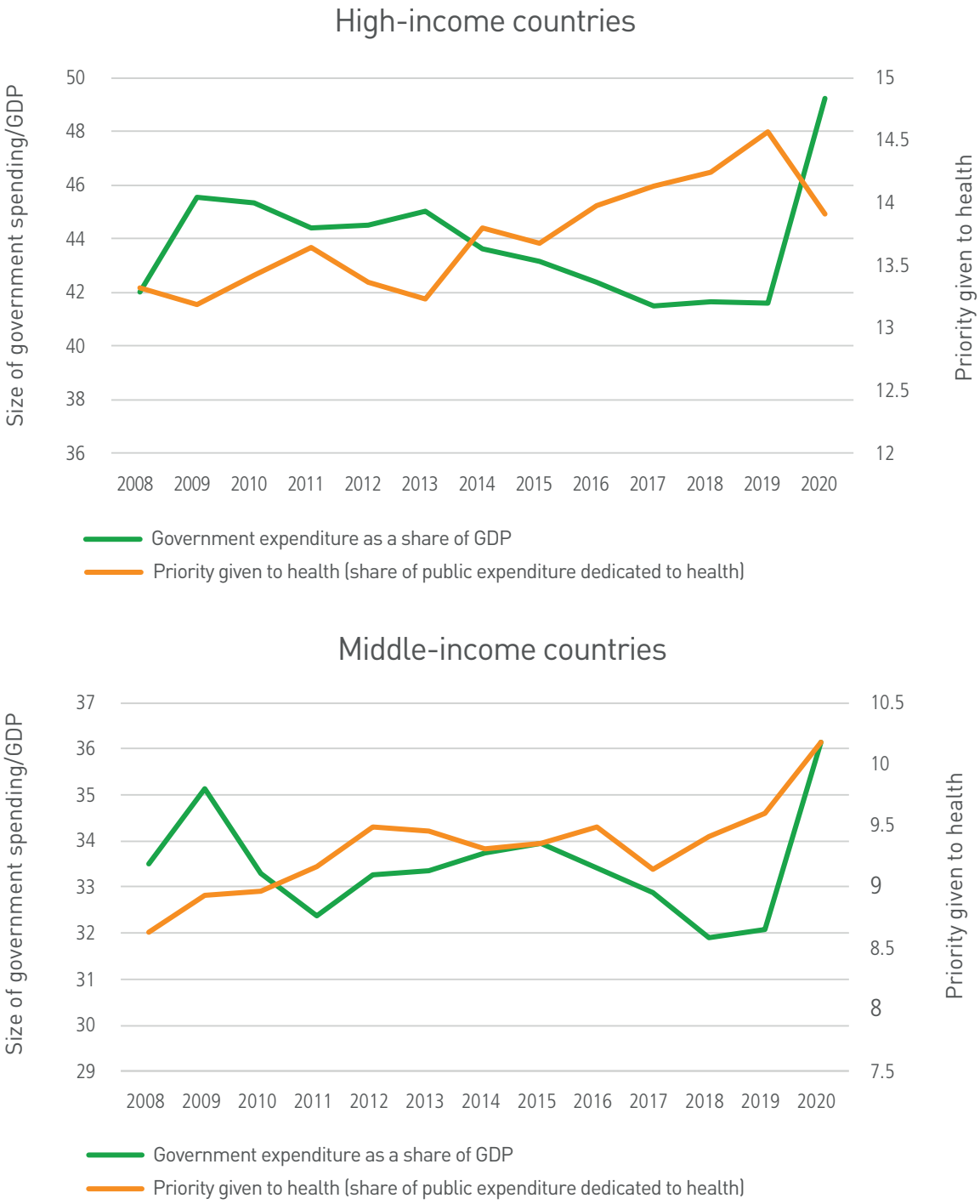
Ultimately the declining size of government expenditure overall relative to GDP coupled with an increasing priority for health means that on average the share of GDP spent on health care by government funds has remained fairly stable from 2009 to 2019 at around 5%, after increasing slightly between 2008 and 2009 (Fig. 3). This pattern is consistent across both high-income and middle-income countries in the Region, although of course it is not the case in all countries. Between 2008 and 2019, domestic government health spending as a share of GDP ranged from 0.6% in Turkmenistan in 2008 to 9.3% in Sweden in 2018. Only 15 countries reduced their spending on health as a share of the economy between these years. The largest increases in government spending on health as a share of GDP between 2008 and 2019 occurred in San Marino (3 percentage points), Sweden (2.4 percentage points) and Norway (2.3 percentage points), while the largest decreases were in Ireland (–2.3 percentage points), Greece (–1.8 percentage points) and Moldova (–1.5 percentage points).

Overall, the data suggest that countries have been maintaining or increasing their health spending despite less government spending overall. This is a positive reflection of the importance policy-makers have given to health.

Evidence suggests that, on average, countries achieve better outcomes by spending more on health; but at the country level, there is large variation in what is accomplished with current levels of financing

Prioritizing health has helped many countries to progress towards universal health coverage. This is evident by looking at data on treatable mortality – causes of death that should not occur in the presence of timely and effective health care interventions – and comparing them with domestic government per capita spending for those countries with

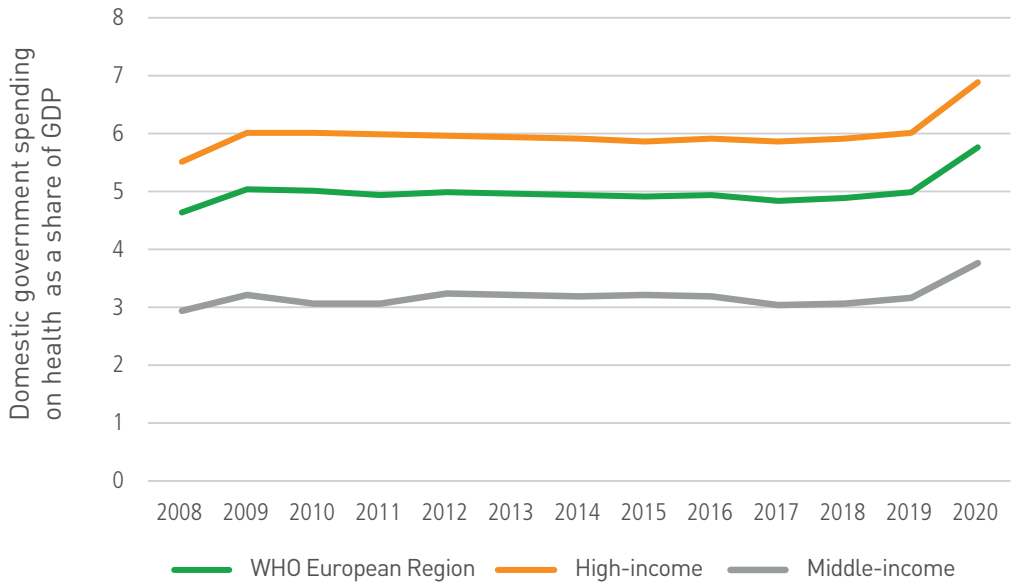
Figure 2: Trends in government budgets and priority for health in the WHO European Region, 2008–2020, by country income group



Source: Authors' own compilation.

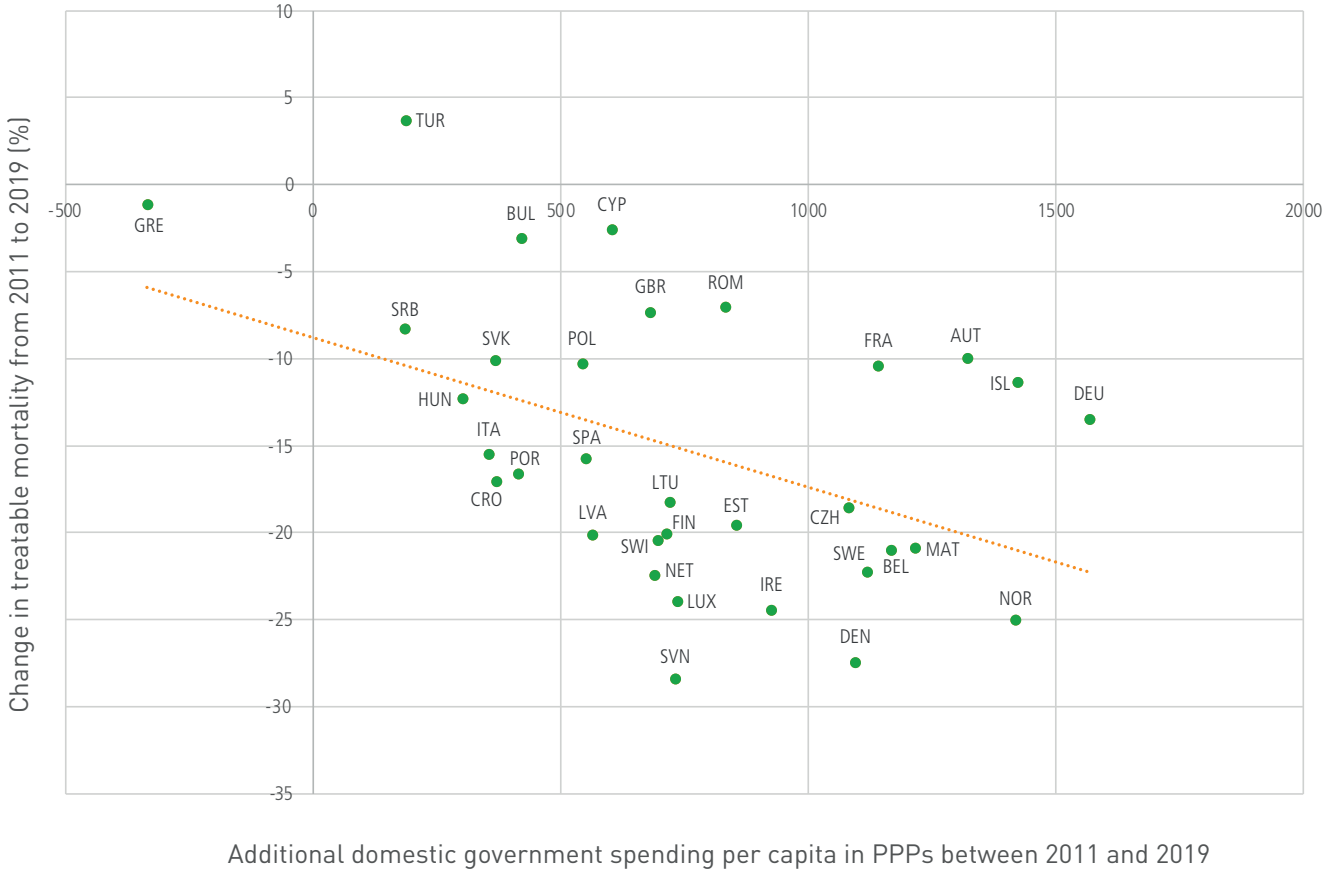
data available. Fig. 4 shows that among countries with data available, those that increased their per person spending more generally saw greater improvements in treatable mortality. For example, between 2011 and 2019 (the years for which data are available from Eurostat) Greece's per capita health spending fell by nearly int.$ 334 purchasing power parity per person whereas in Türkiye spending increased by just int.$ 188 purchasing power parity per person; these countries saw treatable mortality fall by 1.2% and increase by 3.6%, respectively, over the same time period (Fig. 4). Germany meanwhile spent int.$ 1 567 purchasing power parity per person more and reduced treatable mortality by 13.5% between 2011 and 2019, and Norway increased spending by int.$ 1 418 purchasing power parity per person and reduced treatable mortality by 22.5%. It should, however, also be noted that there are longer-term health impacts from reduced spending on services such as cancer screening and routine vaccination, which may not appear as treatable mortality in these current figures and time period.

Figure 3: Trends in government spending on health as a share of GDP in the WHO European Region, 2008–2020, by country income group



Source: Authors' own compilation.

Figure 4: Changes in government spending on health versus changes in treatable mortality, 2011–2019



Source: Authors' own compilation.

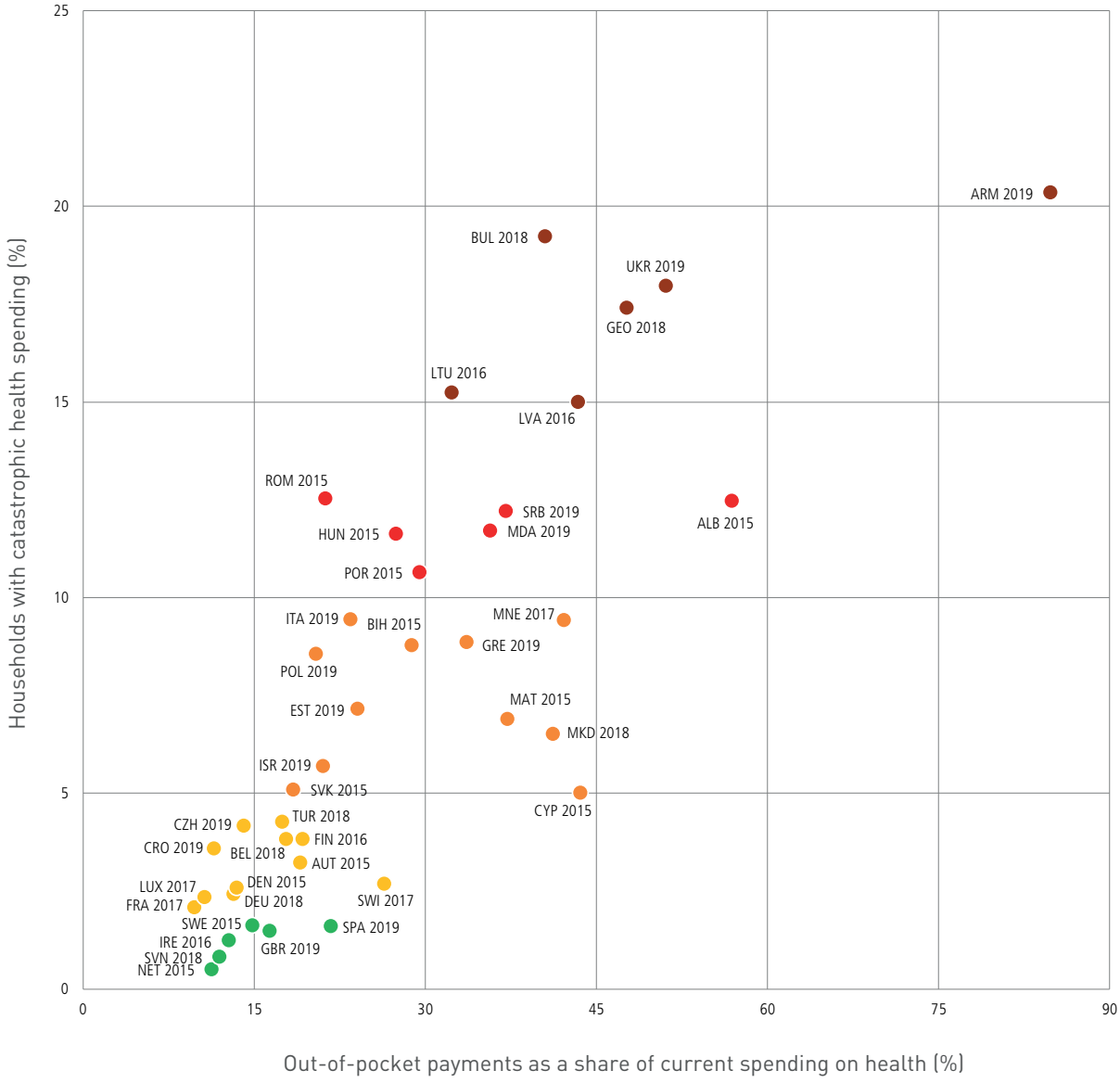
Some countries achieve good health outcomes without being among the highest spenders

Not all treatable deaths can be attributed to the health system, but some countries appear to have achieved better health outcomes than others while increasing their spending by relatively less. The largest decline in treatable mortality was in Slovenia (–28.4%,) which increased its government spending on health by int.$ 731 purchasing power parity per person between 2011 and 2019, and the second largest decline (–27.5%) was in Denmark, which increased spending by int.$ 1 095 purchasing power parity per person over the 8-year period (Fig. 4). Overall, this suggests some positive but diminishing returns on expenditure: countries achieved better outcomes by spending more, but some countries managed to achieve better outcomes without being among the highest spenders.

Greater public and pre-paid funding for health is also linked with lower rates of financial hardship

More spending has also helped countries to ensure that households do not experience financial hardship when using health services. Data available for 40 countries show that countries that rely less on out-of-pocket spending – and therefore, more on public and other pre-paid funding – to pay for health care have consistently lower incidence of catastrophic spending (Fig. 5) (WHO Regional Office for Europe, 2023ia).

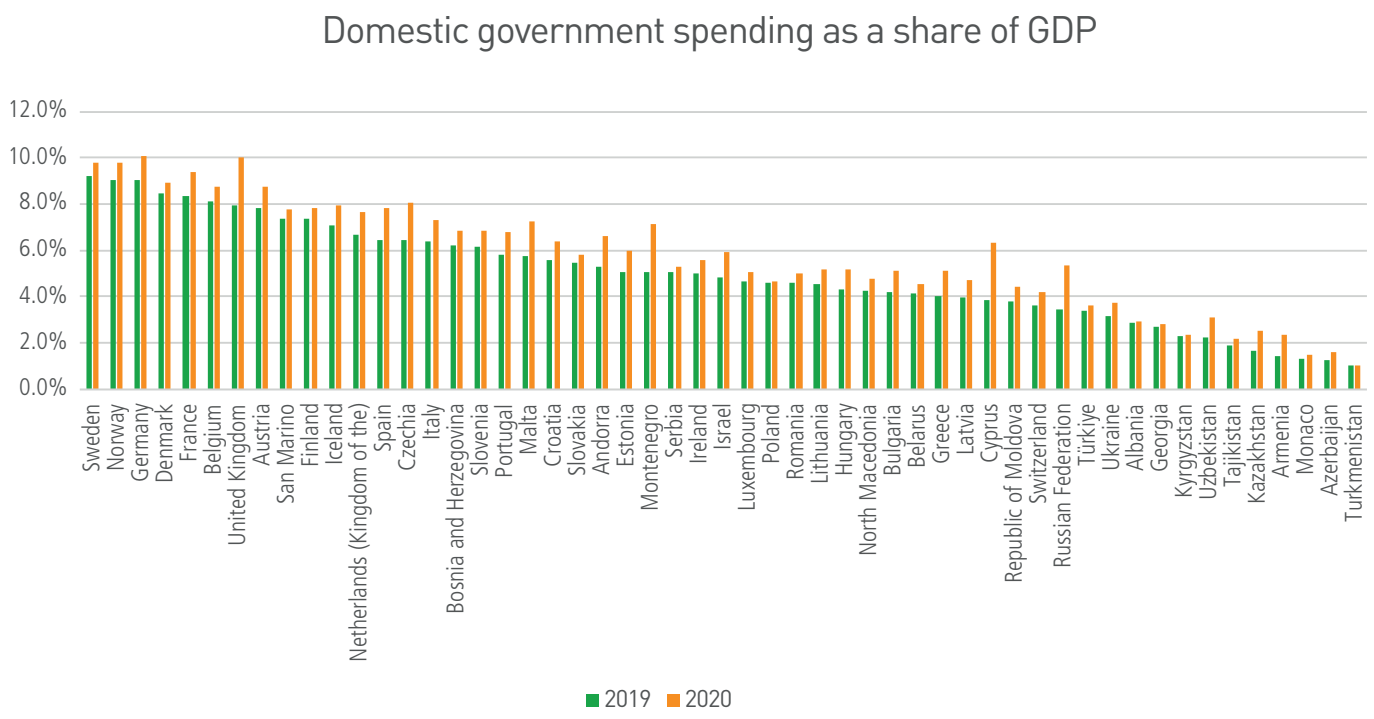
Figure 5: Share of households with catastrophic health spending and out-of-pocket payments as a share of current spending on health, 2019 or the latest available year before COVID-19



Notes: Data on catastrophic health spending and out-of-pocket payments are for the same year. Dots are coloured based on the incidence of catastrophic health spending: green <2%, yellow <5%, orange <10%, red <15%, dark red ≥15%. The Kingdom of the Netherlands cannot be compared with other countries because the data used to calculate catastrophic health spending do not include the annual deductible amount that households pay out-of-pocket for covered health care; our simulations suggest that catastrophic health spending was underestimated by up to 1.8 percentage points in the Kingdom of the Netherlands in 2015.

Source: WHO Regional Office for Europe (2023). *Can people afford to pay for health care? Updated evidence on financial protection in Europe.* Copenhagen: WHO Regional Office for Europe.

Figure 6: Domestic government spend pre-pandemic versus in the first year of COVID-19



Source: Authors' own compilation.

Taken together, one could argue that in the years since 2008, many countries have taken steps to prioritize health spending relative to other areas of the public sector. Even in many countries that made cuts during the financial crisis, spending on health rebounded afterwards. In some countries, this prioritization of health has contributed to better health outcomes and better financial protection, though attributing these improvements to health spending is empirically challenging.

Nearly every country in the WHO European Region allocated more public funding to health during the COVID-19 pandemic

In 2020 in response to the pandemic nearly all countries spent more than they had done previously on health care from public funds, even as GDP fell and as non-COVID-19 health care services were severely restricted (Fig. 6). On average, domestic government spending on health care increased from 64.9% of current expenditure in 2019 to 67.4% in 2020 (WHO, 2023a). This was mainly achieved through substantial increases in government spending overall. Government spending accounted for 44.5% of GDP in 2020 in the average country in the WHO European Region, up from 38.2% of GDP in 2019 (WHO, 2023a). On a per capita basis in national currency units, government spending grew faster between 2019 and 2020 than average annual growth between 2009 and 2019 in all but seven countries (Belarus, Kyrgyzstan, Montenegro, Tajikistan, Türkiye, Turkmenistan and Uzbekistan) (WHO, 2023a).

This meant that countries could maintain or even reduce the share of government spending devoted to health and still spend considerably more of their resources on health than in previous years. As a share of GDP, all countries in the WHO European Region (aside from Turkmenistan) spent more domestic government resources on health in 2020 than they had in 2019. In 2019, domestic government spending as a share of GDP ranged from under 2% of GDP in Armenia, Azerbaijan, Kazakhstan, Monaco, Tajikistan and Turkmenistan to over 8% in Belgium, Denmark, France, Germany, Norway and Sweden. To illustrate the scale of the increase in spending, in 2020, 13 countries (Andorra, Cyprus, Czechia, France, Germany, Greece, Israel, Malta, Montenegro, Portugal, Russian Federation, Spain, and United Kingdom) increased domestic government spending on health by 1 percentage point of GDP or more.

Additional public spending on health was essential for most countries in the first year of the COVID-19 pandemic

In many cases, how much countries spent on health care in 2020 was linked with the extent to which they were able to manage the pandemic, limit loss of life due to COVID-19 and ensure some continued access to health care services. In countries that could afford to allocate additional resources to health, additional funding went towards much needed personal protective equipment, medical equipment and infrastructure, as well as to supporting delivery of other health services; this increase in health spending as a share of government spending was evident in high- and middle-income countries (Fig. 2).

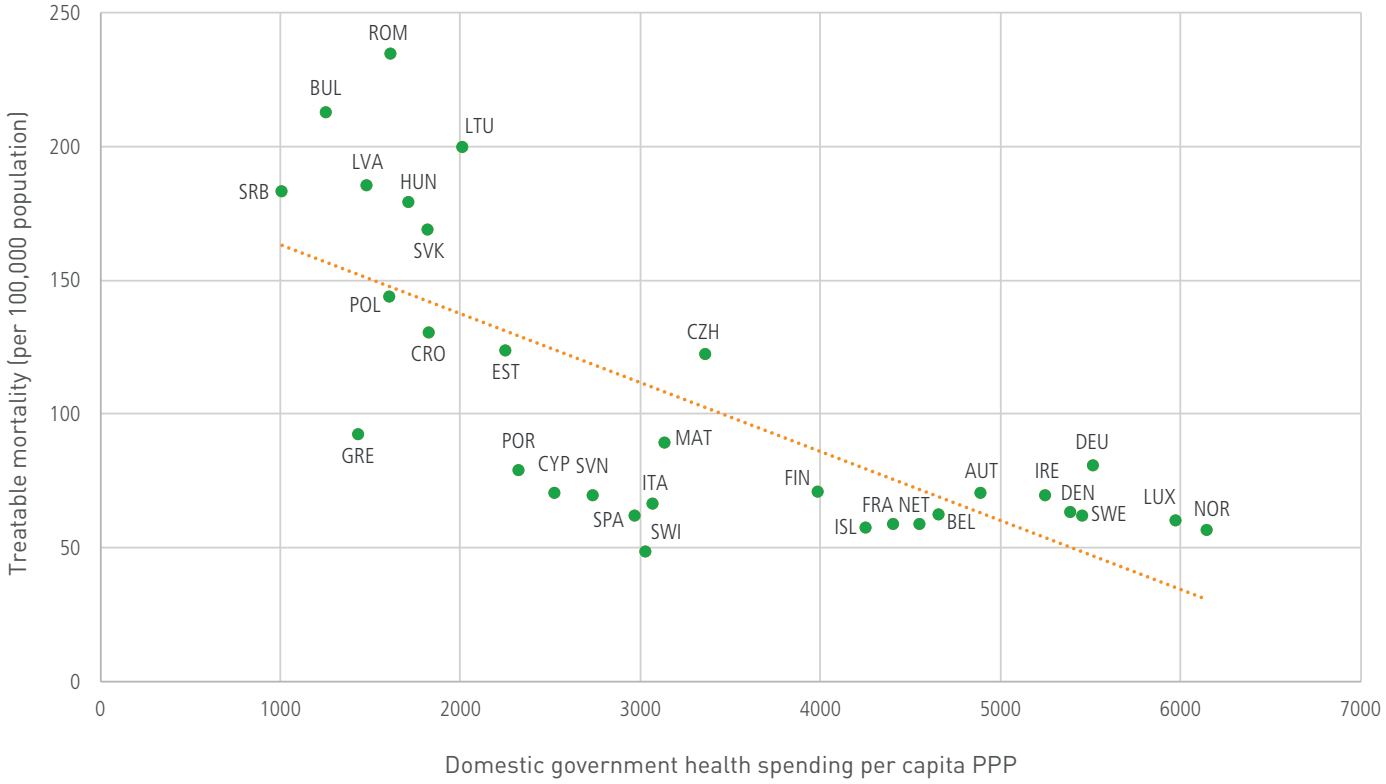
The WHO Regional Office for Europe set out a 'dual-track' scheme for transitioning out of the acute pandemic phase while maintaining routine and essential services and addressing the needs of COVID-19 patients (WHO Regional Office for Europe, 2023a). It complemented this with advice on key health financing actions that countries could take to reduce the adverse effects of the pandemic as part of a broader health system response (WHO Regional Office for Europe, 2020). In countries with statutory health insurance schemes, many governments provided additional funds to compensate insurance schemes for revenue losses due to declines in social contributions as unemployment rose and wages fell (Thomson et al., 2022). Moreover, some countries used public funds to cover the costs of extending entitlement to services, increasing access to care through expanded benefits packages, or making some additional care free at the point of use. This undoubtedly had impacts on improving access to care and reducing the risk of catastrophic health spending.

It is difficult to ascertain how well additional funding contributed to COVID-19 outcomes because of differences in reporting. Nevertheless, treatable mortality rates in 2020 for those countries with data available were typically lower in countries with greater per person government spending on health in 2020, as has been the historical pattern (Fig. 7).

Going forward, some countries may need to spend their resources more effectively and others may need to increase their spending levels further (or both)

Most countries in the WHO European Region have committed considerable shares of their fiscal resources to health in the years since the signing of the 2008 Tallinn Charter, though the priority given to health remains lower in middle-income countries compared with high-income ones. Government health spending as a share of GDP has stayed largely unchanged on average across the Region before the pandemic, a notable accomplishment given reductions in the size of government in many countries and the growing burden of non-communicable diseases, demographic ageing and introduction of newer and high-priced medicines (also varying by country). Although much of the increase in spending in 2020 was in response to the COVID-19 crisis rather than being an investment in the health system per se, and both service and cost coverage gaps remained, this spending contributed to improved outcomes. During the pandemic, spending on health increased substantially in nearly all countries, which was necessary – though not always sufficient – for an effective response to the crisis, saved lives and enabled improved access to health services.

Figure 7: Treatable mortality versus domestic government spending in 2020



Source: Authors' own compilation.

Looking to the future, there are a number of factors that are likely to put further upwards pressures on health spending and threaten gaps in coverage of affordable and accessible care. Ageing populations are expected to contribute further growth in health spending, though the additional rise from year to year is likely to be relatively negligible because of how slowly the age-mix of the population changes. There are, however, considerable costs associated with rehabilitation services (WHO Regional Office for Europe, 2022a), palliative and end-of-life care (WHO Regional Office for Europe, 2023b), and these are increasing. Indeed, a study of 16 higher-income countries in the WHO European Region showed that where public financing and organization of long-term care are particularly strong, there is a lower rate of hospitalization and in-hospital deaths, which may be particularly costly (Orlovic, Marti & Mossialos, 2017). Moreover, the extent to which countries will be able to cover these additional costs due to ageing also depends on choices about how countries finance and deliver health services (European Observatory on Health Systems and Policies, 2023). There are also going to be rising pressures from price growth stemming from wider inflationary pressures, as well as changes in societal expectations as people demand the latest medical technologies, which are often expensive.

In light of the view that pressure to increase health spending levels will only continue to grow, some policy-makers may take the perspective that the health sector as a whole has received enough resources and that it cannot continue to receive the same (or more) priority and level of investment as it has had in recent years. This perspective, of course, ignores that many countries are still struggling with increased waiting times, backlogs and unmet needs, which have resulted from postponed service provision during the pandemic and also the workforce crisis (Van Ginneken et al., 2022). Nevertheless, such a viewpoint can be pervasive among policy-makers who do not take into account the value produced by health systems.

This analysis of available data raises important questions, both about how health systems can use their current level of resources more effectively as well as how health policy-makers can best argue their case for sufficient and stable resources. It is important to restate that there is no single narrative for the WHO European Region as a whole. The level of spending, both as a share of GDP and as a share of government resources varies considerably from country to country. Some countries have consistently spent well below their means and would need to increase spending levels to achieve improvements in health system goals. In others, the returns from health spending have not been apparent and in some cases, marginal increases in spending have not delivered commensurate benefits. In these countries there may be arguments for reassessing how countries spend on health care.

3. Where are the key opportunities to transform health systems by spending better?

As highlighted above, even though there are overall positive associations between greater public spending on health and improved health system performance – in particular, better health outcomes and greater financial protection – countries with the highest public spending levels on health do not necessarily have the best health system performance. Likewise, political and fiscal challenges may make it difficult to increase levels of public spending on health even if that spending is arguably likely to deliver substantial gains. Hence, in all settings, reconsidering how existing resources are allocated and spent is essential for improving health care outcomes, reducing costs and ensuring health care services are accessible and effective. It is also crucial to counter common accusations that the health sector is particularly wasteful – a black hole of expenditure out of which there are no tangible returns, as this is a reductionist viewpoint and soundbite that fails to reflect differences in understanding of what constitutes wasteful spending in health care (for example, inefficient administrative practices versus unnecessary services) and differences between organization of health service provision (Olivares-Tirado & Zanga, 2023).

Ultimately, spending better revolves around finding and funding areas that provide good value for money. In many places the resources to support this do not need to come solely from public budget increases for health, and instead there is some scope for reallocation of funds from cost-ineffective interventions to more effective ones (Cohen, Neumann & Weinstein, 2008). A selection of priority areas that countries may wish to consider if they aim to 'spend better' is presented below.

Allocating more funds to primary health care and prevention efforts can help to avoid more expensive and intensive treatments down the line

Prevention has long been acknowledged as superior to more expensive and intensive secondary and tertiary care, but in many countries only a small portion of public spending is dedicated towards prevention efforts (though not all prevention efforts are captured in health spending data) (European Commission, 2021). When considering ways to spend better, this is a key area for countries to focus on as investing in preventive measures is often thought of as a cornerstone of value-driven health care (Smith et al., 2020). Primary health care offers an important point of contact to provide these services that can prevent health needs and expenses from escalating. Vaccinations, screening programmes, health education, regular check-ups and public health campaigns that promote healthy lifestyles and reductions of risk factors are all examples of prevention measures where financial resources can be directed. Relatedly, working across sectors, including education, housing, employment, and social services can help address the social determinants of health and ultimately impact health outcomes for the better (WHO Regional Office for Europe, 2023c).

Even for those who are past the point of preventive stages and are living with chronic disease, primary health care can serve as an important venue to manage these conditions and avoid higher costs in the long run (both for the individual, and for the health system). Primary care does not only include visits to general practitioners, but provides access to treatments and medication at the outpatient level to monitor and manage illnesses (WHO Regional Office for Europe, 2023i). If management of diabetes, hypertension and obesity is successful in the primary care setting and keeps patients from needing later stage treatment or hospitalization, then this will create much less of a burden on the individual, their loved ones and the public funds that support their care.

While each country is different and has its own needs for strengthening primary health care, common opportunities centre around working at larger scale (WHO Regional Office for Europe, 2023d). Here, spending better on primary care may involve investing in features that can change the way primary health care is organized: development of multidisciplinary teams and networks, digital services, diagnostic tools and services, and greater management structures and capacities (WHO Regional Office for Europe, 2023d).

Ideally, when designed and funded effectively, primary care systems will prioritize patient responsiveness and care coordination. In turn, this can foster greater value and quality of care in the system. Hence, when countries spend more public funding on health or shift existing resources around, prevention and primary health care are important areas to consider directing funds towards.

Improving recruitment and retention of the health workforce is necessary; particularly as the population and health workforce age in tandem

Our health systems hinge upon health and care professionals and support staff to deliver and facilitate health care services. Evidence suggests that the returns on investment in the health and care workforce are strong (WHO, 2016), yet the health and care workforce is currently grappling with a multifaceted set of challenges that necessitate immediate attention. As health care professionals increasingly find themselves overwhelmed and overworked by the relentless demands of their roles – particularly during the COVID-19 pandemic and in its aftermath of backlogs and long-COVID; burnout and retention challenges have become rising issues. Inadequate compensation, poor working conditions and inequities in the workforce exacerbate these challenges (McPake et al., 2023; Ziemann et al., 2023).

However, these are legacy issues from before the pandemic. There have been longstanding concerns about an ageing health and care workforce, demographic shifts that see health professionals moving from rural to urban areas creating so-called 'medical deserts' in many Member States, and increasingly outdated medical curricula unequipped to serve changing needs (WHO Regional Office for Europe, 2022b). So while much of the focus is now on strengthening the health and care workforce for increased health system resilience, the post-COVID-19 'crisis' in fact reflects a historical lack of investment in human resources for health in most countries. It is clear, therefore, that gaps and shortages in the workforce can lead to inefficient, ineffective, inaccessible and low-quality care.

To address these challenges, smart investment in health and care workers is needed. The 53 Member States of the WHO European Region have committed to this through the recent signing of the Framework for Action on the Health and Care Workforce in the WHO European Region 2023–2030 (WHO Regional Office for Europe, 2023e, 2023f). Countries can consider directing their resources towards improving working conditions and compensation (particularly for medical professions that are typically less financially rewarding, such as nursing or general practice) (Kroezen, Rajan & Richardson, 2023). This is especially important given that strong primary health care is associated with better coverage and can keep individuals out of expensive specialist and tertiary care in the long run. These investments will need to be carefully made to account for wider impacts on public funding and to avoid unintended consequences.

Measures can also be implemented to fix the systems from the very start of the medical and nursing career paths (McPake et al., 2023). In coordination with other sectors, countries can direct resources and make efforts to improve education and professional entry requirements and development curricula to be fit-for-purpose and encourage suitable skill mixes in the workforce. Professional training opportunities can be made available throughout careers, rather than just at the start, and be adaptable to the latest innovations and technologies in the field. Furthermore, salaries must be adequate to keep up with cost-of-living increases, otherwise health workers will seek employment in other sectors (Rigby et al., 2023).

The above efforts will hinge upon the development of and access to reliable data, best available evidence, and forecasting on which to base decisions. They will also rely on structured decision-making processes and consistent engagement of different stakeholders who will be affected by these decisions. Furthermore, they will require the investment narrative both within and outside the health sector to demonstrate clearly the co-benefits of a strong health and care workforce, which can keep societies healthy and productive (Caffrey et al. 2023; McPake et al., 2023).

Digital technologies can provide opportunities for efficiency gains, but they are not a panacea

In recent years, the promise of digital innovation and its potential for valuable change in health care settings has facilitated attention and excitement. The COVID-19 pandemic brought this into focus with a surge in digital solutions to meet the needs and demands of patients at the time with services like teleconsultations and e-prescribing. This provided first-hand and real-time evidence of the transformative capabilities of digital innovation across the spectrum of health care delivery. Wearables and near-patient testing (for example, lateral flow tests for COVID-19) are also examples of tools that can aid patients to look after their own health while also helping to keep consultations and costs down. The pandemic also demonstrated that it is

possible to deliver effective and efficient health care with digital innovations and to achieve equal or better outcomes compared with more traditional health care mechanisms.

However, not all digital technologies and innovations are equally valuable (WHO Regional Office for Europe, 2023g). Amid this increased interest in digitalization, it remains imperative to make careful decisions and only invest in those technologies that provide good value for money (WHO Regional Office for Europe, 2023g). As investments in digital infrastructure typically demand substantial upfront payments and resources, strategic thinking that carefully balances digital investment choices based on upfront costs, current pressures across the health system and potential long-term benefits is needed. Furthermore, the value of digital technologies is tied to the capacity of users to optimize their capabilities and integrate them effectively into their systems. Hence, investment decisions around digital technologies link not only to the costs and benefits of the technology itself, but also to the costs and benefits of research which explores administrative and organizational processes and policies for using these innovations to promote efficiency, streamline workflows and enhance patient outcomes. For example, health information systems, which were once considered the backbone of many health care systems, faced scrutiny during the COVID-19 pandemic because they were found to be unable to capture critical patient data, reflect socioeconomic indicators or facilitate seamless data-sharing among health care providers. Hence, in countries that faced these issues, there are opportunities to target resources towards improving these systems with the promise of long-term efficiency benefits and shorter term advantages like error reduction and enhanced care coordination.

In essence, the advancement of digital technologies in health care represents both opportunities and challenges in shifting towards better use of public resources in the health system. The excitement surrounding digital innovation is well-founded, and its transformative potential is undeniable. However, it is the careful allocation of resources, a commitment to ongoing research and innovation, the need to ensure the equitable availability and uptake of these innovations, and the enhancement of processes and policies that will ultimately ensure that the promises of digitalization are fully realized.

Mental health care has been left in the shadows for too long; it must be shifted to a health system priority with sufficient financing

Despite making up a substantial burden of disease, mental health conditions remain undertreated and service systems remain under-resourced. Mental health is often largely overlooked in health care benefits packages, resulting in relatively low public funding in proportion to its significant impact (WHO Regional Office for Europe, n.d.). Although many countries have increased investments in recent years, estimates indicate that the average proportion of the total health budget allocated to mental health in the majority of WHO European Region Member States is still below 4% (WHO Regional Office for Europe, 2023h). A paradigm shift in the approach and prioritization of mental health within health care and financing systems is required to address this disconnect – and a move from historical budgeting methods to more adaptable allocation of funds based on needs analysis (WHO, 2022b).

Not only is it important to increase funding for mental health care, but it is also necessary to optimize those investments to maximize impact. The active inclusion and participation of people with lived experience of mental health conditions in policy and service design is critical to ensure that services are acceptable and sought out by those who need them. Good governance practices and effective collaboration of stakeholders, both within the mental health space and across sectors, is also critical, requiring engagement of all those actors – from education, finance, welfare, employment, industry – with influence over the promotion and protection of population mental health.

Preventive and promotive interventions must be prioritized as much as treatment, care and rehabilitation (WHO Regional Office for Europe, 2023h). Some mental health services may be seamlessly integrated into the broader health care ecosystem. This involves embedding mental health support within primary care and general health care settings, enabling individuals to access assistance at the earliest and least resource-intensive level of care and moving to higher levels of care only as required. This approach can facilitate timely interventions by providing a more accessible pathway into care. It is therefore imperative that mental health care is no longer considered an isolated component, but rather an integral part of health care services. By embracing this holistic perspective, resource allocation improvements are possible, and so too is the fostering of a more equitable health care system that prioritizes the well-being of individuals and communities.

There is a strong economic case for investment in mental health: one global analysis found that for every US$ 1 invested in scaled-up treatment for depression and anxiety, there was an estimated return of about US$ 4 in better health and productivity (Chisholm et al., 2016). As with most chronic illnesses, regular care and treatment of mental health disorders can help to prevent the need for more intensive and costly care later on. Furthermore, good mental health contributes to individual and population health and well-being, which allows for social interaction and labour productivity – ultimately yielding co-benefits beyond health.

It is important to continually scrutinize and re-evaluate pharmaceutical pricing and reimbursement models for efficient and effective spending

In many countries, it will be important to re-evaluate pricing and reimbursement models for pharmaceuticals to ensure finances are spent effectively. Although Health Technology Assessment has made notable strides in assessing the value and pricing of medical interventions, there is a growing body of evidence indicating that countries often find themselves overpaying for certain pharmaceuticals relative to their actual value (Woods et al., 2021). Financing decisions around pharmaceuticals are commonly complicated by a lack of transparency of prices paid to manufacturers (leading to pricing variability) across countries (Webb et al., 2022).

This underscores the inherent complexity of drug pricing, necessitating ongoing scrutiny and adaptation to ensure cost-effectiveness, and affordability and accessibility for patients.

The escalating costs associated with novel medicines – particularly in therapeutic areas such as oncology where over 100 new medicines are expected by 2025 – continue to strain health care budgets. Additionally, the emergence of gene and cell therapies, as well as other advanced therapy medicinal products, introduces another dimension to the pharmaceutical funding landscape. These therapies hold the promise of cures, but they come with huge costs often exceeding US$ 1 000 000 per patient; and they are expected to represent half of high-income countries' total pharmaceutical spend by 2026 (Årdal, Lopert & Mestre-Ferrandiz, 2022). In many countries, covering these escalating costs of novel medicines often carves out a large share of public budgets for pharmaceuticals, leading to more cost-shifting to patients for care and medicines that are more cost-effective, less expensive, and that affect large population groups. This tends to have greater impacts on those with chronic conditions and those on lower incomes, and can lead to financial hardship for these groups (WHO Regional Office for Europe, 2023i).

Countries face a moment in time that necessitates careful consideration and robust regulation to strike a balance between fostering innovation and ensuring equitable and affordable health care. Because of the large allocation of spending that is already directed to this area, re-evaluating pharmaceutical pricing approaches becomes not just a financial imperative but a moral and ethical one, as it shapes the accessibility of essential medications and the sustainability of health care systems in the future. In this regard, joint assessment and procurement initiatives such as BENELUXA and the Valetta Declaration provide good examples of working together in order to collectively address pricing and bring costs down. The WHO Regional Office for Europe has recently established a multistakeholder novel medicines platform to examine and help address issues around affordability and access (WHO, 2023b).

Focus on coverage policies that ensure access to needed services and financial protection is essential

All health systems ration health services either explicitly or implicitly because resources are finite. This is unavoidable, even in the wealthiest of countries. However, policy-makers can make informed decisions about how they ration care and allocate resources accordingly. Countries should carefully consider how to extend coverage, what services are covered and the extent to which the costs of care are covered while staying mindful of the important role health systems can play to reduce the risk of financial hardship when using health services, especially among those who are less wealthy and/or regular users of care. In doing so, policy-makers should consider pro-poor coverage policies that reduce the burden of out-of-pocket payments as a key element of health system transformation (WHO Regional Office for Europe, 2023i).

For example, in countries that have historically based entitlement to services on payment of social insurance contributions, those households that do not pay contributions are most likely to face barriers accessing care and are at increased risk of experiencing catastrophic health spending (WHO Regional Office for Europe, 2023i). In recognition of this, some countries, for example France, have moved away from basing entitlement on contributions and instead provide coverage to all residents. In doing so, France has broadened the revenue base for the health system beyond contributions linked to the labour market. This not only improves financial protection for those who would otherwise not be covered, but also helps to enhance the broader sustainability of the health system by diversifying the sources of revenue.

Another key area of coverage policy that countries should consider is the way co-payments are levied. Co-payment policies determine how much of the cost of publicly financed care households are exposed to. Most countries in the WHO European Region have some exemptions for co-payments, but only around one third of countries for which there is information available explicitly exempt the poor (WHO Regional Office for Europe, 2023i). Other policy mechanisms such as income-related caps on co-payments or the use of low-fixed co-payments (as opposed to percentage-based co-payments) can also help to ensure users of health care are not unduly exposed to out-of-pocket payments, reducing the risk of financial hardship.

Crucially, protective coverage policies must be backed up with sufficient financial resources, otherwise they will not deliver on their objective of delivering financial protection. This is evident in countries that nominally cover the entire population, but where underfunding results in either inaccessible publicly funded services, increased use of direct payments for private services and/or informal payments (WHO Regional Office for Europe, 2023i). As health systems transform, they must ensure that they are not a source of increased financial hardship.

The above six areas, are important, but spending better for health system transformation is a complex and nuanced endeavour

Investing public funding more efficiently and effectively in health is essential, but it is also a nuanced endeavour that extends beyond the straightforward allocation of funds to specific areas. In many countries, budgetary practices and rules may restrict the easy reallocation of funds, making it challenging to pivot resources to areas that require immediate attention. Moreover, health care is an ever-evolving field, marked by continuous advancements in medical technology, pharmaceuticals and treatment approaches, which demand dynamic and adaptable strategies. The presence of numerous stakeholders, each with their own priorities and demands, further complicates the process. These stakeholders, including patients, health care providers, private sector companies, insurers and policy-makers, often have competing interests, necessitating difficult balancing acts to align their goals and foster consensus on where resources should be directed.

Consequently, investing better in health does not only require strategy, financial acumen and careful cost–benefit analyses, but also agility, collaboration and a deep understanding of the intricate health care ecosystem to navigate these multifaceted challenges effectively.

4. How can health policy-makers better make their case for additional resources?

While countries can arguably improve how they spend their current resources, many will also need additional funds to deliver real, transformative change

Although there is indeed scope for spending better, many – if not all – countries also need to secure more government funds for health so that their systems are equipped to provide the accessible, high-quality care and services needed for population health and well-being. These may include countries that have traditionally spent relatively little government funding on health, where simply reallocating existing budgets will not be sufficient to deliver real change. It may also include countries that have higher government spending levels on health, but with gaps in particular areas of their health systems. Or it may simply include countries where the reality is that system level changes require government funds on top of other efforts to improve efficiencies. As highlighted above, the competing demands on public budgets for high priority health expenditure are rising, but there is wide variation in government health spending across the WHO European Region. Some countries continue to spend relatively little on health, and even in countries that already direct high levels of public funding to health, there may still be particular areas of the health system that need more resources, such as prevention and mental health, which are historically under resourced. As the burden of chronic disease increases, new and expensive medicines and technologies are introduced, climate crises become more frequent, and other challenges are added to the mix, the need for public funding to support high-quality, accessible, affordable and transformative health care systems will only become more apparent.

As countries wind down their COVID-19 pandemic response, many health systems are struggling to prove their worth to public budget holders

To health policy-makers, practitioners, experts and advocates, it may seem intuitive that population health and well-being leads to better social and economic outcomes in the short, medium and long term. Although there is considerable evidence of this, already tied to the endorsement of the Tallinn Charter in 2008 (Figueras & McKee, 2012), it cannot be assumed that those outside the health sector have the same knowledge and understanding of the positive influences that health has on meeting public sector goals.

Indeed, as pressures on government finance rise across all sectors, health often remains insufficiently valued by those holding public finance purse strings. As noted earlier, some may see health as a ‘money pit’ or black hole where government resources continue to be directed, but the requirement for and requests for more funding also keep rising. This is particularly relevant as countries exit their COVID-19 pandemic phases, during which many health systems received peak levels of public financing. They face a

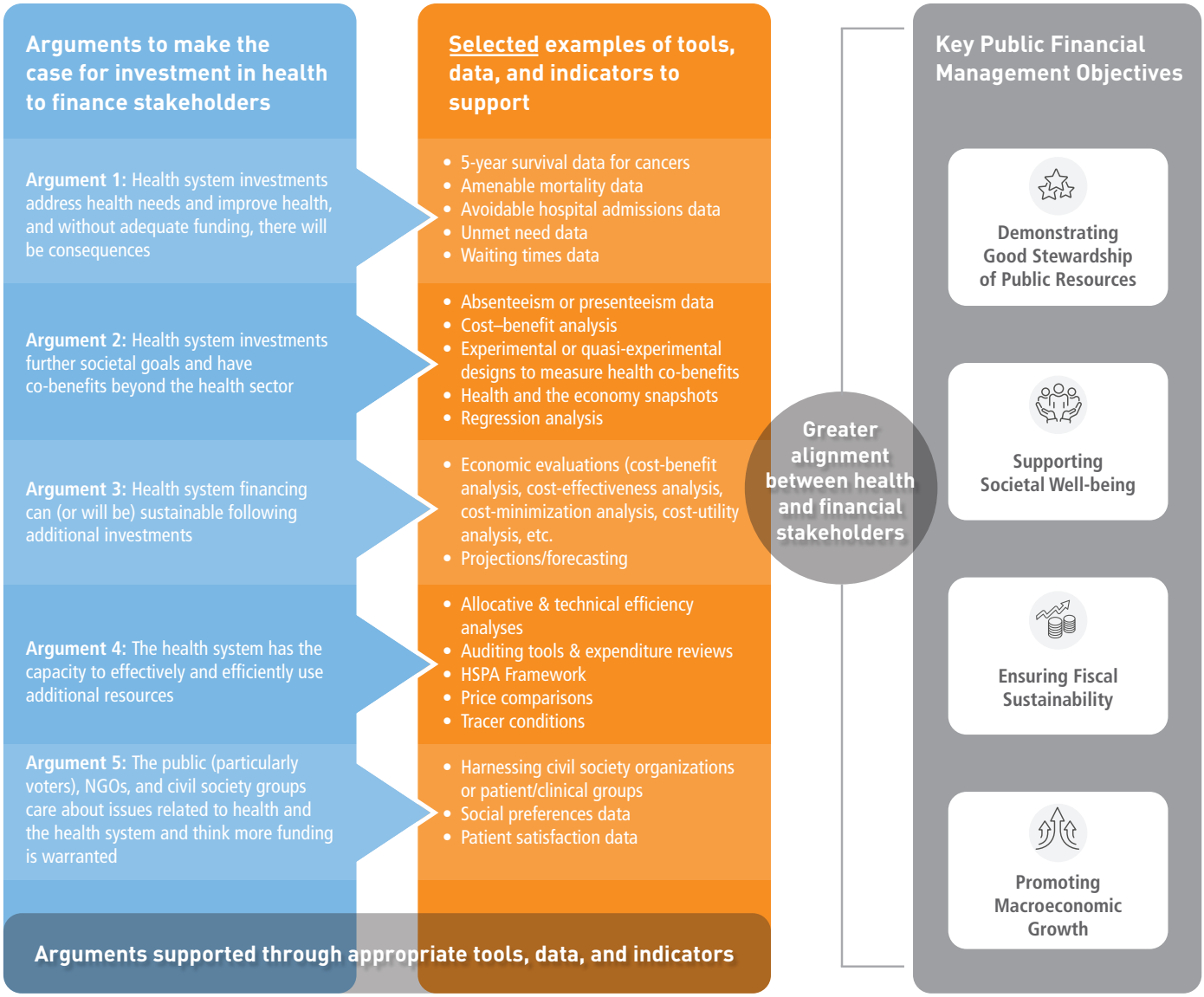
key challenge in negotiating with public finance stakeholders and demonstrating what has been achieved with additional funding for health thus far and convincing them that continued (and even additional) investment is necessary and worthwhile.

Whether countries are focused on spending more or spending better on health, the sufficiency of public resourcing hinges on successful budget negotiation

In any negotiation, it is important to understand the needs and values of the other side so that strategies towards agreement can be tailored accordingly. In negotiations for public funding for health, it is essential that health policy-makers make their cases for health spending in a way that strikes a chord with the constraints and objectives of public finance purse holders; or, as reflected in the title of a 2007 International Monetary Fund working paper: 'What should macroeconomists know about health care policy?' (Hsiao & Heller, 2007).(46)

Recognizing this, and at the direction of the European Commission's Directorate General for Structural Reform Support (DG REFORM), a multi-country (Austria, Belgium, Slovenia) Technical Support Instrument was initiated in late 2022 to strengthen capacity to successfully make the case for increased public funding for health (workstream 1 of the project) and to use EU funding mechanisms to their maximum capacity, effectively and efficiently (workstream 2 of the project). As part of these efforts, the European Observatory on Health Systems and Policies produced a report that describes the outcomes of a two-part exercise to identify approaches and tools to make the case for public investment in health in a manner that creates better alignment between health and finance stakeholder goals (Forman, Feil & Cylus, forthcoming).

Figure 8: A Framework for Making the Case for Public Investment in Health: Aligning Health and Finance Objectives



Source: Reprinted from forthcoming Technical Support Instrument workstream 1 report (Forman, Feil & Cylus, forthcoming).

The exercise – and particularly the interviews with over 20 stakeholders from ministries of health, ministries of finance, health insurance funds and academia – shed light on some of the values and information that are important to align on when it comes to negotiations around public financing for health. The importance of these themes is also reflected in some countries' push for the adoption of an economy of well-being perspective (see Box 1), and the consequent need for not just health policy-makers, but also other public sector stakeholders, to make the case to central banks and work increasingly closely with ministries of finance or economy (WHO Regional Office for Europe, 2023k).

There are cross-cutting lines of argument that can be used to support the case for additional public resources for health

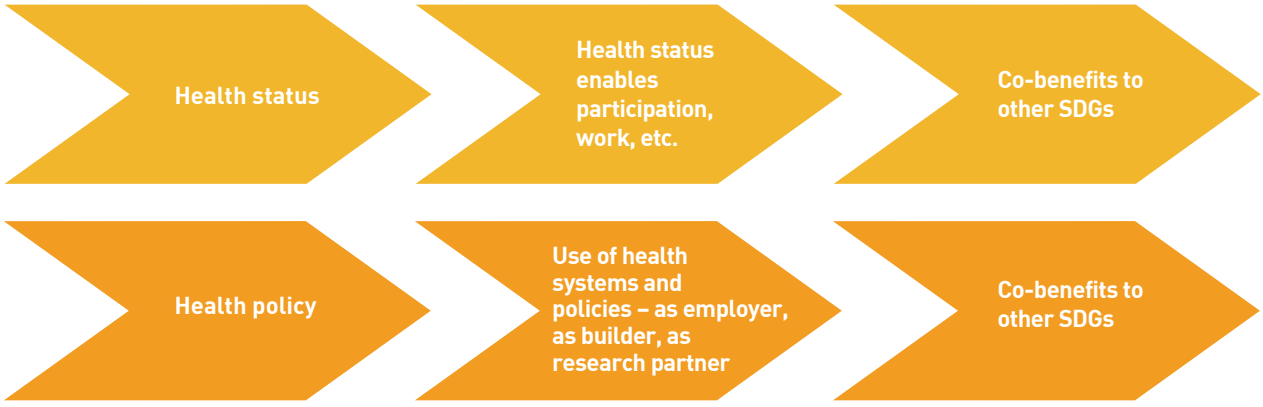
Through the above-mentioned exercise, five key cross-cutting lines of argument for additional funding for health emerged and formed a framework for considerations to make when developing a budget negotiation strategy (Fig. 8) (Forman, Feil & Cylus, forthcoming). Each argument in the framework can be backed by appropriate tools, data and indicators to support the case for increased health funding. Importantly, these arguments do not just demonstrate why public funding for health is necessary to achieve certain health outcomes, they also highlight the wider value of good health outcomes to society and are linked to four key public financial management objectives: (1) demonstrating good stewardship of public resources, (2) supporting societal well-being, (3) ensuring fiscal sustainability and (4) promoting macroeconomic growth (Cylus, Permanad & Smith, 2018; Forman, Feil & Cylus, forthcoming).

These arguments are based on evidence and indicators, and they align with key public financial management objectives

The framework serves as a foundation for health stakeholders to explore potential strategies to strengthen their arguments for health system investments. The five arguments and the evidence to support them offer a comprehensive, but non-exhaustive, array of possible choices for constructing and framing a budget case for health financing. Each argument carries a positive and a negative (or counterfactual) framing. However, the framework itself does not provide an instruction manual for building and negotiating a successful budget proposal, as ultimately, each case should be crafted with a unique narrative that aligns with the specific contexts, objectives and priorities of their intended audience (Forman, Feil & Cylus, forthcoming).

1. The first of the five arguments is simply that spending on health meets population needs and demand, contributing to population health and well-being improvements; and as needs and demand change and grow, and assuming that improving population health and well-being is indeed the goal, so too must the spending. The negative framing is to emphasize that without adequate public funding for health, deleterious consequences vis-à-vis health care access, affordability, quality and outcomes are likely. Using data and indicators (such as 5-year survival data for cancers and amenable mortality data) this argument can be used in budget cases to show how increased spending on health supports societal well-being, and therefore to demonstrate that those who invest public funds in health are good stewards of resources. While it is important to be clear on the methods and application of traditional economic models (Turner et al., 2023), at service level too it can be shown in dollar or rate-of-return terms what the benefits of a given public health intervention are (or are likely to be), and what the down-the-line costs of not implementing the intervention would be (Masters et al., 2017; van der Vliet et al., 2020). WHO has recently expanded its list of 'best buys' for non-communicable diseases to further the case for specific interventions on health outcomes and cost-effectiveness grounds (WHO, 2023c).
2. The second argument centres around the co-benefits of health investments where well-functioning and well-funded health systems do not just lead to positive health outcomes, but have positive impacts on financial

Figure 9: The two routes to achieve the co-benefits of health to other Sustainable Development Goals



Note: SDG: Sustainable Development Goal.

Source: Reprinted from Greer et al. (2023).

protection, and hence on the broader economy, education, equity and more. This is not the same thing as investing in an economy of well-being approach (see Box 1) but can be a compliment. Here, the benefits of health to other sectors can come directly through improved health status, or indirectly through the impacts that health policies have on other areas of life (Fig. 9) (Greer et al., 2023; WHO Regional Office for Europe, 2023j). Appropriately designed logic models can be useful tools to trace an issue over time and quantify co-benefits. As Greer et al. (2023) highlight, the Sustainable Development Goals provide a useful framework to analyse the links between sectors and how changes in one area affect another. The negative framing here is to highlight the co-consequences of inadequately funded health systems. Backed by the identification and measurement of co-benefits of health, this argument can emphasize the contribution of health to all four of the key public financial management objectives.

Box 1: Promoting an economy of well-being approach that goes beyond GDP

Although related, emphasizing the co-benefits of investing in health is not the same as promoting an economy of well-being (EWB) approach. The EWB sees well-being and quality of life – both influenced to a large degree by the health status of individuals and the population – as central to a thriving economy. It aims to put people and their well-being at the centre of fiscal and economic policy and decision-making by quantifying the benefits and costs of public goods such as food, fuel, housing, safety, decent livelihoods and publicly funded primary care, which are central to promoting equitable societies. The tagline 'beyond GDP' is often used in relation to the EWB, and this captures the notion that other measures of economic productivity and robustness like the physical and mental health of the population, their life satisfaction, the degree of social cohesion and environmental sustainability, are more important measures of an economy's success than economic output. The question for decision-makers, therefore, is how investing in health can contribute to an EWB approach, and in this direction a number of arguments can be made.

The EWB approach sees the potential to enhance productivity both on a large scale and an individual level by health improvements. Healthy individuals tend to be more engaged and effective in their professional and community roles, ultimately contributing more to the economy, while reducing absenteeism due to health-related issues. Consequently, a healthier population tends to incur lower health care costs, initiating a positive cycle in which the prevention and management of chronic diseases through healthy lifestyles and early interventions alleviate the burden on health care systems, thus freeing up resources for broader well-being initiatives. In this framework, EWB places significant emphasis on mental health as a critical component of overall well-being, contributing to the economic and societal success of individuals. There is also strong focus on healthy ageing as a way for longer and happier life expectancy. Strategies in this area can alleviate pension and health care expenses for older persons, channeling savings towards other well-being initiatives. The EWB approach also highlights the creation of healthier communities as a means to foster increased social cohesion, reduced crime rates and greater attractiveness for businesses. Recognizing the close relationship between health and well-being and educational outcomes, a focus on children's health implies not only a healthier but also a better-educated future workforce. Lastly, individuals who prioritize physical activity and healthy diets are often more environmentally conscious, aligning with the EWB approach's assertion that a healthy population is more likely to support environmental sustainability efforts. In summary, a focus on health stands as a fundamental cornerstone of the economy of well-being, empowering governments, businesses, and communities to cultivate a more prosperous and sustainable economy that benefits individuals and society as a whole (WHO Regional Office for Europe, 2023c).

3. The third argument asserts that increased spending on health can strengthen fiscal sustainability, especially in systems that are chronically underfunded. Alternatively, it can be used to highlight that without sufficient public funding for health, there are threats to fiscal sustainability. This argument centres around demonstrating that investments in the health system can lead to greater efficiency (through economic evaluations, projections and forecasting models), and ultimately drive growth and improvements in the medium- to long-term. Hence, it can be used to refute common misperceptions that health spending begets more spending, and instead can show that health spending can meet the finance policy objectives of responsible resource management and ensuring fiscal sustainability.
4. The fourth argument can either demonstrate that a health system is already equipped to responsibly manage resources and absorb new funding without waste (and that it takes sufficient de-implementation steps where waste is identified), or alternatively, it can show that additional public funding for health is needed to enhance efficiency and capacity within the system. The argument hinges on evidence such as allocative and technical efficiency analyses, auditing tools, governance analyses and health system performance assessment frameworks to demonstrate how additional funding aligns with key finance policy objectives of stewarding and managing resources responsibly, ensuring fiscal sustainability and supporting societal well-being.

   While this can be a very important argument for making the case for public funding for health, it is essential to use efficiency arguments cautiously and with consideration of the specific needs and context of the health system they revolve around. Narratives that highlight efficiencies or inefficiencies of a system should be presented thoughtfully, being careful to avoid unintended consequences (of providing justification for reductions in public spending on health, for example).
5. The fifth argument can be used to demonstrate that investing in health aligns with the desires of the public (and particularly, constituents); so showing that public investment in health not only benefits health, the economy and society, but that it also has political merit. The inverse is of course that by not investing in health, public interest is not being served, and therefore there are potential political repercussions such as through the ballot box. Through data and indicators on public preferences/satisfaction and by leveraging the voices of civil society groups, this argument can convince finance decision-makers that the public values and depends on the adequate financing of their health systems, so voter preferences will be reflective of this.

Box 2 highlights an example of how the Estonian Health Insurance Fund successfully made the case for increased state budget transfers by using elements of all five of these arguments.

Box 2: How the Estonian Ministry of Social Affairs successfully led a coalition and made the case for increased state budget transfers to broaden its revenue base?

In the mid-2000s, questions around the sustainability of the Estonian health system arose. As the population was ageing and the working population was shrinking, concerns arose regarding the country's health system, which relied entirely upon wage-based contributions. Data and long-term forecasting demonstrated that continuing on this health system financing path would result in broad health consequences (**Arguments 1 and 3** in the Framework). However, change did not happen overnight.

In 2015, after several years of growing concerns and evidence regarding the health care system's unsustainability, a coalition comprising multiple political parties was formed to explore alternative revenue sources for the health care system. Led by the Estonian Ministry of Social Affairs, this coalition collaborated with the Ministry of Finance, the Estonian Health Insurance Fund (EHIF), the WHO and the Estonian Hospitals Association in a working group to address these issues. The prominence of health care system sustainability challenges continued to increase in 2016, as an analysis predicting health care system revenue and expenditures (related to **Argument 3**) and projecting potential effects on population health (related to **Arguments 1 and 4**) and other sectors (related to **Argument 2**) ignited discussions about revenue-related matters.

Towards the end of 2016, a window of opportunity for budget change emerged when the government underwent a reshuffle, with the Centre Party replacing the Reform Party. Recognizing some of the issues with the health system, particularly related to access to specialist care, the new government made a State Budget transfer of EUR 10 million to the EHIF. However, budgetary pressures persisted in 2017, prompting health care professionals to threaten a strike if the government failed to devise a plan to address health care system financing sustainability issues (**Argument 5**). This pushed forward parliamentary discussions on the matter, eventually leading to legislative amendments that expanded the EHIF's revenue sources by providing state budget transfers for non-working pensioners (effective from 2018).

Hence, successful negotiation for additional budget for health in Estonia not only depended on each of the five arguments and the evidence to support them, but also largely relied on a window of opportunity opening up where there was increased political will and focus on health system sustainability issues.

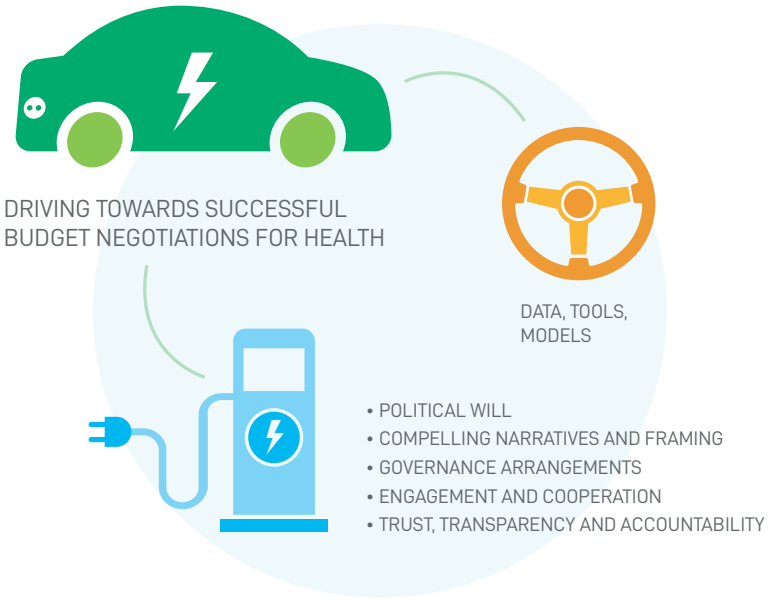
Source: (Habicht et al., 2018)

Arguments backed by robust evidence can steer decision-making, but they are not sufficient to drive transformative change on their own

As countries consider ways to improve the fiscal sustainability of their health systems and enter into negotiations between health and finance, the arguments discussed above, and the data and evidence that can be used to support them, can be useful elements to review; however, they are insufficient on their own for transformative change. Building consensus around that evidence and its relevance to economic and social well-being is the key challenge and often hinges on political will; cross-sectoral engagement, communication, language and framing; transparency, accountability, both of which are important prerequisites for building trust; and seizing windows of opportunity.

As the report on Making the Case for Public Investment in Health describes using a metaphor of driving a car: the five cross-cutting arguments and the data and evidence to support them can serve to steer decision-makers towards good policy choices (or at least, steer them away from making poor ones), but the aforementioned (and more) political economy factors are necessary elements to drive the budget case for health forward successfully (Fig. 10) (Forman, Feil & Cylus, forthcoming).

Figure 10: The factors to fuel and steer budget negotiations forward successfully



Source: reprinted from forthcoming TSI workstream 1 report (Forman, Feil & Cylus, forthcoming).

Recognizing existing windows of opportunity and building the right environments for new ones to open is often key in negotiating for health funding

As demonstrated by the Estonian case study example (Box 2), harnessing windows of opportunity can play a vital role in pushing a budget case for public funding for health forward. Despite stakeholders gathering crucial evidence and building arguments for additional public resources for health for over a decade, they did not receive an increase in budget until there was a shift in the party government. Building trust between stakeholders was crucial, as was cross-sectoral communication. But actively building and facilitating arrangements that allow windows of opportunity to arise more frequently and get recognized quicker is a key step that health stakeholders can take to transform their health systems. In their policy brief on harnessing the co-benefits of health, Greer et al. (2023) highlight that 'immediate opportunities can be seized for high-salience, low-conflict issues'. Thus, experts and advocates of health system financing and policy have the task of recognizing and capitalizing on issues that already fit into this category, and increasing the salience and decreasing the conflict around those issues that currently fall outside. Other examples from Europe highlight the importance of seizing windows of opportunity. An Irish stakeholder interviewed for the Technical Support Instrument project described how a reform to eliminate hospital co-payments was recently reframed, and subsequently passed and funded as a cost-of-living measure when political discussions emerged on how to deal with rising costs in the country (Forman, Feil & Cylus, forthcoming). A French stakeholder highlighted the importance of having timely data with regular updates so that negotiators can quickly seize windows of opportunity when they arise with evidence-based arguments and approaches (Forman, Feil & Cylus, forthcoming).

Good governance practices and tools can help facilitate the conditions for these opportunities for transformation to arise and thrive. For example, ministerial linkages, interdepartmental committees/units, and regular engagement with non-governmental stakeholders (for example, public, civil society groups, industry) can help to facilitate trust, coordination, communication, and shared priorities and vision. In turn, these elements can help to build successful budget cases for health that are driven by and framed in a way that meets the needs of those they are intended for. Returning to the example of Estonia, the current Supervisory Board of the Estonian Health Insurance Fund consists of the Minister of Health, the Minister of Finance, the Chairwoman of the Estonian Chamber of the Disabled People, a Member of the Estonian Trade Union Confederation, and the Charman of the Estonian Employer's Unit (Tervisekassa, n.d.). This allows for cross-sectoral collaboration and communication on needs and priorities at the highest level and helps to build consensus between stakeholders.

There is no one-fits-all solution to negotiations for additional resources for health, but strategic budget development and narratives and having fiscal governance arrangements in place can help

As countries face the challenge of securing more resources for their health systems, it is important to be strategic in developing budget cases – particularly when negotiating with stakeholders who traditionally have seen health as a drain on public resources. Furthermore, implementing and maintaining fiscal governance structures that facilitate communication, understanding and trust between stakeholders can help to facilitate an environment that is more open to negotiation and exchange of ideas in the first place.

There is no silver bullet to negotiating for additional public funds for health, and in some countries, it may be particularly challenging to argue for greater health spending if government budgets are small in relative and/or absolute terms. However, the five cross-cutting lines of argumentation and the evidence that can be used to support them can serve as a useful starting point when planning budget cases for health. These arguments are closely linked with key public financial management objectives, and as such, they can be used to build a compelling narrative when carefully considered to account for the context under which they will be negotiated.

5. Conclusions

It has been 15 years since the signing of the Tallinn Charter – a landmark moment in the pursuit of stronger and more resilient health systems. During this time, countries in the WHO European Region have made significant strides in prioritizing health despite financial challenges and crises that have emerged. Nevertheless, the work for health system transformation is far from complete. In an ever-changing world, the need for better and more financing for health systems remains paramount.

The COVID-19 pandemic underscored the necessity of constant vigilance and investment in health systems

The COVID-19 pandemic brought to the forefront the importance of prepared and resilient health systems. In the face of unprecedented challenges, countries that had historically given higher priority to health in their public budgets fared better in managing the crisis. They were better equipped to provide critical care, to deliver vaccines and to implement public health measures effectively and in conjunction with one another.

Countries that had designated less priority to health in the years before not only fared worse in terms of health outcomes, but also in other sectors. In these settings, COVID-19 led to consequences and inequalities in education (Bryant et al., 2022), it caused industrial disruptions and shortages and severe economic and job losses, and it pushed back progress that had been made towards gender equality and other sustainable development goals (UNCTAD, 2021). These impacts further carried secondary health impacts for many. Even for those who managed to stay free of illness, most were impacted by COVID-19 in one way or another, highlighting the knock-on effects of health crises in underprepared settings. As countries move to their post-pandemic phases, it is important that they learn lessons from the successes and challenges they faced during COVID-19 and recommit to the principles of the Tallinn Charter and to the prioritization and transformation of health systems.

Health system transformation is dependent on countries spending more public funds on health as well as using those funds more efficiently and effectively

As countries chart their courses for more effective and equitable health care, they face a public budget landscape fraught with challenges and complex trade-offs. The vast majority of countries in the WHO European Region will not only need to allocate a higher percentage of their national budgets to health in recognition of the pivotal role it plays in societal well-being, but they must also couple this with a commitment to continuously assess the impact of health care spending, agility to make evidence-informed decisions and flexibility that allows for adjustments in resource allocation as needed. Even countries with high levels of public spending on health will probably need to spend more to transform their health system due to institutional rigidities and stakeholders that make simple shifting of funds politically and practically challenging in the short-term.

Key opportunities for spending better and spending more lie in allocating adequate resources to prevention and primary health care, training the health care workforce and incentivizing people with the right skill-mixes in the settings where they are most needed, harnessing innovative digital technologies that provide value-for-money, integrating mental health care services into health benefits packages , revising pharmaceutical pricing and reimbursement models to ensure that medicines are accessible and affordable for individuals and the health system and designing coverage policies which ensure access to services and financial protection. These six priority areas, while important, represent only a subsample of the areas that countries may need to consider strengthening in order to transform their health systems and spend better. Many other opportunities exist, from rationalizing end-of-life care to recognizing the important role health systems play in reducing poverty and financial hardship and designing coverage policies accordingly (Norman et al., 2021; WHO Regional Office for Europe, 2023i). Ultimately the priority areas that will lead to health system transformation will vary based on each country's starting point and strategic objectives. This will require negotiations and consensus building with stakeholders within and outside the health sector, in addition to careful consideration of contextual factors and competing priorities on public budgets.

Changing the way health systems allocate resources is not easy. It requires clear strategic goals and a concerted effort to monitor progress towards those goals. Complementing this policy brief are four other policy briefs that outline objectives of trust and transformation in health systems and tools for measuring progress in these areas. Developing clear goals and implementing a monitoring framework for assessing progress towards achieving those goals, and understanding how to argue for more resources and learning how better to use existing ones can help policy-makers make the government changes required to shift countries' focus away from policy instruments and old models of care towards those which deliver real progress. This, in turn, can facilitate trust that health systems are using public funds in an efficient, effective and sustainable way to adapt and transform their systems to deliver high-quality, affordable, accessible care for all.

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Print ISSN
1997-8065

Web ISSN
1997-8073