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# *Social Sector Reform Activity*

## *Alternative Provision of Social Services*

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## TABLE OF CONTENTS

- I Introduction
- II Family Practice A For-Profit Model for the Provision of Primary Health Care Service
- III Social Contracting in Poland Local Government Contracting of Social Services with Non Governmental Organizations
- IV Housing Reform in Kazakhstan and the Role of Apartment Owners' Cooperatives
- V Cooperative Housing in a Market Economy, Poland
- VI The Role of Training in Supporting Social Services Selected Success Stories
  - A Albania Innovative Training Improves Albania's NGO Sector
  - B Croatia New Legislation Opens Alternative Care for the Elderly in Croatia
  - C Slovakia Fighting Drug Addiction in Slovakia
  - D Uzbekistan Creating a New Substance Abuse Prevention Center in Tashkent

**Introduction Alternative Provision of Social Services**

*Submitted by  
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## ALTERNATIVE SOCIAL SERVICES IN THE TRANSITION PERIOD

### *A State-Dominated Social Benefits System*

Under the Communist system in Central and Eastern Europe (CEE) and the former Soviet Union, resource allocation for social protection was highly centralized. In place in most countries was a universal benefits system for housing, health, education, and employment, and cash subsidies for families, the disabled and the elderly.

Full employment led to a distorted labor market as governments strove to employ all workers regardless of their skills or the needs of the organizations employing them. Full employment was a stated objective of the Communist governments, and whether workers had low pay and not much work to perform, most people were employed in some fashion (unemployment existed but was not acknowledged). The educational system, especially basic education, was highly developed, and prepared workers for the state-run enterprises. Adult education and training, or continuing education, was confined to on-the-job training provided by the enterprises. Individuals were not encouraged to take responsibility for their career development, indeed most workers were expected to remain in their first occupation throughout their working lives, within the same state-owned enterprise.

The social benefits system relied on broad-based consumer subsidies provided by the state, or state enterprise-funded education and health services. One's job entitled a person to housing, owned by the enterprise, child-care and pre-school facilities provided by the enterprise, and a series of other social benefits, distributed by the enterprise.

The services, while supportive of employees, were costly to manage. One source recently estimated that enterprise managers spent nearly 25 percent of their time on just managing the employee housing – “worrying about plumbing problems, not profit,” he said.

### *Transition Issues in Post-Communist Societies*

As a result of the transition from a state-controlled economy to a free market economy, a number of dislocations have occurred, particularly as the enterprises are privatized. The communist systems guaranteed education, employment, child-care, health care, and pensions for all. In most cases, these services are no longer being provided by the state or state-owned enterprises.

State-owned enterprises are closing or privatizing and reducing social contributions. Driven by the need to shrink a redundant work force, increase productivity and profits, many of the social assets have been spun off. Enterprise-owned housing has been largely privatized in a variety of ways, ranging from condominium development to

outright sale to individuals. The disposition of the other social assets is less well understood. In fact, some experts suggest that the assets may have “disappeared” in the confusion of the transition.

Replacement of the services by other state agencies is weak, provision of the same services by private groups is emerging, but slowly. As national governments strive to decrease spending, they have cut basic services and entitlements, which then generally become the responsibility of local governments. The national government, however, rarely provides local governments with enough resources to provide services and entitlements.

Women are emerging as a vulnerable group in Central and Eastern Europe and the New Independent States (NIS). Women are leaving the workforce faster than men. One major reason is that citizens and governments can no longer afford child-care. For example, in the Republic of Kazakhstan, the responsibility for pre-schools has been passed to the municipal governments which can ill afford to run them. By 1994 enrollment had fallen to less than 30 percent of the targeted age group, compared with 60 percent during communism. This decline reflects approximately a one-third reduction in available places between 1984 and 1994.

The dismantling of the centralized systems has created the need for innovative solutions that include the contributions of the public, private, and non-profit sectors. Volume I of the report on alternative mechanisms for providing social services contains four case studies. The four cases discuss

- primary health care services provided by the private sector in Ukraine,
- services provided by non-governmental organizations through a contractual relationship with local government in Poland,
- owner cooperatives to achieve housing reform in Kazakhstan, and
- the use of cooperatives to build housing in Poland

**FAMILY PRACTICE A FOR-PROFIT MODEL  
FOR THE PROVISION OF PRIMARY HEALTH CARE SERVICE**

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## **FAMILY PRACTICE A FOR-PROFIT MODEL FOR THE PROVISION OF PRIMARY HEALTH CARE SERVICE**

### **Introduction**

The Polyclinic of Family Medicine (PFM) in Dneprodzerzhinsk, Dnepropetrovsk Oblast, Ukraine, was founded in September 1989 by Dr A V Mostipan as a private practice without state funding. The clinic provided primary care, "family medicine", under its own insurance plan. In exchange for a flat monthly premium payment, the clinic provided ambulatory care, home care, medicines, and a physician available at all times.

Over time, the PFM adapted to client requests for partial state funding and a system of fees. Building on the fundamental principle of service to the patient, the clinic reached a high point of membership of 15,000 in 1992 with 80 employees and 25 physicians, but, due to a variety of external financial factors, enrollment has fallen to its current level of 5,600. The quality of care and health of the membership are better-than-average yet the per capita cost of all their health care is less than half of the city and oblast averages. The success is achieved through giving responsibility for most of a patient's care to a single family physician. The result is good quality care with far less use of diagnostic testing, specialist care, and hospital care. The PFM experience proves that a model of increased primary care and reduced specialty and hospital care is achievable in the Ukraine. Implications of expansion of the PFM and widespread use of the PFM model are discussed.

### **Background**

Prior to founding PFM, Dr A Mostipan worked as chief physician and administrator of the health system of a large industrial plant. He left his position because he could not address what he felt was the primary problem of Soviet medicine: the system did not respond to the needs and interests of patients because funding and patients did not come from the same source. When the funding of services provided does not come from the person receiving the services, the provider is not accountable to the person to whom services are being provided. Also, he believed that health care workers needed incentives to work "harder and better." The experience of the PFM over its entire history, but especially during the very difficult period of the past two years, provides useful lessons about obstacles to implementation of primary care systems in Ukraine and elsewhere. While the PFM is a private for-profit enterprise, many of the principles that have guided its development and lessons learned during that process have direct relevance to the development of primary care systems and family medicine, whether public or private. The PFM has experimented with most of the major innovations proposed to reform the health care system of Ukraine. The purpose of this paper is to describe the largely successful experience of the PFM with these reforms.

## **Health Care in the City of Dneprodzerzhinsk**

Dneprodzerzhinsk is a medium-sized, heavily industrialized city that straddles the Dnieper River near the easternmost point in its course in east-central Ukraine. All of the industry and two-thirds of the population are located on the southern (right) bank while the northern (left) bank is entirely residential. The distribution of medical facilities other than the PFM is rather unbalanced: the left bank has only one polyclinic and one ambulance sub-station, while the right bank has all the hospitals, six polyclinics and six industrial medical units.

## **History of the Establishment of the PFM**

When PFM was established in 1989, it was understood that it would be extremely difficult to persuade a significant number of individuals to purchase their own medical coverage. While the idea of payment for better health care services was not new, the idea of pre-payment was quite novel and a major innovation in the late 1980's. Enterprises, on the other hand, were accustomed to financing medical and recreational facilities for their workers. Most large enterprises already had their own medical facilities, although they often served only their workers and not the workers' families. Working with small firms also had the advantage of making it easier for the firms' managers to judge the workers' satisfaction with their family's medical care.

Initially, PFM was able to enlist 25 firms with 5,000 workers and dependents. The PFM management petitioned the City Health Administration for permission to operate independent "polyclinics for family medicine." On September 26, 1989, the City Health Administration ordered the creation of an experimental self-financed family medicine polyclinic and contributed a single telephone line.

In January, 1990, enrollment reached 10,000 workers and dependents. The program was simple. In exchange for a flat monthly fee (eight rubles per month), the clinic provided ambulatory care, home care, medicines, and a physician available at all times. Because the PFM director believed that much of the care given in hospitals could just as well be provided at a clinic or at home, the program effectively included a great deal of hospital care.

Initially, the only physicians practicing in the PFM organization were Dr. A. V. Mostipan, the founder, and his brother. Their only facility was a single rented room, most care was provided at the patient's home or place of work. By the end of 1990, the PFM staff had increased to 8 physicians, and for each physician a car and nurse were assigned. They also succeeded in obtaining from the city a kindergarten building that had been closed in disrepair. After extensive remodeling and repairs done at the expense of PFM, the building now serves as the principal clinic facility.

By October 1992, the PFM had enrolled 15,000 members and had 80 employees, including 25 physicians. Because enterprises began to object to paying the full cost of PFM services as they were also paying taxes for publicly funded services, attempts were made by PFM to obtain

government funding Reforms in the health care budgeting process in mid-1992 allowed the oblast government to pay PFM a fixed amount for each enrolled member (1500 karbovantsev per person per year) This occurred near the beginning of the period of hyperinflation At the initiation of government funding in October 1992, the government payments represented 80 percent of revenue because enterprise premiums had been eroded by inflation Subsequently, the ratio of revenue coming from the government to enterprise contributions has fluctuated wildly With the continuing economic crisis in Ukraine, the number and size of economically viable enterprises has decreased and enrollment has declined to its current level of 5,600

### Organization of the PFM

Today, the PFM has 16 physicians and a total of 46 employees There are 5 primary care physicians, 11 specialists (including a surgeon, an ophthalmologist, an obstetrician-gynecologist, an otolaryngologist, a neurologist, a cardiologist, an endocrinologist, a dermatologist, and a urologist) They are distributed among the principal clinic, located near the center of the city, and two satellite offices located in left bank residential areas

Each office has examination and consultation rooms and a procedure room for electrocardiograms Four industrial enterprises, subscribing to the PFM, provide dispensaries for which PFM provides management supervision and supplies

**Table 1. Physicians per 5,300 Population (PFM client population)**

Physician Category	Dnipropetrovsk Oblast	PFM
District Internists	1 31	3 00
District Pediatricians	0 98	2 00
Dentist	2 71	1 50
Emergency Physicians	0 68	0 27
Hospital-based Physicians	3 58	1 92
Other Specialists	11 91	8 00
Total	21 17	16 69

The primary care physicians are assigned to one of the four geographical districts, two on the left bank and two on the right The two left bank offices each staff one district while the two right bank districts are based in the principal PFM facility Each district team consists of one internist, one pediatrician, and two nurses, all of whom live in the district The specialists divide their time among the offices All facilities are open until 8 00 p m (seven days a week) There is no longer coverage at night—physicians demanded too much money to supply this service

Home visits continue to be an important part of the service All primary care physicians make home visits on a frequent basis A system of radio-equipped cars for all the physicians is no

longer in use partly because it was found to be unnecessary and partly because most of the vehicles originally provided by the PFM have been purchased by the physicians who were using them. Home visits have decreased in frequency over the past two years primarily because a number of the client companies have begun to deduct the cost of home visits from employees' salaries. This was especially true of home visits for pediatric cases. Supporting the practice are several other departments. The most clinically-oriented department is the clinical laboratory. An engineer repairs and maintains PFM's medical equipment. The accounting department programs and maintains a computer database connected to a local area network that collects registration and billing information entered by nurses and clerical personnel (the satellite clinics have personal computers but these are not connected to the network). A most remarkable innovation for a medical institution in Ukraine is the Marketing Department staffed by three people. This department has been given four responsibilities: 1) to identify and analyze prospective clients—both firms and individuals, 2) to reach those prospective clients through advertising and direct contact, 3) to conduct surveys of existing clients to judge their satisfaction with care they have received and their interest in other services, and 4) to collect past-due accounts.

### **Approaches Taken Goals and Principles of the PFM**

The Polyclinic for Family Medicine was founded on a number of principles

- A client was never to have been left with an unanswered complaint. When this principle was conceived nine years ago, it was quite rare in Ukraine and was similar to the customer orientation and "zero defect," continuous quality improvement philosophies of the most progressive Western organizations. Many difficulties were encountered trying to put this principle into practice, and it has proven to have been too idealistic. On the one hand, the client population is still relatively uninformed regarding the technical and financial limitations of the current system of medical care, on the other hand physicians continue to have difficulty in taking patients' complaints seriously. The PFM organization and its physicians still are in the transition phase of understanding the patient as a client and consumer of health services.
- Continuous operation. This philosophy was followed the first year of the PFM's existence but could not be sustained. PFM physicians are no longer available at night. Given the lack of financial incentives (when the PFM is closed, patients may turn to the city emergency health system at no cost to PFM), the actual availability of PFM services for 80 hours a week is still a major achievement. Commitment to the truth. No false information on medical certificates or medical records or alteration of records after the fact is permitted. Personnel, including physicians, have been discharged for violating this principle.
- Maximum convenience for the patient. Initially, this was both the goal and the practice. During the early years of the PFM, this was also the actuality. Home visits remain heavily emphasized. However, the number of home visits have decreased from the early years,

and home visits deemed to be for the convenience of the patient rather than for medical necessity are charged for. The reduction of home visits is also a reaction on the part of the patients to having the cost of home visits deducted from salaries of employees of some of the firms that have contracted with PFM.

- Family doctors and nurses reside in the same district as the clients they serve. This not only facilitates greater familiarity with the patient's living environment, it promotes identification with clients and strengthens the fact that the primary commitment of the PFM staff is to the patient. The emphasis of the management of the PFM is that all of the employees of the organization are to be seen as supporting the family physicians.
- Medical practice must be based on science. Non-scientific methods such as bioenergy, homeopathy, ESP, astrology, etc., are discouraged. When the PFM was founded, this was a very radical departure from common practice. It is less so at the present time, but it is still an important operating principle in the sense that a mechanism is in place to facilitate replacement of scientifically disproven procedures as new evidence becomes available to justify the change.
- Constant striving to incorporate new technology and expand the range of services. This is a positive movement in the direction of continuous quality improvement. The PFM has continued to pursue the realization of this principle in the face of severe financial crises in Ukraine. New technology is expensive and some new services that depend upon new technologies are, thus, also expensive, but a constant effort is made to track the expressed needs of the client population and to incorporate new technologies as financial constraints permit.
- Performance-based pay. This principle is a reaction to the disincentives of the old, centrally-planned health system in which rates of pay were fixed by the Ministry. The PFM pay system relates pay directly to revenues generated as well as the volume and quality of the work performed.
- Employee support systems. Although providing extra benefits to PFM's employees is difficult due to financial constraints, when the financial conditions permit, extra compensation in the form of goods and services are provided to employees as part of the basic principle of positive incentives.

### **The Meaning of "Family Medicine"**

The concept of "Family Medicine" as practiced at the PFM is close to the American concept of primary care. Each PFM staff member can identify a single physician who has principal responsibility for an individual patient's care. In the existing system of polyclinics, an entire polyclinic is seen as sharing responsibility for the individual patient. In family practice, the patient not only begins each episode of care with the same physician, the PFM physician also provides a

much greater proportion of that care. In the larger system, district internists and pediatricians may act as first point of contact for patients as intake physicians, but the strong tendency is for these intake physicians to refer the patient to a specialist rather than treat the problem themselves. One basic principle of family medicine, therefore, is for the primary care physician to do a greater portion of the work for a smaller number of patients.

There are several benefits to the family medicine approach. From the physician's standpoint, a physician who is familiar with a patient's life circumstances and all of the patient's health problems, as well as those of his family, can make better diagnoses and provide more realistic and effective care. The physician can also be more efficient because he has less need to repeat examinations and tests. While it is sometimes advantageous to have the skills and knowledge of a specialist as a backup, they are often unnecessary. A good primary care physician should be able to make good judgments about when a specialist is necessary and when not. Often, a patient prefers to be cared for by a single physician because they fear being lost among different physicians and different diagnostic and treatment facilities. A patient needs to know that a specific individual physician is responsible for his or her care. It is frequently the case that the confidence gained by doing this outweighs the patient's confidence in the skills and knowledge of a specialist. The operating principle of PFM has ideally meant that each family can identify a single physician who is responsible for them. This is the philosophy of the specialty of family practice in the U.S. and Canada.

### **Financial Structure**

Since the founding of the PFM, clients have regularly requested that the financing structure be changed from the original simple capitated rate. The client enterprises want to be certain that they were actually getting something for their money. The result is that they are now billed a reduced fee-for-service in exchange for a lower capitation rate. The capitation rate is adjusted according to the size of the enterprise and the length of time it has been a client of PFM. These factors reflect reductions in administrative costs and risk. Government funding was being received but was limited to salaries and payroll taxes of PFM physicians and were similar to the rates of publicly employed physicians. Government funding ended in mid-September 1998 due to government cost cutting. The PFM coverage plan charges patients 20 percent co-payments for cosmetic, contraception, abortion, and dental services, as well as for eyeglasses and contact lenses. Full rates for fee-for-service are charged to patients who are not enrolled in the plan.

**Financial Statement for 1997 and First Eight Months of 1998**  
(percent of total expenditures)

Category	CY 1997	CY 1997/1998	CY 1998 (8 mos)
State funding	Total 38.1%	Total 37.1%	
	Salaries	27.8%	27%
	Payroll taxes for salaries	10.3%	10.1%
Client Charges	83.3% [+20% VAT]		
	Premiums	44.1%	36.6%
	Fees charged to enterprises	37.8%	48.9%
	Co-payments	1.8%	1.2%
	Fees charged non-members	16.3%	13.3%
Client Revenue	Total 61.4%	Total 62.9%	
	Funds from enterprises	27.4%	39.0%
	Cash from patients	14.2	8.3%
	Barter	19.8%	15.6%
	Bad debt	(22.0%)	
Expenditures			
	Physician salaries	22.3%	20.1%
	Other salaries	38.1%	35.7%
	Payment in goods	5.0%	4.0%
	Capital expenditures	--	6.0%
	Transport	6.1%	5.7%
	Supplies & materials	12.9%	4.7%

There is an excess of revenue over expenditure. A large part of fee-for-service income, although listed as revenue, is given directly to the physicians and nurses performing the services, it is not listed as expenditure. The physician and nurses negotiate between themselves an agreeable split of the fee income.

### Income of PCM for 1997 and First Eight Months of 1998

Source	1997	First 8 Months of 1998
Services Provided	298,727 88 Hr	153,548 07 Hr
Average Monthly	24,893 99 Hr	19,193 51 Hr
Revenues Received	144,852 46 Hr	151,826 21 Hr
Cash Receipts	21,832 75 Hr	25,827 67 Hr
Percent of Cash Received	15%	17%
Monthly Average Revenues	12,071 04 Hr	18,978 28 Hr
Monthly Average Revenue in Cash	1,819 40	3,228 46

### Capital Funding

Aside from buildings, which were received from the municipal government in poor condition in exchange for nominal rent, all equipment expenditures are funded out of income. This practice has been encouraged by the inflationary environment. Any large influx of funds is converted into capital equipment before its value becomes eroded by inflation. Although depreciation of equipment is not considered in the financial statement, capital expenditures are amortized in the calculation of the rates charged for services. There is no debt financing primarily because of both the prohibitive cost of credit and the incident vulnerability of the organization.

### Results and Achievements

#### Quality of Care

In the United States over the past seventeen years, it has become increasingly clear that, for most patients, large amounts of hospital and specialist care do not improve the quality of care and do little more to improve the patient's health than what can be done by a good family doctor. This is not because the skills and equipment of specialists are poor — they are simply not needed. The experience of the PFM in the Ukraine demonstrates that this is also true in the Ukraine.

Despite using far less hospital and specialist care, the health of PFM patients is as good or better than the general population of Dneprodzerzhinsk. The death rate for PFM patients is less than half that reported for the city or for Dnepropetrovsk Oblast. Even when the difference in age distribution is corrected (the PFM treats fewer older women), the death rate for the PFM is almost 30 percent lower than the general rate. The birth rate is 50 percent higher among PFM members than the city average and over 15 percent higher when adjustment is made for the higher proportion of women of child-bearing age among PFM members. Other figures indicating better quality of care at the PFM are the higher proportion of physicians with certification and higher rates of prenatal screening.

Because there is no reason to believe that treatment by PFM produces inferior health outcomes,

the issue of quality of care rests on the patients' satisfaction with their care. The PFM places great importance on patient satisfaction. Although the severe financial crisis in the region has eroded some clients ability to pay, the fact that large numbers of clients continue to pay is an accurate and important indicator of patient satisfaction.

### **Efficiency of Care**

The greater expenditure on primary care by PFM has led to far greater savings overall. The PFM reports that the rate of hospitalization for its members is 28 percent of the average rate for the city of Dnieprodzerzhinsk, and the rate of emergency ambulance use is one-third of the city average (which is already much lower than the oblast average). This reduction in specialist, emergency, and hospital care is substantial. Compared to the averages for Dniepropetrovsk Oblast, PFM members use nearly twice as much primary care doctor time but one-third less physicians' time overall.

The reduction in hospital care is almost entirely due to a reduction in non-surgical admissions to hospital. Rates of surgery for PFM patients are similar to the general population. The reduction in non-surgical hospital admissions occurs for two reasons. First, because PFM members have family physicians whom they can readily identify and contact, there are fewer ambulance calls. Ambulance calls usually result in the admission of the patient to the hospital, even when the patient is not severely ill. Second, PFM physicians do not admit patients to the hospital if the necessary tests and treatments can be given at a clinic or at home.

### **Impact on the Local Economy**

In 1997, PFM was providing health services to a client population of 6,996 people which is 2.5 percent of the population of Dnieprodzerzhinsk (280,500). Now that the government is paying PFM nothing, the government is saving 2.5 percent of its health budget because PFM and the client enterprises are paying those costs, and government no longer has to pay these costs.

- The PFM has been creating new wealth over the past nine years and the spin-off businesses from PFM are as well. (In 1997, for PFM this was \$95,750.) The figures for the spin-off businesses are not available but the dental spin-offs are quite lucrative operations, relatively speaking, so it can be assumed that they are making at least half of what PFM is making.
- The PFM is not operating in a vacuum. The following linkages with Dnieprodzerzhinsk and Dniepropetrovsk all impact the economies of these two cities (Dnieprodzerzhinsk and Dniepropetrovsk are very near each other so some business spills over city boundaries).
- The employees of PFM and the spin-off businesses are well-compensated relative to the salaries of comparable positions and they pay taxes and they pay them in cash. This is significant not so much because of the amounts paid but because there are very few non-

governmental tax sources in either city (new tax revenue source)

- The three facilities operated by PFM and the facilities of the three spin-off businesses pay rents to the city governments (new income)
- Although this could not be said through the entire history of PFM, at the present time, the entire income of PFM can legitimately be said to be offsetting an equal public expenditure for the health care of the clients of PFM. Add local currency amount (savings to city health budget)
- The PFM facilities and the spin-off businesses pay in cash for gas, electricity, water, and telephone while the vast majority of health care facilities and educational institutions either do not pay their utility bills or are exempted from payment (new revenues)
- The PFM and the three spin-off businesses buy medicines, medical, dental, office, and computer equipment on the open market and thus contribute to the local economy (new money in the system)
- The PFM purchased and subsequently sold to PFM physicians 6 vehicles that have to be operated, maintained, and repaired which also contributes to the local economy (new money in the system, approximately \$25,000)
- Over the time period when PFM was providing care to the dependents of enterprise workers who were clients of PFM, the fact that services were being provided to spouses and children of workers who would otherwise be using public facilities, reduced the cost to government of providing those services (savings to the city health budget)
- The fact that hospital admissions and emergency ambulance services have been drastically reduced within the PFM client population significantly reduces the costs that these cases would have otherwise cost the government medical system. Dollar figures cannot be placed on these cost reductions because there is currently no means by which the costs of the government health care services can be calculated
- A significant part (approximately 50%) of the revenues of PFM are in barter goods. The fact that PFM provides brokering services to turn these goods into cash revenue is serving to keep the local economy functioning. Since PFM pays taxes on the official price of these bartered commodities rather than on the real selling price, they are paying inflated taxes
- The renovations that PFM has and continues to pay for on the facilities they rent are increasing the property values of those facilities. If and when, the government either leases anew or sells these properties the renovations will be value added to government assets which contributes to the economy even though it may be unfair to PFM

- The renovations of PFM and PFM spin-off business facilities are contributing to the local economy because trades people must be paid and materials must be purchased
- All the employees of PFM and of its spin-off businesses are currently being paid private sector salaries and benefits. If these private businesses did not exist, these people would be on the government payroll and thus a financial burden
- The enterprises that have contracted with PFM for the provision of health care services to their employees have realized significant savings. Prior to the founding of PFM, most large and medium-size enterprises had their own clinics, dispensaries, and health care systems that had become quite expensive to operate by the late 1980's. Also, the cost of these in-enterprise health services were in addition to the taxes that the enterprises paid to the government for health services. Over the past 9 years, these enterprises have negotiated and renegotiated the premiums rates paid to PFM for health services. The result has been a constant reduction in costs to the enterprises for health services that have continued to improve over what they were in the past

### **Impact on Job Creation**

- Two of the spin-off businesses of PFM are private, for-profit dental clinics. One is a sophisticated dental facility that includes laboratories for doing modern ceramic dental work and dental prostheses. Dental work in the Soviet Union had been a rather crude utilitarian sort so this new business is doing very well with providing consumer-oriented dental work that is more cosmetically attractive. This first spin-off is located on the ground floor of the main PFM facility building and renovations on the facility are nearly completed. The second dental facility is located in a downtown storefront office facility and is modern, efficient, and consumer-oriented. It is also doing quite well financially. The first dental spin-off is about four years old and the second, about two years old
- The third spin-off is an auto repair shop that originally functioned within the PFM organization when the PFM operated about 9 vehicles that were principally for use of physicians to do home visits. As most of the vehicles were sold to the physicians who used them, the need for an in-house repair shop decreased and the group of mechanics were encouraged to start their own small enterprise. Other than the fact that they have been in operation for 2 or 3 years and are making it financially. Little is known about them
- The fourth spin-off business is still in the planning stage. It is comprised of three full-time and one half-time PFM staff members who function as the Marketing Group, although the name is a bit of a misnomer. They are in charge of conceiving, designing, and managing all the print and media advertising (including billboards, flyers, promotions, radio and TV pieces) as well as the constant process of tracking patient satisfaction with the services of PFM. They are, however, most involved in dealing with past due accounts and managing

the very complex transactions required by the fact that half of PFM's revenues are in the form of barter goods. Given the economic situation in Dneprodzerzhinsk, it would appear that two spin-off businesses might be created out of this "Marketing Group" one, a true marketing group that could sell its services to burgeoning private businesses, and the other a group that could provide services in managing barter transactions, which, at least at the present time, are numerous and proliferating.

## Lessons Learned

There appears to be a structural inability on the part of the Ministry of Health to deal effectively with the health care needs of the population. Historically, this incapacity may have its source in the relative inexperience of policy makers and top government officials in comprehending their responsibility for the health and welfare of the population they govern and effectively dealing with these needs in a prolonged period of economic scarcity. In the Soviet era, all policy, health system designs, and budget allocations came down from planners and technical institutes in Moscow. The governmental regimes and bureaucracies in Ukraine basically carried out the orders of Moscow and had little, if any, role in decision-making or changing policies. With independence, the leadership was prepared only to continue issuing orders following the policies and patterns that were inherited from the Soviet era. Mechanisms did not exist to change the system nor reallocate resources based upon what worked or not at the level of oblasts, cities, and rural regions. The structure remains highly centralized with few mechanisms or channels to provide feedback to higher levels of government. Although the system remains highly centralized, some cities and oblasts have taken the initiative to begin tentative steps to develop local solutions to local problems within the health care system. This is seen in Lviv and Odessa where experiments have begun with the development of primary health care service delivery within the government health system. In most other parts of Ukraine, the directors of the health care system are waiting for the initiatives to be defined and orders from Kiev to be issued. The only experimental programs that can be seen in these areas of the country are outside government, an example being the PFM.

### Specific Lessons from the PFM Experience

- The PFM has found that the mentality of a specific group of physicians is such that they have proven to be a constant problem in the staffing of the PFM. Specifically, after the PFM began operations and started to recruit additional physicians, the search targeted finding male internists. Since the startup of PFM operations, a total of 40 male internists have been hired and subsequently dismissed. There was no single reason for these dismissals but rather a combination of difficulties that ranged from their not wanting to do anything beyond the minimum, to lack of interest in patients, to lack of motivation to increase their skills.
- There is a lack of interest on the part of patients in their own health. It appears that one of the attitudinal vestiges of the Soviet health care system is that the system was set up to

take responsibility for the health care needs of the population. One of the less unfortunate outcomes is that the population, as a result, sees the state health care system as responsible for the citizen's health, and the individual takes little personal responsibility for his or her own health behaviors.

- In the early years of the PFM, the managers of the city enterprises took a great deal of interest in the health and well-being of their workers. This interest was genuine and not based on self-interest of the enterprise managers. In recent years, this attitude has changed. Increasingly, the enterprise managers are becoming resentful at the cost of providing health care to their workers. This is due to at least two factors. First, the enterprise managers do not see that their workers are at all grateful to the enterprise management for the health services provided, and, second, the enterprises are already paying taxes to support the public health system so their costs to provide additional care is seen as unfair. This is not simply the exceptional case but rather the general tendency among over 100 large and small enterprises with which PFM has contact.

#### **Ways in Which the City Government Has Been Supportive of the PFM**

- The government allowed the establishment of PFM as an "experimental" family practice provider of primary health care services.
- The government provided a facility for PFM at a very low rent. Although the facility was in need of significant repair, it was in fact provided and provided at a cost that was manageable for PFM. It also provided a single telephone line at the start-up of PFM operations.
- For a brief period of time in 1991-92, the government provided budget allocations equivalent to that of a facility with a patient population similar to that of PFM. This was done on a per capita basis.
- The government gave the PFM physicians the authority to sign for workers' absences from their jobs for reason of illness or accident.
- The government has allowed the PFM to continue to operate when it could have closed down the company at any point of time.

#### **Ways in Which the Government Has Been an Obstacle to the Development and Operation of PFM**

- The taxation policy of the government has been oppressive in the sense that when the PFM was actually relieving the health care system of part of its load, the government increased PFM's tax burden and the rigidity of its enforcement rather than giving PFM tax concessions.

- When PFM has had to deal on a barter basis in enterprises' payments for services, the government has taxed PFM for the official (higher) price of the bartered goods rather than the significantly lower actual market price
- The City Health Administration has never permitted PFM physicians to treat their own patients in government health facilities
- The City Government has recently informed PFM that it plans to sell the facility occupied by PFM. The selling price is prohibitively high for PFM after major expense has gone into refurbishing and repairing the building

### **Conclusions**

- 1 Despite the fact that PFM is a private, for-profit medical enterprise, in the opinion of the directors, a free-of-charge public health care system is the best
- 2 The compensation of all health care workers should be based entirely upon the quantity and quality of their work
- 3 Professional accountability systems have to be built into the health care system to ensure that health care workers are doing what they are paid to do and that high standards of honesty and quality are maintained
- 4 The primary care physicians and nurses need to live and work in close proximity to the population they serve
- 5 The most effective way for people to learn how to handle responsibility well is to have real practice handling responsibility and being held accountable for how well or poorly they deal with it. In environments in which individuals have had little or no opportunity, and, thus, experience in dealing with responsibility, it is essential that the skills required to handle responsibility are provided and that punitive measures for mistakes made in the learning process be minimized

## APPENDIX

Selected Statistical Comparisons of Dnepropetrovsk Oblast,  
Dneprodzerzhinsk and the Polyclinic of Family Medicine

Category	Dnipropetrovsk Oblast	Dnieprodzerzhinsk 1997	PFM
Population	3,880,000	280,500	6,996
Male	46.5%		51.3%
Female	53.5%		48.7%
Age			
0-14	21.2%		9.8%
15-49	48.4%		47.1%
50-59	13.3%		8.3%
60-64	6.4%		3.1%
65-69	3.3%		1.6%
70 & above	7.4%		1.4%
Males			
Ages			
0-14	23.4%		12.4%
15-49	50.7%		65.1%
50-59	13.5%		12.5%
60-64	5.7%		5.0%
65-70	2.4%		2.5%
70 & above	4.3%		2.1%
Females			
Ages			
0-14	19.4%		15.0%
15-49	46.3%		67.1%
50-59	13.1%		10.8%
60-64	7.1%		3.6%
65-70	4.1%		1.8%
70& above	10.0%		1.7%
Births per 1000	8.6	6.7	3.7
Age and Sex Adjusted Births per 1000	8.6	6.7	7.8
Deaths per 1000	15.8	14.6	1.2
Age and Sex Adjusted Deaths per 1000	15.8	14.6	0.8
Infant Mortality (<1 year) per 1000 births	14.6	18.2	0
Daily Ambulatory Visit Capacity per 10,000 pop	216	186	171
Working Physicians per 10,000 population	42.5	35.2	21.4

Physician Extenders (Feldshers) per 10,000 pop	106.5	85.3	0
Percent of Physicians with certification	51.7%	56.4%	90.9%
in two highest categories	36.2%	72.8%	70.0%
Percent of Internists with certification	46.2%	72.4%	100.0%
in two highest categories	27.9%	50.4%	100.0%
Percent of Pediatricians with Certification	49.5%	58.3%	100.0%

<b>Category</b>	<b>Dnepropetrovsk Oblast</b>	<b>Dnieprodzerzhinsk</b>	<b>PFM</b>
In two highest categories	30.3%	39.3%	50.0%
Percent of Other Physicians with Certification	52.8%	77.3%	85.0%
In two highest categories	34.0%	59.2%	66.6%
Ambulatory Visits			
Per person per year	10.1	9.0	3.0
Home Visits/person/year	0.8	0.8	1.4
Ambulance Calls/1000 pop	350.7	217.6	72.8
Hospitalizations/100 pop	23.9	16.7	0.9
Hospital beds	52,459	3,970	
Per 10,000 population	134.9	81.0	
Occupancy Rate	82.4	82.3	
Average Length of Stay	16.8	18.2	7.4
Operations/10,000 pop	577.0	446.9	415.9
Pregnancies with prenatal visits in first trimester	81.4%	78.9%	93.7%
Pregnancies			
With syphilis testing	90.2%	68.1%	100.0%
With ultrasound exam	79.9%	64.3%	100.0%
Radiologic Procedures			
Per 10,000 pop	4317	2517	754
Ultrasound procedures			
Per 10,000 pop	2144	1191	164
Endoscopic procedures			
Per 10,000 pop	450	231	130
Laboratory Procedures per 100 clinic visits	88.5	71.0	54.8
Laboratory Procedures per 100 clinic, home, and dental visits	48.7	63.1	19.8

**SOCIAL CONTRACTING IN POLAND  
LOCAL GOVERNMENT CONTRACTING  
OF SOCIAL SERVICES  
WITH NON GOVERNMENTAL ORGANIZATIONS**

*Presented by  
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## SOCIAL CONTRACTING IN POLAND LOCAL GOVERNMENT CONTRACTING OF SOCIAL SERVICES WITH NGOS

“Instead of operating as mass suppliers of particular goods or services public agencies are functioning more as facilitators and brokers and seed capitalists in existing or incipient marketplaces. As the past decade has taught many of the leading private corporations, this more entrepreneurial role cannot be performed well by traditional command-style bureaucracies ” (*The Corporation for Enterprise Development*)

### *Introduction and Background*

Bielsko Biala has one of the first city governments in Poland to begin formally contracting with non-governmental organizations to provide social services for its citizens

It is useful to recall that the first local government elections in the post-Communist Poland were held in 1990. According to one source, “This constituted nothing short of a revolution in the administration of local affairs,”<sup>1</sup> as during the Socialist period, municipal offices only executed decisions from the central government. Over the last eight years, “local governments have been struggling to modernize and further develop local infrastructure, (and) improve the standard of municipal services in their communities ” as decentralization of public functions require local government to be responsible for a larger number of services

Simultaneously, the culture of non-governmental organizations (NGOs) and private voluntary organizations (PVOs) (defined as groups of private individuals working to accomplish a common goal or represent a common viewpoint) was thriving in Poland. Associations of citizens emerged to advocate for and provide services in a broad range of sectors. Based on a tradition born of the rich cultural heritage of the country, the number of NGOs and PVOs has grown to over 30,000

A culture of cooperation between the two sectors, however, was not growing naturally. In fact, contentious relationships were the norm. While commonplace in western democracies, cooperative agreements and contracts to provide service were uncommon in Poland. Reaching this significant juncture in the post-communist transition is a result of an eight-year process that compelled both sides to

- break through the layers of distrust built up between citizens and government in the communist era,
- increase cooperation gradually through grants from government to local organizations, and
- allow both city government and local civic groups to evolve into mature organizations

The following case study describes the process in Bielsko Biala that led the city government to establish a system that would permit issuing contracts to the flourishing civic society represented by the NGOs, to improve the quality of life in the city and create an environment conducive to economic growth

### *Socio-economic and Political Context for Action*

Bielsko Biala, the capital city of the Province of Bielsko Biala in southern Poland, has successfully survived the period of economic transformation following the downfall of Communism. Indeed, the city is often referred to as "a pioneering city," where its citizens are open to new ideas. Some ascribe that characteristic to its unique historical tradition. During a seven hundred year period, three communities, Polish, German and Jewish, lived together in friendly cooperation and coexistence. Perhaps, they suggest, it was just this tradition of cultural heterogeneity that explains why the people in Bielsko Biala are so open and able to collaborate.

Located on the borders of the Czech Republic and Slovakia, the city is home to 187,000 people and considered not only one of the fastest growing cities in its region, but the city with the highest economic potential for Polish cities of similar size.

The local economy is flourishing, mainly because of large foreign investment (especially from Fiat Auto Poland, one of the largest foreign investors in Poland). Fiat Auto employs 11,000 people, generating over one billion US dollars per year. Large industry does not dominate the economy, however. Small and medium private enterprises related to the automobile industry, light manufacturing, and machine industries number about 18,000 and produce 57 percent of the profits of the local economy. Forty-five percent of the working population are employed in industry. The rapid development of these small private businesses absorbed many who had lost their jobs in the decline of the textile industry shortly after the transition began.

The city's business support infrastructure is growing rapidly. Bielsko-Biala is home to the Bielsko-Biala Business Center, the Agency for Regional Development, the Polish-American Small Enterprise Foundation, and 16 branches or subsidiaries of major Polish banks. The local education-and-training sector is sound, thanks in part to the Bielsko-Biala School of Business and Information Technology, the School of Banking and Finance, the School of Information Technology and Management (a branch of the Lodz Polytechnic), and many training organizations.

Local unemployment is relatively low (9% in the province and about 3.6% in the Bielsko-Biala municipal area). Women over the age of 35 still register high unemployment, however.

The local government has actively sought new and progressive solutions in many fields. City officials have cooperated with a number of foreign assistance programs, especially with USAID - sponsored projects. For example, the city participated in the Pilot Local Government Partnership Program (Pilot LGPP), which helped turn its 1996 housing policy bill (drafted with USAID

support) into a specific action plan. The city also received technical assistance and secured a preferential loan from PKO Bank to implement its housing policy.

Bielsko-Biala's Third Sector is also well developed. Among the city's 320 organizations are a number of groups that are active nationally and have strong reputations for innovation and significant achievements. The Beskidy Non-Governmental Initiatives Support Association is an active integrator, facilitator, and representative for the sector.

A small group of about eight to ten strong NGOs have tapped foreign assistance programs and private foundations both in Poland and abroad, raising an estimated \$89,000 in 1997. The largest single grant totaled \$22,000, three others were for more than \$15,000.

Though prospering, municipal authorities are aware of a number of problems that allowed to grow unchecked can hinder continuing economic growth. While the city currently reports an estimated twelve thousand (12) high school students, the percentage of young people is decreasing every year. This is attributed to a declining birth rate and the out migration of well-educated young people to other cities. Indeed, the loss of a skilled work force may be the most important problem the city faces in the near future.

#### *The Problem or Challenge That the Community Faced*

As in other cities in Poland, NGOs in Bielsko Biala had begun to fill the gap in services, including improving air and water quality in the city, providing direct services to vulnerable populations, and increasing recreational opportunities for residents. The municipal government was supporting the sector's work with ad hoc grants.

Complaints arose on both sides. The NGOs, accustomed to receiving direct support from government, expected increased monies for their activities. The organizations complained that the process by which public funds were allocated to the private sector was not clear or transparent. On the other hand, local government grumbled that the NGOs decided upon their activities without consideration of the priorities set by the local government. Standards for accounting for the use of public money were not in place, and accountability for specific results was lacking.

While local officials were proud that several national environmental groups were based in the city, some leaders said the groups had done very little for the community.

Local officials also observed that a strong level of citizen activity was not developing quickly enough to contribute to a well-articulated and coordinated response to the community's problems. A number of barriers were identified, including lack of money, lack of professional staff and equipment, and finally a lack of confidence.

#### *Approach taken to address the issue*

In 1997, Mr. Klosowski proposed a program to increase the collaboration between the public and Third Sector called the "local partnership" program. This program was launched nationally in 1997 by the Democracy Network Project coordinated by the Academy for Educational Development. The purpose was to help communities design a framework that would allow for joint ventures between local governments and the Third Sector. Over the nine months of the project, communities received training and technical assistance in the principles, regulations, and mechanisms needed to establish a contractual relationship. A series of manuals was produced to guide local government and NGOs through the process of letting contracts, on the one hand, and performing as a contractor in a formal procurement process, on the other. Out of 15 municipalities that participated in the program, Bielsko Biala was one of only three cities that prepared the necessary systems for contracting services to NGOs and let a contract.

Resistance from members of the Town Council was very strong. Council Members argued that as the elected representatives of the people, it was *their* duty as *local government* to decide what was needed in the town, not the citizens or their organizations. Others, including the Mayor and some members of the Council, argued that local government needed adhere to a basic principle of democracy - citizens know best what the issues and problems are that need to be resolved and have a right to be involved in the debate about how the city should allocate its budget.

In November 1997, the City Council adopted a Local Partnership program, with the goal of creating a sustainable environment for strong local government support to valuable NGO endeavors and NGO assistance to the local government in the form of complementary services. The City built its program on the legal foundation provided in the new Constitution of the Republic of Poland, dated April 2, 1997. The principle of distribution of "public tasks" among diverse levels of public administration, including state and local self-government, was introduced. The Constitution established for the first time a provision declaring that NGOs could function as "expressions of civil society" and therefore could be regarded as "instruments to perform public tasks." This provided the legal foundation for contractual agreements between local government and civil organizations.

To carry out the new program, the mayor has appointed a municipal officer responsible for facilitating this relationship (the author of the case study), and the city reserved money in the city budget to finance projects proposed by either local government or civic organizations. In the new city budget, this amounted to the equivalent of \$125,000.

The most critical component of the new approach, however, was the Council's proposal to standardize the funding process to distribute public monies to civic organizations. The two components are

- Grants would be given to NGOs through semi-annual competitions. The competitions established clear standards and are open to all NGOs ("Micro grants" will also go to small but valuable non-governmental projects being implemented on an ad hoc basis) <sup>3</sup>

- Local government would adapt its public procurement mechanisms to facilitate sub-contracting with NGOs to complete tasks for the municipality

Local officials consider that the two elements complement one another

### *Results and Achievements*

The two sectors' working relationship is currently intensive and well established. Local government opinions about NGOs in Bielsko-Biala are generally positive.

The local government reports that the program has achieved the following

- more cost effective public spending,
- strengthened the local sense of citizen empowerment,
- support and education for local leaders,
- assistance for local officials to develop an ability to respond to local problems early, and
- improved communication between the local government and the general public

The program provided a framework for a transparent system of allocating public funds and increased local government support for the local NGOs. As a result of the competition, both the number and quality of organizations' activities also increased. Some 86 grant applications, worth \$523,000, were received by the local government in the second half of 1998. The total value of the projects was estimated at \$3,100,000 (including financing provided by other sources, such as private sponsors and other donors). As a part of the project, a new coalition of NGOs, the Association for the Support of Non-Governmental Initiatives, in Bielsko Biala was created. The Association is cooperating with the City Council's commissions and is encouraging wider participation by the NGO sector on each commission.

While only ten percent of the applications received were funded, it is widely believed that the program stimulated an increase in civic activities. Organizations are stronger and many projects are extensive, with gross revenues as high as \$100,000. While there are no exact statistics on the employment generated by the sector, it is widely accepted that NGOs are becoming a meaningful source of employment especially for middle-aged women, a group that has found difficulties in obtaining employment during the transition.

Examples of some of the 25 activities supported through the competition include

- ADA Association, a group that provides daily transportation for handicapped children to school and to the rehabilitation center,
- GAJA Club which formed a small nature reserve with the city as a place for ecological education and recreation,
- Association "Inna Kultura" (A Different Culture), a group that provides "poetry for youth," through meetings with poets and poetry workshops,
- Polish Deaf Society, provides training in sign language for municipal employees to increase public service to a broader base of residents,
- POMOST Foundation, a group which trains volunteers who work "on the streets" with drug addicts,
- Polish Red Cross which provides first aid training for secondary school students, and
- The Association for Mental Health Protection, a housing program providing "protected" flats for ex patients

The contracting process, however, is the most innovative part of the program and is the aspect that is saving the city money. In many specialized areas, the Council members determined that NGOs are far better qualified to offer services than the municipal bureaucracy and do so at a lower cost than the city. Instead of expanding the municipal institutional structure to take on new tasks, the city decided, it is better and cheaper to give an NGO a contract to provide a given service. The city learned how to write concrete requirements and specify what is supposed to be done.

An example of financial efficiency is the homeless shelter in Bielsko Biala which city authorities are obligated to provide under Polish law. Initially, the Council planned that the Social Department would run the shelter, at a cost of \$2.37 per person per night. Instead, the city announced a public bid for the services. Four NGOs submitted bids and the contract was awarded to "Wyspa w Mielcie (The Island in a City)". The group is providing the services for \$1.14 per person per night, less than 50 percent of the city's cost.

The homeless shelter has been in operation for five months, employs six people, and makes a substantial profit. Since the association is a non-profit organization, it must allocate all the profits to its next goal, which is useful for the local community. In such cases, the money works twice! The association is using the profits to implement a very important program entitled "No More Violence," a program against family and school violence.

The Local Partnership Programs has generated an unprecedented surge in activity among the local NGOs. Some five years ago, there were almost no organizations employing staff, or even using computer technologies. Today, NGOs employ an estimated 450 people and are contributing in a small way to solving the unemployment problem of middle-aged women, as many of the staff of NGOs are women over the age of 35. The Third Sector also contributes to the local economy through its purchase of goods and services.

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A new phenomenon is the employment generation created by the NGO's demand for specialized services. A number of small enterprises have sprung up to offer accounting, legal, and tax consultation services for the sector. The Local Partnership Program has positively influenced the local labor market. Indeed, when one sector of the community is activated, other sectors of the community are indirectly activated.

### *Lessons Learned*

Bielsko Biala's municipal officials' experience in implementing a contracting system is that it is beneficial to the city in improving the quality of services at a lower cost. While city officials maintain that it is easy to implement, this city is nevertheless only one of three in Poland that has moved to a contractual arrangement with non-profit organizations.

The authors of the program offer some suggestions for cities interested in moving forward with a similar program. A first step is to educate both the local authorities and the local NGO leaders *together* about the expectations of a contracts program. Second, both local government and the NGOs must have matured to fully functioning organizations. NGOs must be professional organizations, with financial accounting systems and high standards of service provision. Local governments must understand and be willing to engage in a participatory relationship with the residents of their community.

Finally, while the program brings economic benefits to the community, directly through savings to the local government, and indirectly through employment generation, the benefits of the program extend far beyond its economic benefits. The Local Partnership has achieved another main goal, increasing the base of groups within Bielsko Biala that are assuming responsibility for identifying and solving the social problems within the community. By doing so, an atmosphere of enterprise and growth is established.

What can other communities learn from the experience? While NGOs can provide effective and cost efficient services for the municipal government, a sustaining and valuable result of the program is the enrichment of democratic participation in the life of the community.

### *Endnotes*

<sup>1</sup>"How Municipalities Learn." A Report Prepared for USAID Poland by Daniel E. Hall, September 9, 1998.

<sup>3</sup> The Local Partnership Program also identifies non-financial ways of supporting the Third Sector: providing advice and training opportunities, aiding in fund-raising with external sources, engaging in joint public relations, building an information system for NGOs. Most of these methods have already been applied in Bielsko-Biala and the other contributions, such as free office space, are valued at about \$68,000.

**HOUSING REFORM IN KAZAKHSTAN AND  
THE ROLE OF APARTMENT OWNERS' COOPERATIVES**

*Presented by  
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## **HOUSING REFORM IN KAZAKHSTAN AND THE ROLE OF APARTMENT OWNERS' COOPERATIVES**

### *Introduction and Background*

Kazakhstan, one of the Central Asian Republics, gained independence from the Soviet Union in December, 1991. The following were the primary features of housing policy before comprehensive reform began in Kazakhstan in 1994:

- Centralized distribution of all resources and strict state planning,
- State monopoly in construction and municipal economy,
- Government financing of housing direct from the state budgets,
- Strict control over housing costs (all residents paid the same amount, no matter the type of housing or the resident's wages)

Beginning in 1985 (prior to independence), the government of Kazakhstan began privatizing apartments in state-owned buildings, these apartments were granted to residents for perpetuity. By 1989, 9,100 apartments had been privatized. By 1995, 80 percent of the population owned their own apartments. Despite privatization of housing, municipal services continued to be subsidized at 80 to 90 percent of costs by local governments.

### *The Problem or Challenge That the Community Faced*

One of the main reasons for implementation of housing reform was the fact that the local governments were no longer able to provide housing services. Housing and its maintenance were financed directly from the local governments' budgets. However, the economic crisis following perestroika placed significant restraints on local budgets.

City governments were not able to overcome the economic crisis without taking measures, such as decreasing expenditures for housing services and requiring residents to pay more of the costs. In addition, because of years of neglect by the government, the housing stock was in extremely bad repair, and no funds were available for needed improvements.

Because all housing services were paid for by the state, a monopoly in housing maintenance and construction existed (with state-owned enterprises controlling these sectors). These monopolies hampered efficient construction, maintenance, and repair of housing.

In addition, the subsidy structure for housing services was not equitable. Subsidies were based on the size of the apartment, therefore, families with larger apartments (and larger incomes) received higher subsidies.

Following housing privatization, it became illogical to continue subsidizing housing which no longer belonged to the Government. Therefore, the government transferred responsibility for upkeep and maintenance of apartments (living facilities) to the owners of the facilities. In the provinces, the step-by-step transition process to non-subsidized living facilities was accompanied by implementation of tender (bid) policy principles and transparency of expenses. The tender process also resulted in reduction of municipal service tariffs that before were poorly controlled by the Government.

The Government was very interested in privatization of housing services and utilities as up to 10 percent of the total budget was spent on subsidizing housing. Budget problems were the reason why the Government took an active part in implementation of reforms in housing policy and municipal economy. The conductor of the Government's policy was the State Antimonopoly Committee. It should be noted that prior to this process, owners of living facilities in provinces started to resolve problems of housing maintenance themselves. By 1994 in some cities, there were already apartment cooperatives. In May 1996 the Government legalized massive demonopolization in housing and housing services. Since that time, the process of demonopolization in housing and housing services has been accomplished.

Municipal companies and organizations managed by the Government were required to increase their fees and cover their own costs (without subsidies from the Government). Some companies providing municipal services were sold to private owners. The price of municipal services at the present moment is equal to cost. Raising prices, however, led to the problem of support of indigent families. As a result, a support program has been developed. The support of needy families is provided through benefit centers in major cities. By September 1997, housing support had been provided to 174,000 families through 110 benefit centers.

### *Approach Taken to Address the Issue*

There are currently 5,000 cooperatives in Kazakhstan covering 92 percent of all apartments. Forced by privatization to take responsibility for their own apartments, residents began to use their housing cooperatives to increase competition for housing services, get better services, and lower the costs for services (housing services include maintenance, garbage collection, installation of metering devices, and rehabilitation and repair).

Cooperatives are a major force behind the introduction of market competition and contracting in housing services. Cooperatives can choose to establish their own companies to provide housing services or purchase services through competitive bidding. In 1998, twenty percent of cooperatives had their own housing services businesses, and the number is increasing.

Cooperatives without private service companies solicit tenders for services. Companies — including state-owned companies, private companies, and companies owned by other cooperatives — then compete to win the contract. This process has led to 1) increased

competition for housing service provision, resulting in better services and lower prices, and 2) an increase in the number of companies providing these services

Cooperatives have also helped encourage economic development in their neighborhoods by offering space for rent on the first floors of their apartment buildings to local entrepreneurs. These spaces then provide rental income to the cooperative, allowing it either to expand the services it provides or reduce its fees. These expanded services have also created jobs.

For example, one cooperative has many elderly residents and pays (from residents' dues) for a physician to maintain an office in the building and provide reduced-fee services to residents. Another cooperative created a day care center for residents.

### *Cooperation between Stakeholders*

Cooperatives formed regional associations and a national association to provide training and technical assistance to individual cooperatives in management and business practices. The National Association's role includes 1) assisting cooperative leaders in managing their cooperatives and the businesses they create, 2) providing training in business and management on a fee basis to cooperative leaders who request it, and 3) coordinating with national and local governments.

The National Association and the national and local governments coordinate and work together closely on housing issues. The National Association also works with individual cooperatives and local governments to resolve territorial disputes arising from the fact that cooperatives were not given the property surrounding their apartment buildings during privatization. One indication of the level of cooperation between the National Association and the national government is the Association's invitation by the national government to participate in its monthly housing conference call.

In addition, the National Association has had a positive impact on housing policy: it helped create the housing subsidy centers for poor families and won the right for public hearings at meetings of the Anti-Monopoly Committee when rates are set for housing services and utilities.

The National Association also provides its training manuals on housing to government officials.

The Governmental role in housing today has been reduced to the work of the Anti-Monopoly Committee, technical inspection of apartment buildings, provision of housing subsidy benefits to poor families, motivation of the development of market competition, and promises to provide funding for capital repair.<sup>1</sup> The main actors in housing dealing with all former and present

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<sup>1</sup>Apartments were privatized after years of neglect. Apartment owners have little or no money for the extensive capital repairs many buildings need. Local governments have promised to provide money

problems in this complicated field are the housing cooperatives

### ***Barriers***

Apartment owners still face problems of finding efficient ways to use market mechanisms for the purpose of improving the quality of their living facilities. Cooperatives play an important role in management and operation of living facilities over huge territories. The National Association is convinced that in the future they will play a key role in the improvement of housing quality.

Many cooperatives face financial and administrative problems that cannot be resolved in a short period of time. Cooperatives have to use existing resources to maximize income due to the limited payment ability of their residents. To fulfill this task, cooperatives have to achieve a high professional level in property management and in financial issues. Cooperatives have to become more efficient, democratic, and financially stable organizations.

Other barriers to housing reform include

- Local authorities do not always follow governmental regulations and decrees. A lot of very useful regulations have been issued, but they were fulfilled only 30 to 50 percent. There is no control over implementation of governmental decisions in provinces.
- The population lacks interest and activity in matters concerning improvement of their housing, control over the way their money is spent, and control over operations of cooperatives. The National Association is trying to resolve this problem using mass media and explaining to the population their rights and obligations.
- Companies providing housing services want to increase their tariffs, set their conditions, provide service of poor quality, and to receive at the same time 100 percent payment.

### ***Lessons Learned***

Kazakhstan's housing reform — especially the experience of providing services through market-driven competition — can be applied to all CEE/NIS countries as the existing housing models are similar. For example, Russia has a plan for housing reform over seven years with a step-by-step reduction of subsidies.

In the implementation of housing reform, the following sectors have been involved in Kazakhstan

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for capital repairs, but so far, these remain promises

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the anti-monopoly committee, local governments, non-profit organizations (cooperatives), and private businesses. Most importantly, the majority of the population of Kazakhstan has been involved in the reform.

Cooperation between these sectors resulted in the establishment of similar housing services in cooperatives, training for cooperatives in operations and management, and protection of users' rights in the housing field.

The National Association coordinated the activity of cooperatives throughout Kazakhstan. The National Association believes the success of housing reform was due in large part to the fact that cooperatives take an active part in reforms together with local authorities, can influence the process of tariffs and price setting for municipal services, and have helped de-monopolize the housing sector.

All tariffs for housing services and utilities became more transparent. Regional cooperative associations obtained the right to send their representatives to meetings held by local government officials of provinces and cities and to governmental conferences concerning housing reforms. Members of the Government and state agencies participate in meetings of the Board of Directors of the National Association.

Future activities of the cooperatives and the National Association will be to improve property, accumulate means for future capital repair, and implement internal social programs such as support to needy families and establishment of children's clubs.

### ***Results and Achievements***

Because of residents' demand for housing services, cooperatives have added 30,000 new workers in jobs for maintenance, garbage collection, repair, and rehabilitation. The cooperatives themselves have hired managers and other administrative employees. Most of the cooperative managers are women.

The National Association believes that the needs will increase in the future as the quality and quantity of services provided in this important field are far from perfect. Besides the new jobs created in cooperatives and their businesses, other additional working places were created in private companies providing the same services such as removal of garbage, maintenance of engineering grids, repair-construction teams, and teams for installation of commercial metering devices.

One of the most important results is that local authorities increased their budgets up to 30 percent due to termination of subsidies for housing, housing services, and utilities. These cost savings resulted in increasing pensions and wages for municipal employees.

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*Example Atyrau city provides an example of cost savings to local governments As a result of implemented reforms and the reduction of subsidies for housing, the city saved approximately 100 million tenge, or 1/5 of the local budget*

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De-centralization of ownership of living facilities, including transferring control of engineering equipment and communications in the apartment buildings, allowed cooperatives to resolve problems of maintaining and operating living facilities Competition is developing, and it has resulted in reduction of service prices and in an increase of service quality It also helped to develop competition among specialized companies (those that existed before and those newly established) and among highly-skilled specialists

To sum up the results

- Cooperatives' use of competitive bidding practices led to 1) increased competition between companies (state-owned and private) providing housing services, 2) lower prices, 3) better services, and 4) more companies created to provide these services
- Competition also led to the creation of new companies providing housing services Twenty percent of cooperatives have their own businesses that provide housing services
- Since privatization of housing, cooperatives themselves have added an additional 30,000 jobs
- Local governments saved as much as 30 percent of their budgets due to privatization of housing and reduction in expenditures for housing services and maintenance
- Residents' bills for housing services and utilities have decreased despite the loss of state subsidies

**COOPERATIVE HOUSING IN A MARKET ECONOMY, POLAND**

*Submitted By  
Aguirre International  
January, 1999*

## COOPERATIVE HOUSING IN A MARKET ECONOMY, POLAND<sup>1</sup>

A cooperative housing model, developed by the Cooperative Housing Foundation through a contract with USAID, was implemented in 32 Polish cities. The model uses trained AWIMs (a Polish acronym for Agencies to Support Housing Initiatives), non-governmental organizations tasked to develop apartments or single-family homes in the community and other agreed housing-related issues. AWIMs serve as non-profit developers and work together with a coalition of community partners — local government, banks, and families in need of housing — to design and implement new housing.

The cooperative housing model includes two primary activities:

- Training and capacity building. AWIM staff members, local government officials, and cooperative members participated in workshops and seminars on cooperative development. Training topics included housing project organization and planning, democratic small cooperative formation and operation, project financing, land acquisition process, bidding, contractor selection and negotiations, construction process management and oversight, and internal capacity development and business planning.
- Collaboration between local government, private investors, the construction industry, and housing finance organizations. AWIMs acted as “go-betweens” and facilitators of new housing projects, working with all groups involved to implement the housing project.

Each AWIM is an economically self-sufficient small business that provides professional housing services to cooperatives. AWIMs have contractual arrangements with cooperative members and charge fees for services to those members, as agreed. AWIMs charge an average of three to five percent of the cost of the housing as compared to an average of 30 percent for private developers. One hundred percent of the cost of the housing is paid for by cooperative members (no assistance is received from governmental or international donor sources).

By December, 1996, 760 new housing units had been developed by AWIMs throughout Poland. CHF estimates that AWIM-developed housing has led to thirty percent cost savings to local governments over non-cooperative housing. Cost savings for local governments include 1) the cost of the housing itself, 2) maintenance costs, and 3) additional property taxes that can be charged on the new housing.

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<sup>1</sup>This summary was taken from project documents describing the project, “Strengthening Decentralized Market-Oriented Housing Delivery Systems through NGOs” and through personal interviews with Judith Hermanson, Vice President, Barbara Czachorska-Jones, Senior Housing Advisor for Europe, and Michael Hornblow, Special Assistant, Cooperative Housing Foundation, August 13, 1998.

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Building private housing has eased the housing shortage in Poland. Building has also led to new construction jobs, plus jobs in maintenance, building supplies, furnishings, and other housing-related businesses. For example, stores selling household goods are cropping up throughout Poland — stores that did not exist prior to the housing boom.

For example, in the city of Bialsko-Biala, the AWIM will employ 50 persons full-time throughout 1997, 1998, and 1999 in construction and infrastructure jobs, while building 110 single family homes.

**The Role of Training in Supporting Social Services Selected Success Stories**

*Submitted by  
Aguirre International  
January, 1999*

## VI The Role of Training In Supporting Social Services Selected Success Stories

Many professionals responsible for social sector reform received USAID sponsored in the U S The training, of whatever duration or content, exposures participants to the U S business and socio-economic culture and lifestyle This western culture, with fundamental roots in a democratic market economy, offered the participants from CEE and NIS countries insights into different approaches and possibilities for their own work Exposure to Americans as a people was also important for facilitating international business and professional relations Participants saw and assessed different ways of looking at problems and of approaching solutions to common problems

This broad exposure to new ideas and approaches had a direct impact in helping participants break free from the group thinking of decades of isolation and accept that new ways are possible To actually see different approaches working in the U S had a profound impact on people's attitudes and motivation

The specific utilization and impact of training also varied considerably among programs In general, the shorter, overview kinds of training provided a general understanding of U S systems When linked to either follow-on training, to in-country support from technical advisors, or to on-going links with the U S training institutions, this kind of training was a catalyst for action

NGOs, non-profit organizations, social service groups, and in some cases municipal governments were especially able to make immediate use of the training in their work Often just a handful of individuals make all-important decisions and usually do most of the work The key issues facing many of these groups were not highly technical, but rather were related to management or general activities such as fundraising, public relations, or kinds of services For these kinds of programs, substantial benefits were derived simply by exposure to innovative programs of others in the same field and relatively short discussions with colleagues about how they respond to similar challenges

approach to training For this kind of program, the broad exposure of as many people in the field as possible is needed to create a critical mass of voices in the medical profession with a new vision of how it can be Social change will come with these voices are numerous enough and articulate enough to begin to change social and professional attitudes and overcome skeptics

In terms of direct application of knowledge and ideas gained in training programs, a few individuals showed unusual ability to create new activities or organizations and actively promote change despite significant obstacles

Following are four examples of successful application of training throughout the region Additional cases are found at <http://www.enttraining.net> and <http://www.socialsector.net>

## **Innovative Training Improves Albania's NGO Sector**

In March 1997, trainers of Non-Governmental Organization (NGO) management attended a PTPE training program. The program not only provided the Albanian NGO sector with capable individual trainers, it has also led to the strengthening of an NGO training institution in Albania. The training, designed and delivered by CHP International in Chicago, provided numerous field visits and job-shadowing opportunities for the Albanian trainers to observe first hand techniques for everything from NGO fund-raising and community needs assessment to recruitment and motivation of volunteers.

### ***Individual Trainee Performance Improvement***

Anila Vendreshi, who is now managing her own training organization called DeMeTra, reported that "Everything I learned and heard (in the US-based training program) is helping for the new work." On an *individual level*, Ms. Vendreshi was able to perfect her training and coaching technique and now employs small training groups which results in more interactive training. In a recent initiative to discover the goals of professional Albanians, Ms. Vendreshi used the technique by creating a focus group of business people to reach a group consensus.

### ***Organizational Performance Improvement***

Ms. Vendreshi is also applying what she learned in the US to *re-shape her organization*. For example,

- She incorporated new ways to facilitate staff meetings by using techniques she learned in training to ensure that discussions always lead to solutions with a person responsible for action.
- She employs a new management style for delegating responsibility and alleviating staff problems. "Now I see the need to make DeMeTra an open instead of closed organization," she explains.

With these new insights, she has received new funding to expand DeMeTra. The expansion will allow DeMeTra to serve as a model of sound growth and effective NGO management. Eliana Xhani, another participant in the training program has joined DeMeTra, volunteering her time to train others. Thanks in part to this training, DeMeTra will make a significant contribution to the sustainability of USAID's efforts to encourage citizens to participate in the decision-making process through their involvement in an NGO of their choice.

### ***Performance Improvement in the NGO Sector***

Anila and her colleagues at DeMeTra have reached beyond their own organization to improve the quality of training in the *NGO sector* by training more than 10 NGOs in NGO and project management, again, drawing heavily from her training in the US. The NGO sector is also

benefitting from the training through the efforts of a third participant in the program

Juliana Hoxha is more confident and enthusiastic about taking on training tasks in her work at the USAID-funded Democracy Network Project, a project which supports NGOs in Albania. Her American project director used words like "amazing" to describe the difference she has observed since Ms. Hoxha's return. The project director also reported that Ms. Hoxha is now comfortable using new information to create a training session, and she has contributed several excellent ideas for their project. "The vision of volunteerism", says her director, is an essential ingredient that all those who participated in the US training came back with.

## **New Legislation Opens Alternative Care for the Elderly in Croatia**

The head of the Department of Social Welfare in the Ministry of Labor and Social Welfare in Croatia participated in a USAID training program to improve health care for the elderly in Croatia. The program was sponsored by the College of Public Health at the University of South Florida.

Croatia lacked non-institutional means for providing social care for the elderly. Previous laws addressing elderly care allowed only the state to operate homes for the elderly, eliminating any role for non-governmental organizations to provide such services to the elderly.

The main objective of the program on social care of the elderly was to introduce participants to the various options for elder care available in the U.S. Participants were able to explore such options as nursing and at-home family care alternatives. In addition, the trainees witnessed first-hand various roles non-governmental organizations play in the care of the elderly in the U.S.

During the training program, participants traveled to different nursing homes, saw various at-home care facilities, and met several non-governmental organizations that provide a wide range of services for elder care that are offered by private and public institutions.

Upon returning home, Mrs. Balaband coordinated and chaired a Ministry Working Group of twelve professionals. The group worked to draft a new law which would modify Croatian laws regarding the care of the elderly. The law was passed through the Croatian Parliament without a single opposing vote. This new law provides a greater number of options for the elderly, it allows private persons to open homes for the elderly (previously only state institutions were permitted), gives private persons the option to open centers that provide at-home care, and provides non-governmental organizations the ability to offer a wide range of services for elderly care.

The new law has been well received in Croatia, and Mrs. Balaband stated that the success of this law is in large part due to her participation in the USAID-sponsored training program. The program gave her in-depth knowledge of various elderly care options in the U.S., which she applied to the social care needs in Croatia. With the information she gained in the U.S., she was able to successfully modify Croatian laws regarding elderly care.

Now that the law has passed and non-governmental organizations play a large role in providing elderly care, Mrs. Balaband expressed interest in further training that focuses upon the actual implementation process.

## **Fighting Drug Addiction in Slovakia**

In recent years drug addiction has surfaced as a serious problem in Slovakia. Teenagers are especially at risk to drug addiction, and currently represent the highest risk segment of the population. A large number of the teenaged drug addicts use heroin, a drug that tends to be popular among young adults in most societies, but is the drug of choice for young teenagers in Slovakia.

Centers for drug treatment and prevention exist, however, a more community-involved effort to combating the drug problem is necessary. The U.S. training program provided participants various options for implementing a plan of action that actively involves members of the community.

Recently, the Vice Director of the Zilina Out-Patient Care Center in Slovakia and four others participated in training on drug rehabilitation at the Greenfield Chemical Dependency Center in Jacksonville, Florida. The program consisted of several site visits to drug treatment centers and a short course at the Center's facility.

The training program introduced the participants to various drug facilities that offer preventative and treatment programs. The participants saw various models for actions that they could then take back to their home country and implement.

Dr. Chaban returned from his training with a specific plan of action. He organized an education campaign modeled on the DARE program that he observed during his U.S. training, which he says is critical to getting the message out to youngsters about the negative effects of drug usage. As a result of the new education campaign, students in Zilina at the secondary and university levels are participating in education and drug prevention programs for the first time ever. Former drug addicts and respected leaders of the community are carrying the message to students that drugs can ruin their lives.

Dr. Chaban viewed the drug addiction problem in Slovakia as "a plague that would drain his nation of its best minds for the next generation." He knew he had to take action, but until his involvement in the U.S. training program, he had only vague ideas of what needed to be done. The U.S. training program provided Dr. Chaban the opportunity to visit different drug treatment centers and become familiar with various education programs aimed at preventing drug addiction. He explained that it "wasn't until he traveled to the U.S. on a USAID-funded training program that he actually formulated a plan of action."

Despite implementing a successful education program in Zilina based on community involvement, Dr. Chaban continues to work tirelessly on multiple drug prevention projects. He is currently working with Zilina's local government officials to build a new out-patient clinic as well as an in-patient hospital that would house up to thirty addicts. At this time, Dr. Chaban feels that in-country training would be a great help and hopes to arrange for American experts to travel to Slovakia in order to train his colleagues.

Dr Chaban credits his involvement in the U S training program with helping him to actually formulate a specific action plan. Until his training, he had many ideas, but did not have the necessary knowledge and models to make these ideas a reality. Dr Chaban pointed out, the fight against drug addiction is a difficult one, but he credits his TRANSIT-Europe training program with having provided him "the necessary tools to make a victory possible."

## **Creating a New Substance Abuse Prevention Center in Tashkent**

In Uzbekistan, the President of the Anonymous Alcoholics Association participated in a USAID sponsored training program, NGO Management and Leadership in Washington, offered by Counterpart International

The Uzbek Anonymous Alcoholics Association raises the level of public recognition about the dangers associated with alcohol through an interactive and diverse outreach program similar to that of Alcoholics Anonymous International. The Azeri alcohol abuse prevention and control program organizes seminars and work groups, trains group leaders, provides counseling, and produces educational materials. The organization plans to expand its work by attracting and training more volunteer mentors, increasing its fundraising capacity, and developing new approaches to training seminars and counseling programs.

The NGO Management and Leadership course was a practical hands-on experience based on internships with U.S. NGOs working in different sectors and areas of society development. The program strengthened the individual leadership capacity of the participants through exposure to the function and operation of NGOs in the United States, enabling them to more effectively manage their own organizations' services and build coalitions among local NGOs. The participants came from a variety of different service and advocacy organizations, including agricultural associations, artisan groups, elderly and disabled population support agencies, unemployment programs, and women's and children's initiatives.

The Uzbek participant was placed with Castle Medical Center in Honolulu where she was given an opportunity to observe and get involved with the everyday operations of different units and departments. Upon the completion of her internship, she attended the Annual Alcoholics Anonymous Convention in Waikiki.

After her arrival in her hometown of Tashkent in Uzbekistan, Ms. Turgunova initiated a number of projects based on the information and the experience she brought from the United States. She conducted a training seminar for members and mentors of Anonymous Alcoholics Association where she presented the results of her U.S. study tour. She also submitted a proposal to the main training provider, a Central Asia branch of Counterpart International, on opening an Alcoholic Anonymous Education Center in Tashkent. She is currently working on the cooperative agreement between her internship host Castle Medical Center of Honolulu and her own organization to create a medical consultative center for alcoholics and drug addicts in Tashkent.

Ms. Turgunova effectively utilized professional contacts she established in the course of her training and mobilized her own organizational resources for implementing new programs in the field of substance abuse prevention in Tashkent, the Uzbek capital. The USAID-sponsored training proved to be highly effective in attaining one of its major goals — promoting and strengthening mutually beneficial relationships between the Central Asian NGOs and their professional counterparts in the US.