

Romania



Ministry of Public Health

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# **POLICY TOOLKIT: A GUIDE FOR THE DEVELOPMENT AND IMPLEMENTATION OF DECENTRALIZED HEALTH SECTOR POLICIES IN ROMANIA**

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# **ROMANIA HEALTH CARE REFORM PROGRAM**

## **Policy Toolkit: A Guide for the Development and Implementation of Decentralized Health Sector Policies in Romania**

*April, 2007*

**The Romania Health Care Reform Program (RHCRP) is a technical assistance program in support of the Ministry of Public Health In Romania. The RHCRP is managed by University Research Co., LLC (URC) in collaboration with Health Strategies International, LLC (HSI). The program is financed by the United States Agency for International Development under contract GHS-I-00-03-00029-00.**

### **DISCLAIMER:**

The views expressed in this manual do not necessarily reflect the views of the United States Agency for International Development, the United States Government, or the Government of Romania.

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## LIST OF ACRONYMS

DPA	District Public Health Authorities
EU	European Union
GD	Government Decision
HI	Health Insurance
HP	Health Policy
HS	Healthcare System
HSR	Health Sector Reform
LC	Local Community
M&E	Monitoring and Evaluation
MPH	Ministry of Public Health
NGO	Non-Governmental Organization
PP	Public Policy
PPC	Public Policy Cycle
PPU	Public Policy Unit
USAID	United States Agency for International Development
WHO	World Health Organization

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## Executive Summary

The Policy Toolkit was developed by the Romanian Health Care Reform Project (RHCRP), a technical assistance program to support the Government of Romania's Ministry of Public Health. The project, funded by the United States Agency for International Development (USAID), is committed to building the capacity of Romanian health professionals at the decentralized levels to become highly skilled, empowered participants in defining health service priorities, and formulating policies to support local needs. The Toolkit is a culmination of implementing training programs and pilot policymaking processes in three counties. Throughout, the Toolkit has evolved, been refined and adapted at all levels. We believe the Toolkit, along with training curricula, represents a unique step toward empowering local stakeholders to achieve the goals of health sector reform through the decentralization of the health system and the empowerment of local health authorities and communities.

The Toolkit has been developed during a transitional period for the Romanian health sector that offers significant opportunity to stakeholders at all levels. Health sector reforms and EU accession mandates have focused on decentralization of the health system by increasing local public authority and the roles and attributions of the community. A key example is the Government Decision (GD No. 775/2005) that provides an unprecedented opportunity for civil society to have a voice in policy making. However, with opportunity come challenges. This Toolkit targets a key challenge of health sector reform -- "insufficiently developed institutional capacity at the local level". The Toolkit is an instrument to support health policy capacity building for key stakeholders in order to ensure HSR implementation and health care improvement.

The driving principle in developing the Toolkit was the team's commitment to a truly integrated policy making process that empowers actors from all sectors and levels. At the central level, the team collaborated with educational and health institutions such as the Public Health Department of Bucharest Medical University and the National Institute of Administration. The team worked closely with the MPH and the private sector promoting stronger stakeholder synergies. Inter-sectoral Policy Working Groups (IPWG) were formed at the national and, more importantly, at the county level. The IPWGs now meet routinely addressing reform priority issues that cut across programmatic areas including private health insurance, national health programs, hospitals, and, primary health and community care. Within the three pilot counties, various institutions such as the Prefect Office, Mayor's House, Social Departments at the local Level, and Public Health Authorities have become partners in improving health care in the community.

The Toolkit provides a user-friendly guide offering a step-by-step description of the formulation and implementation of health policies and programs. Chapter 1 presents a framework describing each step in the policy-making cycle from problem identification to evaluation. Chapters 2 and 3 present these stages in detail, starting with the identification process and priority setting, defining and choosing measurable options to achieve best results in terms of cost-effectiveness, available resources, etc. Chapter 4 is a step-by-step guide to transposing policies into operation plans and action, steps for developing effective systems for M&E, the process and impact of health policy as well as guidelines for resource mobilization through project proposal writing. The Toolkit incorporates real-life examples and can be used as a practical text or self training instrument. It is the hope of the entire RHCRP Team that this Toolkit, accompanied by ongoing training and technical support, will provide an important instrument in the empowerment of counties and local communities in Romania.

## CHAPTER 1: GENERAL FRAMEWORK FOR HEALTH POLICIES

### **Chapter 1 provides:**

- General information about the Toolkit;
- The structure of the Toolkit;
- Toolkit principles;
- Toolkit audience;
- The conceptual framework: Health systems, policy cycle, critical processes
- The Context, Processes and Current trends of Health Sector Reform
- Background including Changes, Challenges and Opportunities in formulating policies

### ***1.1. Introduction***

The present toolkit was written by a team of Romanian experts involved in the healthcare system reform process, within the project called “The Romanian Healthcare Reform”, financed by USAID. The Toolkit is meant to support the Ministry of Public Health’s mission dedicated to upholding and improving the health system in Romania, and building policy capacity at decentralized levels.

The Toolkit’s objective is to serve as a practical guide (toolkit) to the Romanian "actors" involved in the preparation, implementation and evaluation of decentralized healthcare policies, by providing them with a set of specific instruments and techniques. It is meant to help them understand healthcare system reform goals and processes, and to develop the skills necessary for the new responsibilities they will assume in the decentralization process. Each chapter of the Toolkit deals with a specific stage in the development or implementation of health policies, and provides real examples and case studies taken from the Romanian health system. This toolkit can be used by experts and stakeholders from all sectors and levels of the health system and by other organizations or individuals from communities that are concerned with health issues.

The Toolkit has been organised to provide a comprehensive guide to policy making and implementation, but can also be used as a reference guide with discrete chapters that can be applied individually.

## ***1.2. The Structure of the Toolkit***

***Chapter 1: General Framework for Health Policies (HP)***: This chapter provides an overview and conceptual framework as well as the principles underlying the Toolkit. It provides a description of the process whereby a HP is being developed. The following chapters describe the specific steps in the development of a HP, and provide practical examples about the way in which the respective techniques can be used in real life. The readers of the guide are recommended to examine such examples in a critical manner and then transpose them at a local level. Chapters 2 through 4 present these stages in detail, as follows:

### ***Chapter 2: Problem Formulation; Health Status and Needs Assessment; Priority Setting Process***

HP may have multiple objectives, but such objectives must be ranked according to the importance they have for the community, so that the resources required to meet the most critical needs can be mobilized. Chapter 2 includes an overview of the methods for the identification of healthcare needs and provides a step-by-step guide for the setting of priorities.

### ***Chapter 3: Policy alternatives: Health policy development and selection***

Once the priority needs are established, one must identify and examine the options for meeting these needs based on several explicit criteria. Chapter 3 provides a detailed description of the process of defining and choosing measurable options for addressing priority needs that will achieve best results based on criteria including cost-effectiveness, available resources, sustainability, and feasibility,

### ***Chapter 4: Policy Implementation and resource mobilization***

Once the most cost-effective option is identified, the policy is more precisely defined by describing measurable goals and objectives including a description of how objectives will be monitored to track success. Chapter 4 gives detailed steps to be taken in the formulation of a HP and a step-by-step guide to transposing policies into operational plans and action, steps for developing effective systems for M&E, the process and impact of HP as well as guidelines for resource mobilization through project proposal writing. Through a systematic tracking of policy implementation processes, outputs and results, decision-makers can proactively identify problems and new opportunities and make necessary adjustments to improve the policy implementation process in the future.

### ***1.3. The principles underlying the development of the Toolkit***

The Toolkit provides a practical working instrument to assist local decision-makers in the formulation and implementation of HP. The following principles have underlined the development of the Toolkit:

- The Toolkit addresses the interdisciplinary and inter-sectoral teams of health policy decision makers and promoters at the local level. In other words it is useful to all actors and stakeholders involved in a promoting, formulating or implementing a HP.
- The Toolkit is user-friendly and provides a step-by-step description of the formulation and implementation of HP.
- The toolkit incorporates real-life examples and provides support for the acquisition of theoretical and practical skills related to the formulation and implementation of HP.
- The toolkit promotes improved partner and inter-sectoral collaboration in identifying cost-effective, sustainable solutions to HSR in Romania.

### ***1.4. Target audience for the Toolkit***

The target audience includes cross-disciplinary and cross-sectoral teams of local level decision-makers and HP supporters. This includes stakeholders outside the health system who may occasionally support the formulation or implementation of HP. It is targeted at all those involved in adopting or influencing public health decisions at local, county or regional level. This may include partners from government institutions, NGOs, and healthcare service providers or from the civil society. Examples include:

- **Representatives of local or county councils, representatives of PHA or HI departments at the county level:** The Toolkit provides a set of practical tools available for the formulation and implementation of public policies that fit the specific needs of local communities, for the selection of fields of intervention and healthcare programmes and for the development of integrated models dedicated to the provision of medical and social services.

- **Professionals from the healthcare system:** Providers may be most affected by health policy and programmes; hence, they must become informed, empowered advocates in each stage of policy formulation and implementation.–The Toolkit will supply them with information about the way in which they can become active participants in the healthcare system reform process.
  
- **Representatives of NGOs and other donors:** The Toolkit will be useful to NGOs and donors for promoting empowered, systematic donor resource allocation decision-making at local levels.
  
- **Members of the local community:** The Toolkit can inform community members, who best understand local health needs, on effective methods for having their voices heard and advocating for policies and programs that reflect priority health status burden.

## ***1.5. Conceptual framework***

### **1.5.1. Healthcare systems – goals and working principles**

When developing health sector policies, it is important to understand and consider all components of the healthcare system and formulate comprehensive solutions to health needs. Policies formulated in isolation are typically ineffective. In keeping with the WHO definition, the health system is made up of the totality of actors (i.e. doctors, patients, regulators, financers of care), institutions (i.e. health clinics, hospitals, research institutions), and resources (public, private and donor) that are involved in producing health actions [3]. The main goals of a health system are good health, responsiveness to the population’s expectations and fairness of financial contribution [3].

#### **The basic roles of a healthcare system are focused on:**

- providing all types of health services;
- mobilization and allocation of funds designated for health;
- production of health resources (health facilities, medical equipments, drugs);
- training of health staff;
- encouraging research and development;
- ensuring management of health and health resources through strategic planning,

The health system, based on the following principles, **equity, universal access, non-discrimination, quality of care, and efficiency**, is a very complex and important component of the overall governing system. It is a great consumer of resources and employs a high percentage of the labor force. Health-related problems often catch the public attention in terms of affordability, costs or quality of services. It is also extremely inter-related with other sectors that are impacted by health policies. Health policy makers must thus ensure that the consequences of policies on all stakeholders are proactively measured and taken into account.

**Other factors that impact health policies:**

- The physical environment – pollution, water quality, air quality, etc.
- The social environment – unemployment, social stability, people living in poverty, etc.
- The type of economy – standard of living, economic development, economic stability, etc.
- The educational system – level of school enrolment, level of literacy.

### 1.5.2. Defining “policy”

In applying the Toolkit, it is important that the user have a clear understanding of the term “policy”. Throughout the guide we will define policy as:

- An understanding or consensus over certain measures that must be adopted in order to generate the expected result or change;
- An agreement over certain goals and objectives, over the priorities attached to such objectives and over the lines of action that will make them a reality.

**Health policies** have a bearing on institutions, organizations, services and financial issues that make up the healthcare system. They are **not only confined to healthcare services as such, but also include actions, or action intentions of any public or private organizations that have an impact on health [6]**.

The policy making process is one whereby governments transpose their political vision into programmes and actions meant to generate changes in the real world. In the present guide we look at policy as a means to create and implement programmes aimed at improving access to quality health

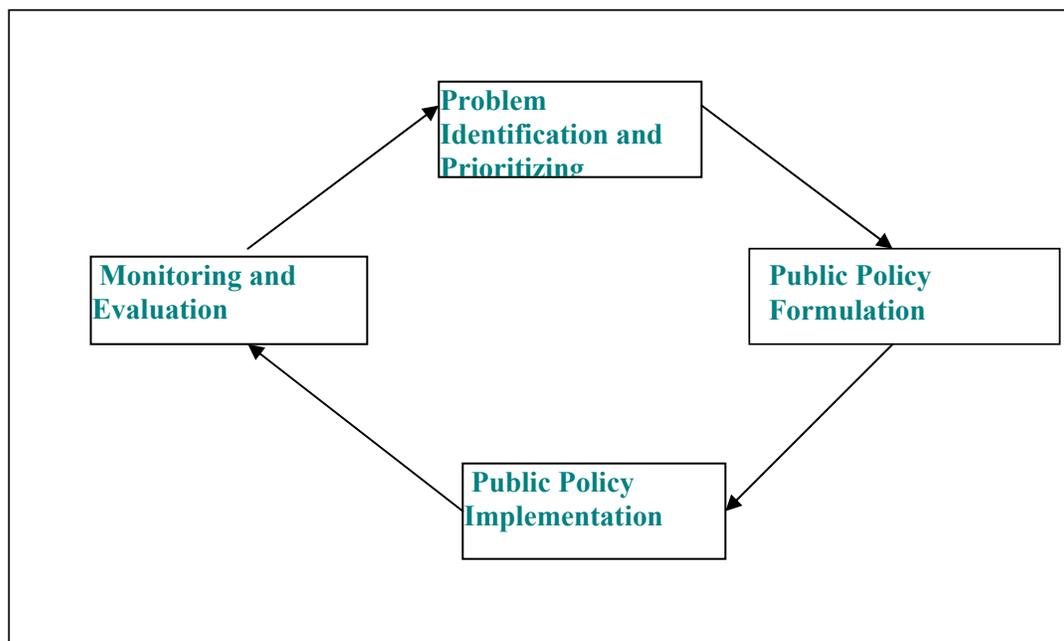
services delivery. Policies can be designed to focus on various healthcare issues, from prevention to treatment or infrastructure. Moreover, such policies must serve as a guide to healthcare specialists, donors, and international organizations, in order to be pursued when attempts are made to restructure and improve the health system.

### 1.5.3. The public policy cycle (PPC)

The following is a general framework that illustrates the highly complex process of policy development. It identifies several stages of PPC including:

- Identifying and prioritizing the problems;
- Identifying alternatives and selecting the most adequate solution;
- Implementing public policy;
- Monitoring and evaluating public policy.

Fig 1. The public policy cycle



#### A. Problem Identification and Prioritizing

**Problem identification and prioritizing** will be presented in Chapter 2. Although it seems to be an obvious step, there are many examples of healthcare system reforms in which their goals and objectives have not been well defined. This may generate confusion in the subsequent steps of the policy formulation and implementation processes. This stage consists in identification of health status

indicators that are abnormal, different compared to the standards, or considered not to meet community needs. Quantitative and qualitative methods are used to identify these differences. Next, the indicators, or health status problems, are judged upon their importance for the community using general or specific methods of prioritization. An important step to take in this stage is to distinguish the causes by consequences and to identify the determinants of the causes. A correct understanding of the causes and a definition of concise, measurable targets and expected outcomes are of crucial significance in the future stages of **formulation** and **implementation** of a health policy in order to gain the support of those involved in the process and to prove its success.

## **B. Public Policy Formulation**

After defining the health problem, the policy decision-making team must define a possible plan to solve it. This plan is in fact **the policy document**. It is developed through a specific analysis that should answer the following questions:

- What are the possible alternatives to solve the problem?
- Are these alternatives realistic, feasible and accepted by stakeholders, and the community?
- What is the social, economical and environmental impact of each alternative?
- What is the most appropriate alternative to solve the problem?

After the policy decision-making team answers the questions above, they may begin to prepare the policy document, passing through the following stages:

- Formulate the technical contents of the public policy (see chapter 3);
- Seek the help of people with technical expertise, in order to present in detail the goals and objectives of the policy (see chapter 4);
- Define an operational programme framework (see chapter 4)
- Assess the necessary resources and current/projected resource envelope;
- Organize a consultation process with the main actors influenced by the health policy;
- Encourage important people and groups to support the respective policy (especially when the efforts of the healthcare reform are underpinned by several external financiers or international financial institutions).

### **C. Public Policy Implementation**

This is the most important step of the process that brings together all the previous steps: problem identification, policy formulation, gaining support of key actors in the system and resource mobilization. In this stage, the actors must stay in close touch, to make sure that each system entity provides empowered input. Likewise, it is very likely that conflicts will appear in this stage and they must be identified and negotiated. At this point, the policy feasibility and sustainability also become apparent.

Implementing effective health policies requires sustained financial, technical and human resources. As will be discussed in chapter 4, it is critical that HP makers at decentralized levels determine projected costs of proposed policies, determine how resources will be mobilized, and quantify projected resource shortfalls. If resources are determined to be inaccessible or unavailable, the policy maker must establish plans to mobilize sufficient support.

The provision of such resources is more than an internal management task of adequate budgeting and workflow programming. A public policy promoter must exercise his/her managerial spirit in:

- Encouraging the parties concerned to lobby in order to gather resources;
- Creating performance-related incentives in order to use the existing resources efficiently or to develop new resources;
- Generating and promoting successes in order to ensure a constant flow of resources.

### **D. Monitoring and Evaluation (M&E)**

The monitoring and evaluation of the policy process starts early in the formulation stage, with clear, measurable objectives for the policy. This should include indicators for tracking the added value and the effectiveness of the implemented policy. It may last for months or years after the conclusion of the implementation process as it tracks the outcome effects of the implemented policy. The information collected in the monitoring and evaluation stage is useful both for the continuation of the respective policy implementation and for safeguarding its sustainability. Such information shows whether the continuation of interventions is still useful, whether they have reached their goal and whether they had the predicted impact. Through the examination of the generated results and the problems and changes which have occurred in the implementation process, the actors involved in the reform process can learn

how to improve its implementation in the long run. In Chapter 4 you will find answers to why and how to provide ongoing, timely monitoring of the process.

#### **1.5.4. Critical processes in the development and implementation of a Health Policy**

The following components of the policymaking process could be key to determining the success or the failure of a health policy:

- **Examination of the causes underlying the problems:** the causes of the problems must be well examined and presented in a policy recommendation. A particular emphasis must be placed on the main levers for the healthcare system regulation mechanism, such as, financing, payment, organization and regulation. This scrutiny must be designed on the basis of the historical background and the key aspects which have a bearing on the problem. The knowledge of the problems' substance will enable policy decision-makers to choose and to rank specific interventions for the problems they wish to address.
  
- **Plan of action and organizational restructuring:** After the formulation of the policies, the next step is to develop the implementation scheme for the reform and organizational restructuring measures (see chapter 4). Having a coherent plan of action will promote efficient implementation of the formulated policy. In this particular stage one must examine all the implementation options to determine which is the most cost-effective. Once the plan of action is defined, a consensus must be reached to implement the policy option with other actors from the external environment, involved or influenced by the planned reform.
  
- **Integration with other actors involved/influenced by the planned reform:** In order to safeguard the coherence and the sustainability of the policy measures, those in charge of its planning must involve all the parties concerned. Such an integrated approach implies making dialogue easier between the parties concerned, planning meetings, consultation and negotiation. The role of each actor in the policymaking process must be determined clearly, in order to facilitate cooperation and avoid duplication. Chapter 3 will further define how policy makers must carry out stakeholder analysis to identify key policy "champions" as well as stakeholders that are likely to block or sabotage policies. Subsequently, plans to win over all stakeholders must be implemented.

- **Resource mobilization:** No change can be achieved without adequate funding; therefore, it is extremely important for those in charge of the policy formulation to collaborate closely with governmental institutions and other donors to promote sustainable resource mobilization. In many cases, the success of the policy is proportional to the allocated financial resources.

## ***1.6. HSR in Romania: Context, Processes and Current trends***

### **Context**

Before the 1990s, the health system was a centralized, state-run system. Health was considered a free good, accessed by everyone, without specific responsibilities or roles, and with medical services organized on territoriality bases. Generally, health policies were planned at the central level by the government or the ministries with influence from donors or politicians and with little input from constituents or beneficiaries of services. After the 1990s, HSR was implemented albeit significantly later than other sectors. The key HSR goals and objectives were targeted toward improving the delivery of healthcare services, the decision-making process and cost-containment within the healthcare system. Special importance was attached to raising public awareness about the significance of health, health education, health promotion and disease prevention. Romanian HSR has equally pursued the increased role of primary care and special emphasis on providing care to vulnerable groups (women, children, teenagers, and the elderly).

### **Processes**

A key goal of HSR in Romania has been to increase risk sharing and mobilization of private financing. Translating this goal into measurable objectives within the Romanian context led to the introduction of a social health insurance system aimed at providing an adequate level of financing as well as transparency in the allocation of resources and the development of contract-based relations and competition in the provision of services. This change went hand in hand with similar HSRs introduced in neighbouring countries.

A key element of the Social Insurance Scheme is the contractual relationship between the health insurance houses and service providers, which functions as follows:

- 1) The patient became the basic contributor to the financing of the health system with a compulsory payment as a percent of total revenue. For this reason, the level of information and requirements mandated for the system increased.

2) The National Health Insurance House, as a payer, became responsible for health services coverage and quality, establishing a payment relationship with the providers. Although the NHIH had started as a “reactive reimbursing”, the latest policy shifts within the MoH have enabled a discrete move towards a new paradigm of a “proactive purchaser”.

3) Healthcare providers could choose to practice as employees of the state (in hospitals or some ambulatory facilities) or as owners of their offices. All general practitioners became private family doctors.

4) The Ministry of Health maintained its roles of strategic planning, regulating and planning of public health services.

## **Current trends**

### ***Under-funded Health Care System***

A problem that concerns the initiators of the reform is its under-funding. The main financing source for the system is the National Unique Health Insurance Fund, composed of quasi-equal contributions from employers and employees, and covers approximately 80% of the health public expenditure. Preventive services are financed by the state budget through national health programmes. The level of the contribution to the system (both of the employer and the employee) has varied, and specified categories of population are exempt from the contribution payment. As compared to other European countries, the public expenditure on health in Romania is considerably smaller (in 2002 the health expenditure in Romania was 4.2% of the GDP compared to 7% and 8% for Hungary and Slovenia, respectively).

### ***Underlining equity***

Major issues in the past and also in the present are the urban-rural access discrepancies. They are considerable in terms of infrastructure and also medical staff. There are isolated rural areas where the population has no access to dispensaries for primary care services, or where such dispensaries exist but have no permanent staff (doctors) and only rudimentary equipment. Even more serious is the fact that it is in these very areas where the poor or elderly population is concentrated – hence, with greater healthcare needs. At present, there are no policies to attract doctors to these underprivileged areas and the issue of having a sufficient number of family physicians in rural areas is still one of the most important.

A **key goal** of HSR in Romania has been to improve healthcare financing including allocative efficiency and improved resource mobilization. Several strategies for mobilizing increased health financing include:

- increasing the financing for health from the state budget;
- involving the local community in health financing;
- introducing private health insurance schemes;
- restricting the categories exempt from the payment of the contribution to the social health insurance fund.

An improvement of allocative efficiency is projected to be obtained by:

- funding basic services (i.e. PHC, emergency services, etc) on a population basis;
- reorienting the use of services to the primary and secondary level of care;
- developing alternative types of health services (e.g. home care);
- optimizing the management skills especially at hospital level;
- decentralizing health services in order to encourage the local communities to contribute to financing the healthcare system, which would enable them to take part in the decision-making process related to local healthcare activities.

## ***1.7. Changes, opportunities and obstacles in formulating and implementing Health Policies***

### **1.7.1. Government's recognition of need for Public Policy (PP)**

The need for systematized initiatives reached its peak with the passage of Government Decision (GD No. 775/2005 on the approval of the Regulation about procedures of PP formulation and implementation) which imposes in practice the PP formulation and implementation procedures at the central level. Such legislation does not exist in many countries. In places where the civil society had a louder voice, the capability to initiate PP from lower levels to the central level did not entail any regulations. In Romania the government has deemed it necessary to impose a formal framework for PP development and implementation.

Three major achievements were gained through this legislation:

1) A specialized structure – the Public Policy Unit (PPU) – charged with the provision of consultancy services to the specialized departments dealing with the development of PP proposals and their monitoring was set up in every central public authority.

- 2) All the pieces of legislation that are being initiated must rely on a PP. This approach is an official recognition of the need to develop coordinated and synergistic initiatives in political terms and it sets the foundation for a natural strategic planning process which underpins the progress of any society.
- 3) The general template of a PP was defined. All the PP's have a unitary structure, established by this regulation.

### **1.7.2. Decentralization**

One of the modern trends in the exercise of the governing, both at the national and international levels, is decentralization, i.e., the devolution of administrative and financial competences from the central government to the local government or to the private sector. In Romania, a piece of framework legislation on decentralization has been recently adopted. Based on this legislation the MPH has developed a decentralization strategy, dedicated to “the implementation of equal access of citizens to basic healthcare and an increase in the quality of living” .

The main objectives of the decentralization strategy are to [7]:

- Transfer health specific tasks and responsibilities from the MPH to regional authorities and the local government;
- Increase the role of county and local government in the development and implementation of public health policies and programmes to meet the specific needs of the local community;
- Decentralize hospital care and enhance the responsibility of local government towards citizens.

The main risks incurred by the implementation of this strategy are linked to the following elements:

- Insufficiently developed institutional capacity at local level;
- Inertia or lack of overall assumption of responsibilities;
- The lack of necessary supplies and equipment;
- The diminution of the response capacity from the central level, in case of need;
- The vulnerability of public policies according to the changing priorities of the political agenda.

### 1.7.3. Globalization

The World Health Organization defines globalization as an increase of connections and dependencies among countries and peoples, characterized by two major elements:

- Open borders and faster movement of goods, services, persons and ideas at the international level;
- Changes of political regimes and failure to facilitate such transformations [5].

The advantages of globalization are, generally speaking, economic growth, liberalization of trade, reduced transaction costs, increased transaction speed, removed restrictions on foreign investments, redistribution of power from inside countries towards international structures, favouring progress of technology and reducing the discrepancies among states, faster dissemination of political liberalism and greater support of human rights.

The risks of globalization are the diminution of national sovereignty and of the states' capacity to decide their own future, especially in economic terms, the increase of financial risks and discriminatory access to benefits, particularly for the poor countries, social and cultural changes that may influence lifestyle by an increased exposure to certain risk factors.

In Romania the EU accession is a particular case of globalization. HSR seems to be not very deeply connected with the globalization process, and although health is based on a subsidiary principle of the EU, there are some general tendencies that influence consumers, providers and the external environment, e.g.:

- General priorities of the Community Action Program for Public Health should be taken into consideration by all the EU member states;
- The free movement of health professionals opened a huge workforce-market and the Romanian Government is concerned about professional migration and is looking for ways to motivate and keep the best staff;
- The free movement of people in general raises problems of access to health services of the immigrants;
- Some public health problems have to be managed in a common way in all member states – for example the communicable diseases;
- There is a huge access to information and consumers become more and more demanding;

- Scientific and economic development open vast possibilities of diagnosis and treatment that raise problems of ethic, access, economic evaluation and cost control.

## ***1.8. Conclusion***

The Toolkit's objective is to serve as a practical guide for the Romanian "actors" involved in HSR formulation and implementation of adequate health policies. Each chapter deals with a specific stage in the development or implementation of health policies, providing real examples and case studies taken from the Romanian healthcare system. It can be used by experts and stakeholders from all sectors and levels of the healthcare system and also by other organizations or individuals from communities that are concerned about health issues (representatives of local or county councils, representatives of non-governmental organizations and other donors, members of the local community).

Chapter 1 provides a description of the process whereby a health policy is being developed. Chapter 2 includes an overview of the methods for the identification of healthcare needs and provides a step-by-step guide for the setting priorities. Chapter 3 describes the process of defining and choosing measurable health service options and priorities that will achieve best results based on criteria including cost, available resources, sustainability, feasibility, and cost-effectiveness. Chapter 4 gives detailed steps to be taken in the formulation of a health policy at decentralized levels and also in transposing formulated policies into operational plans and action.

The background and conceptual framework of the Toolkit refers to the main goals, roles and working principles of the healthcare system. An historical overview of the Romanian healthcare system is described together with the main objectives, challenges and shortfalls of HSR. The term health policy is defined and the legislative framework for public policies and the public policy cycle are underlined. At the end, possible opportunities and obstacles in reaching objectives are discussed in conjunction with the effects of decentralization and globalization processes. The subsequent framework for policy development presents methods and techniques. Use of these techniques will improve coherence between different initiated policies both through uniformity of grounding activities and through identifying the ways of involving and collaboration between public and governmental sector, health service providers, civil society, goods and service consumers, business environment, professional organizations, unions and employers.

## CHAPTER 2: PROBLEM FORMULATION, HEALTH STATUS AND NEEDS ASSESSMENT: PRIORITY SETTING PROCESS

### Chapter 2 provides information on:

- **Why** needs assessment is crucial
- **How** we assess needs and set priorities

### 2.1 Introduction

#### 2.1.1 Why do we need to establish the needs?

##### Why is needs assessment crucial?

- To provide evidence-based information in order to mobilize the required resources and to support political commitment in meeting the needs
- To support the priority setting process
- To ensure targeted interventions to meet the needs of the vulnerable sub-populations
- To guarantee that the decisions regarding the funding reflect the population's needs and not political pressure, pressure from certain funders or other groups
- To empower the local decision makers in establishing priority needs for specific services at that level
- To empower civil society and beneficiaries at the local level through better information in order to get them involved and to influence the priority setting process based on reliable and timely information
- To promote communication at the local level and work in multi-sectoral and multi-disciplinary teams for priority setting
- To make sure that all determinant factors that impact on health are considered in the priority setting process

#### 2.1.2 Actors who can be involved in needs assessments:

- Family doctors and general practitioners; Specialists from hospitals and specialized ambulatory facilities;
- Medical staff with secondary studies, service providers – community nurses and medical mediators (for Roma communities);
- Other categories of personnel working in medical institutions;
- Representatives of local public health authorities and social health insurance houses;
- Non-governmental organizations;

- Representatives of local councils and city halls.
- Representatives of service beneficiaries
- Other sectors with an impact on health

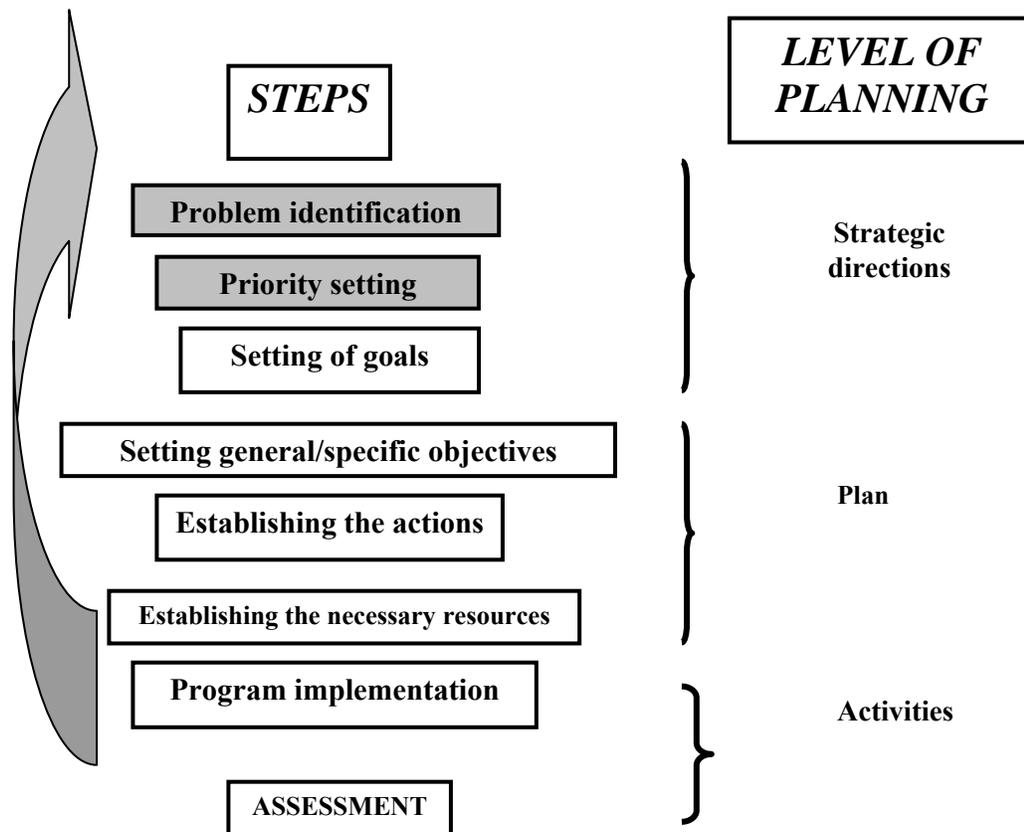
## 2.2 Conceptual framework

This section presents the conceptual framework used in the assessment of the population’s health and prioritized health service needs, together with definitions and a glossary of terms provided in the Annexes.

### 2.2.1 Main steps in planning

The steps to be followed are described in Figure 2.1 [1]. This chapter deals with the steps of carrying out a needs assessment/identification of health services problems, and priority setting, while subsequent steps are presented in the next chapters.

**Figure 2.1 Planning steps**



## 2.2.2. PROBLEM IDENTIFICATION

### 2.2.2.1 Potential approaches

There are three possible approaches to problem identification, each being based on an alternative resource (see Figure 2.2):

- the existing system of indicators (quantitative methods)
- special studies (quantitative methods)
- reaching a consensus (qualitative methods)

**Figure 2.2 Approaches to problem identification**

Approach	Methods	Necessary information	Data sources
<b>Based on the existing system of indicators (quantitative)</b>	<i>Socio-demographic</i> (associated with health status and resource use)	Population structure, age pyramid, birth rate, gross mortality rate, fertility rate, average income, poverty level/rate, unemployment rate, education level	<ul style="list-style-type: none"> <li>• National Information System – managed by the National Institute of Statistics and the local subordinated units – county directorates for statistics. The data is published in the <i>Romanian Statistical Yearbook</i></li> <li>• The information system managed by the National Center for Organization and Provision of the Public Health Information and IT System (CNOASIIDSP). An important institution is also the County Public Health Authority that collects, stores, processes and sends the data to CNOASIIDSP, where it is aggregated at national level. The data is published in the <i>Health Statistical Yearbook</i>.</li> </ul>

	<p><u>Health</u> (mortality, morbidity, risk factors and incapacity)</p>	<p>Gross and specific mortality rates, child mortality rate, life expectancy at birth and at certain ages, standardized mortality rate/ratio</p> <p>Incidence/prevalence rate, hospitalized morbidity</p> <p>Frequency of various risk factors, deaths attributable to certain risk factors, potential years of life lost because of certain risk factors DALY, QALY</p>	<p><i>Mortality</i> – taken from the death certificates from the County offices for Statistics, then aggregated at national level. Institution: The National Institute for Statistics</p> <p><i>Morbidity</i> – taken from various sources: national registries of certain diseases (cancer, diabetes), certain systems for monitoring communicable and non-communicable diseases, the health insurance system. Institutions: CNOASIIDSP, the National Health insurance House, the Center for Prevention and Control of Communicable Diseases</p> <p><i>Risk factors and summary indicators</i> – taken from special surveys conducted by various institutions in the country or in partnership at European level</p>
	<p><i>Use of health services</i></p>	<p>Number of visits to the doctor, surgery rates, number of medical tests (for instance, lab tests, X-rays etc.), number of referrals, hospitalization rate (number of discharges), average length of stay</p>	<p><i>Healthcare services</i> – taken especially from hospital level (DRG system) and from other healthcare providers. Institutions: National Health Insurance House, County Public Health Authority</p>
	<p><i>Resources</i></p>	<p>Number and types of healthcare units, population coverage with various types of professionals (medical doctors, nurses, dentists etc), health expenses</p>	<p>Taken from surveys conducted by the National Institute for Statistics and from current reporting from CNOASIIDSP</p>
<p><b>Based on special studies (quantitative)</b></p>	<p><i>Sampling</i></p>	<p>Interview survey (perception of the health status) Health status survey through medical exams</p>	<p><i>Prevalence surveys</i> – assess the prevalence at the moment of the interview (<i>Health Status Survey</i> conducted regularly by CNOASIIDSP) <i>Longitudinal Surveys</i> – monitor an ongoing phenomenon (<i>Household</i></p>

			Survey conducted annually by the National Institute of Statistics) <i>Health Status Survey through Interviews</i> – assesses the population’s perception on own status of health, survey to be conducted at the European Union level, based on a set of standardized questions developed by EUROSTAT. It shall be conducted by the National Institute of Statistics
<b>Based on reaching a consensus (qualitative)</b>	<i>Delphi Survey</i>	Assesses the opinion of experts on important community issues. It is based on a group judgment, even though the experts do not communicate directly among themselves. The experts answer a sequential number of questionnaires sent by mail until they reach an acceptable level of consensus.	
	<i>Nominal Group Technique</i>	See subchapter 2.3.1	
	<i>Brainwriting</i>	See subchapter 2.3.1	
	<i>Brainstorming</i>	Used especially to generate ideas. The experts are invited and encouraged to express original ideas.	
	<i>Community Forum</i>	See subchapter 2.3.1	
	<i>Key informant technique</i>	See subchapter 2.3.1	

### 2.2.2.2 Step by step in defining the problem, by using quantitative and qualitative approaches

The methods used in the following approaches are based on the system of existing indicators (quantitative methods) and on reaching consensus (qualitative methods). Similarly, when the population’s health status is assessed, a complex set of indicators must be used. Recently, the European Union and the World Health Organization have identified certain sets of indicators that have to be used

when assessing the population's health status. The purpose of introducing these indicators was to work on standardized case definitions, with standard calculation formulas, in order to provide data quality and protection.

### ***Step 1 Problem identification through quantitative methods***

#### *Analysis of health indicators*

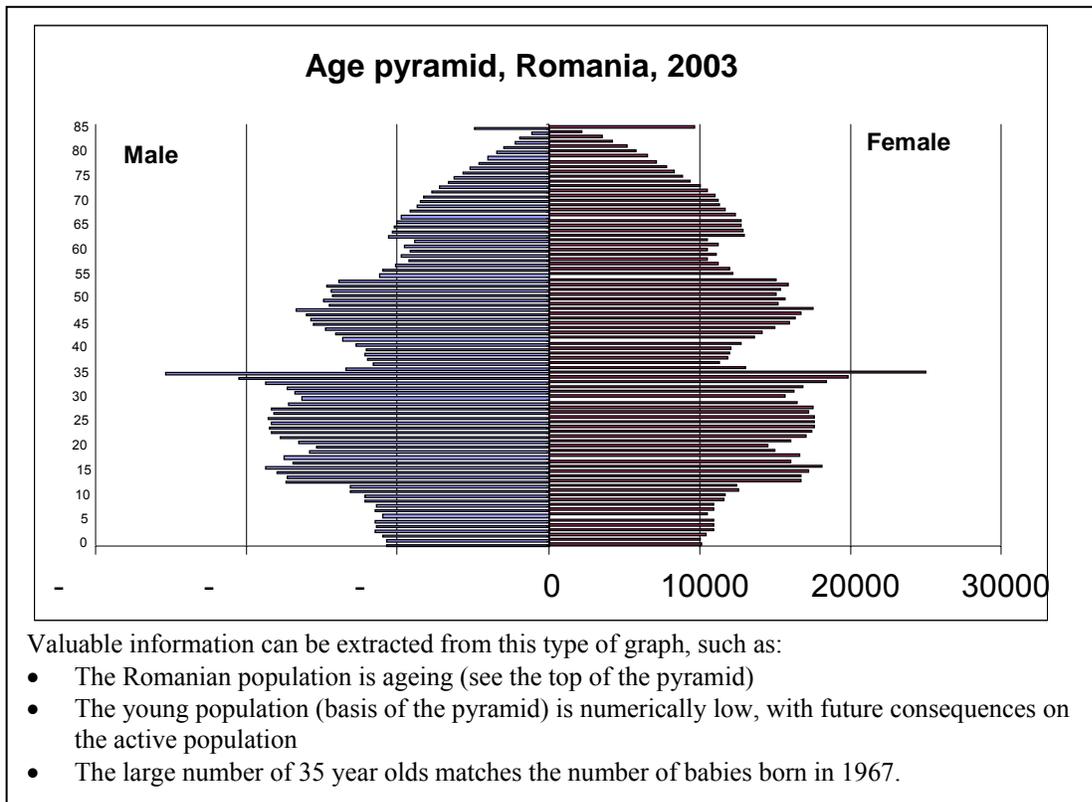
Usually, the quantitative methods do not produce new data, but capitalize on existing data.

The analysis of the level and evolution trends of specific indicators that provide a “snapshot” of a population's health status is the first step in identifying and prioritizing the health problems of a community. Annex 2.2 illustrates a short list of indicators for health status assessment, recommended by the European Commission (ECHI 2) that can be applied in this step.

The main groups of indicators that can be used are as follows:

- Socio-demographic and economic indicators (i.e. population age structure, etc)
- Disease-specific health status indicators (i.e rates of strokes in a population)
- Indicators for the use of health services (i.e. number of admissions per day)
- Resource indicators (number of human resources, number of health centers, number of health technologies, per population, etc).

In general, the analysis and reporting of indicators is conducted by using graphs and tables. An example of a graph used for analyzing socio-demographic indicators is the age pyramid, shown below. Such a graph can provide extremely useful information in assessing the needs of certain population categories. The data needed to build this graph can be found in the census data published by the National Institute of Statistics.



### *Assessing the Burden of Disease (BOD)*

Measuring and ranking the burden of specific diseases within a community is an important approach for identifying priority health services needs. A conclusive assessment of BOD provides a quantified overview and summary indicators of a population's health status.

**Definition:** The burden of disease is a complex indicator for health status assessment that considers both the impact of premature death and the consequences of diseases and accidents, as well as incapacity and disability.

The application of methods that measure BOD are useful for:

- Setting priorities for healthcare services provision and for research
- Identifying disadvantaged groups
- Assessing interventions
- Resource allocation.
- Methods that are most commonly used for the burden of disease assessment:
- Assessment of premature death (the technique of potential years of life lost-PYLL)
- DALY (disability adjusted life years)

### **Assessment of premature death**

*Definition* – by premature death we understand the loss of life before reaching a certain age; the age limit is set arbitrarily, depending on the mortality model. For Romania, the age is 65. In other countries with high life expectancy at birth, the age limit for premature death can be 70 or even 75. Usually, deaths between age 0 and 1 are not considered; only deaths between 1 and 64 years of age.

Premature death reflects the impact of the mortality phenomenon on the population of young children and adults.

*Necessary data* – distribution of deaths per age brackets (five years each), sex and causes of death.

*Method of calculation* – presented in annex.....

The main characteristics in the evolution of premature death in Romania are presented in annex 2.3

### **Disability Adjusted Life Years – DALY**

*Definition* – DALY's express the years of life lost through premature death together with the years of life lived with disabilities of a specified duration and severity. One DALY represents one year of healthy life lost.

*Necessary data* – for the calculation of DALY at county level, one needs:

- the distribution of deaths in a calendar year, per age brackets (five years each), except for the first age bracket (0 -<1, 1 – 4, 5 – 9, 10 – 14,.....85+), sex and diagnosis at death (ICD – 10) (from the IT department of the County Public Health Authority or the County Health Directorate)
- incapacity data included in the model reported by the Public Health Institute of Bucharest based on the methodology provided by the Representative Office of the World Bank in Romania (from 2000)

*Method of Calculation* – is complicated ; it can be obtained from the Institute of Public Health in Bucharest.

The main results for Romania and counties Bistrita Nasaud, Brasov and Suceava are presented in Annex 2.4

### ***Problem identification through qualitative methods***

#### ***The Nominal Group Technique***

This consensus technique, drafted by Delbecq and VandeVen [3], is aimed at applying standardized approaches to facilitate community participation in health status problem identification and problem prioritization. It is a process structured for an exchange of ideas, and it starts with an individual reflection exercise and ends with a community wide-vote.

The method includes 2 main steps after stating the discussion topic:

- Statement (nomination): each participant is asked to nominate a health status problem, after a period of individual reflection. Given that certain ideas may overlap or even duplicate, they shall be discussed and reformulated at group level until obtaining a clear list that covers all

participants' ideas. Following the discussions, the final list may include fewer ideas than the number of participants.

### **Example of using the Nominal Group Technique**

The discussed topic was: health issues at the level of Bistrita-Nasaud and Suceava counties. We organized 2 working groups with participants from the 2 counties (approximately 20 persons). The participants in both groups each nominated an important health issue. In case there were identical problems mentioned by 2 participants, the problem was selected only once. In case 2 or more problems partially overlapped, they were used to formulate one problem that encompassed all nominated ideas. The final list included only 14-15 problems. The final lists were presented in a plenary session and were written down on two pages of flipchart.

- Prioritization / individual vote: Each participant is asked to select from the final list 5-9 ideas that seem to be the most important, then rank them based on scores from 1 to 9 (9 for the most important one). It might be that some problems receive no points in the end. The points assigned for each problem are summed up, thus obtaining the final score. A final prioritization is reached. It can happen that 2 or more problems obtain the same score in the end, so a decision has to be made, by consensus, to select one of them.

Advantages of this method:

- It is applicable to complex decision-making processes
- Produces a large number of original ideas (given that they are nominated individually)

Disadvantages:

- Lack of precision (vague formulation might come up)
- Ideas receiving a small number of points (or even none) are rejected, even though they are innovative.

### **List of health problems identified in the county of Bistrita-Nasaud through the Nominal Group Technique**

- low access to medical-social services for the elderly (score=13)
- high incidence of diabetes (score =3)
- lack of prevention programs in rural areas (score =11)
- lack of information on drug use (score =6)
- lack of educational programs for health in the school curricula (score =4)
- lack of involvement of the local authorities in improving the population's health status (score =8)
- disparities regarding the access to medical services (score =15)
- lack of information on domestic violence (score =3)
- insufficient home care services, especially in rural areas (score =3)
- high incidence of birth defects (score =1)
- increase in the number of neglected children
- lack of specialists (score =2)
- integrating information from existing data sources (score =9)
- lack of communication with the population (score =13)

#### *Brainwriting*

This is also a technique of reaching consensus that is based on individual reflection but, unlike the nominal group technique, some starting ideas are presented at the beginning. It can be used for larger groups as well.

##### Steps to follow

- Stating the topic of discussion
- Establishing the group (6-8 persons)
- Presenting the starting ideas to the group on a flipchart or a screen
- Asking each participant to add their own ideas to the initial list
- Continue just like in the nominal group (plenary discussions and final vote)

The advantages and disadvantages are the same as for the nominal group.

#### *The key informant technique*

The key informants are persons who live or work in the community and know the community's health status problems in the relevant field.

The main element that ensures the method's success (and that depends on the study's coordinator) is the identification of the institutions and persons from the respective institutions who, through their role, can contribute to identifying and finding the appropriate health status solutions. The method itself does not lead to a consensus among the participants, because the participants do not meet each other. It only allows the setting up of a list of problems and needs.

Steps in carrying out the key informant technique:

- The policy making stakeholders appoint a representative “working team” to carry out face to face interviews with key health sector “actors” i.e. community leaders, providers, beneficiaries, to determine a preliminary list of health status priorities.
- Interviews must be conducted by the same interviewer and during the interview, the interviewer can only give explanations, not suggest answers.
- It is recommended, when meeting the informants, to tell them the topic to be discussed in order to give them time to reflect upon it
  - Duration of the interview 10 – 15 minutes
  - The interview should be held on neutral ground
  - The interview is confidential

Scope:

- Understanding / identifying the needs

Methods of use:

- Single or complementary after another survey / method (such as community forum, brainstorming).

Steps to follow:

- Establish the topic for the working group
- Identify the institutions / organizations that can contribute to solving the problem and list them
- Inform the identified institutions / organizations on the setting up of the working group
- Set the objectives
- Identify the potential key informants at the level of the institutions / organizations
- Select the key informants (10 – 15 persons) – can be randomly selected from the list
- Write the questionnaire / questions for the key informants to answer
- Organize individual meetings with each key informant and write down the answers
- Summarize the opinions.

Advantages:

- Provides a good needs assessment
- Easy to make
- Inexpensive.

Disadvantages:

- It is based on the individual perception of the problems
- The results depend very much on the ways of selecting the key informants.

Outcome – a list with the community needs identified by the group. An example on how to use the key informant technique is presented in annex 2.5.

*The community forum*

This is a setting open to all community members for needs identification and prioritization; all community members have free access. Each of them is considered a resource and encouraged to express their viewpoint.

Scope:

- Identification of needs
- Identification of problems
- Prioritization of problems.

Methods of use:

- Single or complementary, after a Delphi survey, a nominal group, a survey with key informants.

Steps to follow:

- Inform the community on the survey
- Identify the members of the working team
- Introduce the survey topic to the working team
- The survey shall be conducted on neutral ground, its coordinator being someone known to the community
- Duration: maximum 3 – 4 hours
- The participants express their opinion one at a time
- Limit participation to the discussions to 3 – 4 minutes
- Ideas are recorded as they come up
- After the forum, the participants shall receive a l
- List the identified problems / needs.

Advantages:

- Economic
- Easy to make
- Provides the possibility to participate to a large number of community representatives
- Allows both users and non-users of healthcare services to express their opinions
- Allows for the understanding of community needs as they are perceived by its members.

Disadvantages:

- Misrepresentations may come up because not all groups are represented
- Certain groups of interest may impose their viewpoint
- Community consultation may induce too great expectations for its members

Outcome – a list of needs identified by the group

### ***Step 3 Identifying problems related to the healthcare system and to resources***

*SWOT analysis:* “The SWOT analysis method is a planning tool with the main objective to assess the health sector strategic positioning of a community. It can be used to address the communities health problems in the context of its external environment. By external environment, we mean all external factors affecting the communities: geographical environment, legal, social and economical environment

Strengths and Weaknesses identify the internal environment of the organization and concern the current situation, while Opportunities and Threats represent the external environment and refer mainly to the future. The results of the SWOT analysis are a set of structured pieces of information on the 4 aspects and a set of strategic options.

The SWOT analysis takes place in 4 rounds [4]:

#### *ROUND 1: ASSESSMENT OF THE INTERNAL ENVIRONMENT*

The data to be analyzed in this round usually include the following aspects, but is not limited to this:

- resources: financial, intellectual, location
- productivity
- organization and functioning of the organization /system
- infrastructure
- access to resources
- skills of the personnel
- reputation and
- quality assessment.

Data from several consecutive years must be studied and analyzed in order to establish the trends and the changes. Strengths and weaknesses characterize the internal environment.

#### *ROUND 2: ASSESSMENT OF THE EXTERNAL ENVIRONMENT*

A major element of this round is the analysis of:

- social, economic and political factors,
- legislation
- advanced technologies available
- public's expectations
- competitors
- potential partners

The assessment of the external environment consists of identifying and describing the way in which key organizations/actors from the outside may affect future planning. These actors may include: government, other line institutions, NGOs, other competing organizations, etc.

**ROUND 3: OUTLINING THE INTERACTIONS BETWEEN THE EXTERNAL AND INTERNAL ENVIRONMENT IN THE SWOT MATRIX**

<b>Internal factors</b>	<b>List of STRENGTHS</b> S1 S2 S3 .....	<b>List of WEAKNESSES</b> W1 W2 W3 .....
<b>External factors</b>		
<b>List of OPPORTUNITIES</b> O1 O2 O3 .....	<b>Interaction: S-O</b> ----- <b>Strategic option: Maxi-Maxi (Comparative Advantage)</b>	<b>Interaction: W-O</b> ----- <b>Strategic option: mini-Maxi (Investment/Divestment)</b>
<b>List of THREATS</b> T1 T2 T3 .....	<b>Interaction: S-T</b> ----- <b>Strategic option: Maxi-mini (Mobilization)</b>	<b>Interaction: W-T</b> ----- <b>Strategic option: mini-mini (Damage Control)</b>

According to Vankova et al [4]

**ROUND 4: SELECTING THE STRATEGIC OPTION**

The SWOT matrix outlines 4 strategic options:

*1. The comparative advantage strategy (S-O) Maxi-Maxi*

If the identified strengths are sufficient, it means that one can build on the existing potential, while taking advantage of the opportunities provided by the external environment.

*2. The mobilization strategy (S-T) Maxi-mini*

If the strengths are strong enough, then this strategic option implies that one can cope with the threats from the external environment, by turning the threats themselves into long-term opportunities.

*3. The investment/divestment strategy (W-O) mini-Maxi*

This is the situation where a favorable opportunity cannot be taken because of the weaknesses in the system. In such a situation, investments can be made to turn the weaknesses into strengths, or one can divest from weaknesses and miss the favorable opportunities.

*4. The damage control strategy (WT) mini-mini*

This option should be avoided. In this case, there are attempts at surviving by trying to control the damage generated by external threats.

This round where the strategic option to be followed is identified and decided upon is crucial because it establishes the overall approach and lays the foundation for the framework needed to formulate the policy aims.

## **Outcomes of a SWOT analysis for the local administration in the county of Bistrita-Nasaud**

### **STRENGTHS**

- ownership of spaces with medical use
- possibility to allocate budgetary resources for healthcare
- openness to building partnerships with other institutions involved
- existence of the legal competency to set priorities and allocate resources
- existence of an information system, even though a fragmented one
- experience in developing health programs
- existence of care centers, rehabilitation centers, special schools, family houses and foster parents
- authority derived from representation, skills and specialists

### **WEAKNESSES**

- lack of inter-institutional cooperation
- insufficient consultation and involvement of the population
- tense relations between the local public authority and GPs
- the population's health needs are not known
- limited resources
- insufficient and unmotivated personnel
- poor coverage and quality of medical and social services
- lack of multi/disciplinary teams
- lack of a local health strategy

### **OPPORTUNITIES**

- existence of a favorable legal framework for the healthcare system reform
- possibility to access structural funds
- involvement of local NGOs in medical and social activities
- existence of grants for medical and social purposes
- the possibility to access in-service education and training programs
- existence of information systems from various institutions that can be integrated and used in the healthcare field
- participation in pilot programs/projects
- existence of the community care program

### **THREATS**

- frequent changes in the legislation
- financial limitations related to the legislation and methodology for fund allocation
- lack of institutional, legislative, economic stability
- unfavorable demographic evolution
- political crisis
- non-participatory attitude of the population

#### ***Step 4 Analysis of the socio-economic and political environment***

There is a strong and dynamic association and a complex relationship between economic status and health. The heaviest burden of disease at the individual level is seen in the most disadvantaged persons. Studies show that the socio-economic status of individuals and families affects their health status due to the poverty phenomenon and extreme adversity, while economic and political stability create the overall economic and social framework. The current concerns of health determinants study on various populations are headed more and more towards establishing the contribution of socio-economic factors. [5]

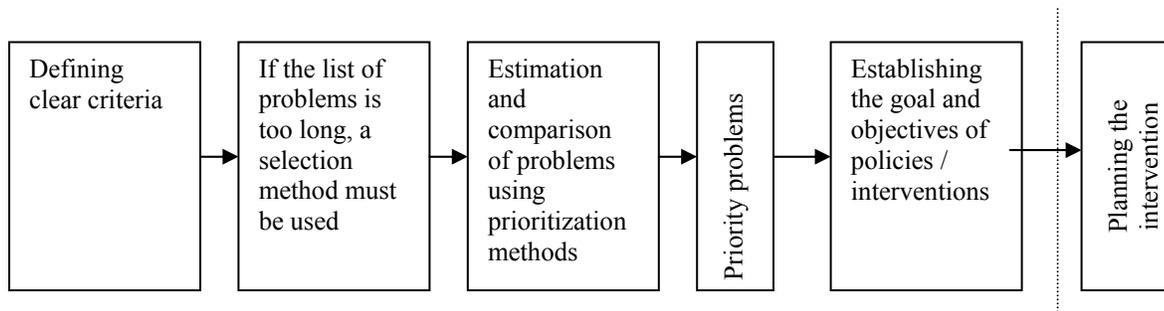
The socio-economic level, determined and defined within a certain political environment, influences: the access and quality of received healthcare; a healthy lifestyle and behaviors, regarding risks; psycho-social processes (socializing, personal development, stress, depression, hostility etc.); physical living environment (through pollution, urban congestion); and social environments, i.e. community, education and work environment, social capital, discrimination and stigmatization. Besides the demographic characteristics, health status indicators, infrastructure and healthcare system resources, and use of health services for needs assessment and health policy drafting, one must consider the *social and economic factors* significant impact on people's health status. They are measured and reported through specific indicators, which add important elements to the complexity of the profile of the studied population. In annex 2.6. we included a list of social and economic indicators useful for the assessment of the population's health needs.

The decision makers need to access at least the *basic* socio-economic indicators in order to recognize and understand health problems and their causes and to substantiate the proposed health programs and policies. These indicators are selected and analyzed according to the type, level, purpose and scale of the relevant health policy/program.

#### **2.2.3 PRIORITY SETTING**

Setting priorities means the process of selecting those problems that were identified in the previous step that can become the object of an intervention. In fact, it is a process of comparing and making a decision, based on special methods and techniques, to prioritize problems according to their relevance. The conceptual framework for the prioritization process was described by R. Pineault [1] as follows:

**Figure 2.3**     **Prioritization process**



In general, three types of criteria are used for prioritizing the identified problems:

- *importance of the problem* (incidence/prevalence, premature deaths, preventable deaths, incapacitation etc.)
- *intervention capacity* (knowledge on the disease/associated risk factors, prevention possibilities)
- *possibility of taking actions* (resources, existing services, accessibility to services)

R. Pineault grouped the instruments for priority setting (hierarchy) in 2 large categories [1]:

- methods specific to health planning
  - analysis grid
  - the Hanlon method
- general prioritizing methods
  - paired comparison
  - linear measurement scale

*a. The analysis grid*

This method is subject to the judgment of 4 areas:

- a.1 - importance of the problem;
- a.2 - relation of the problem with the risk/determinant factor (factors);
- a.3 - technical capacities to solve the problem;
- a.4 - feasibility of a program or intervention to influence the problem.

*a.1 The importance of the problem* is judged based on its scale (number of persons affected measured through rates or indexes - incidence/prevalence) and the severity of the problem which can be measured through mortality, through summary indicators (see burden of disease).

*a.2 Relation with the risk/determinant factor (factors)* is judged according to the existence of scientific studies that prove the association of the concerned disease with one or more risk factors that can be influenced. In analyzing this field, an important emphasis is placed on the opinion of experts with knowledge in public health; the evidence can be found in the specialized literature or in studies posted on the internet.

*a.3 The technical capacity of intervention* is judged based on the knowledge from the specialized literature regarding the association between the disease and the risk factor (factors) and the possibility of intervention or prevention.

*a.4 Feasibility* concerns the existing resources, required in the implementation of an intervention (existing services, qualified personnel, financing possibilities, the population's accessibility to services, compliance to treatment etc.).

The method allows the setting of 16 possibilities of recommendations (in fact, a score), in a descending order of priorities related to each problem.

Every identified problem is judged based on the diagram presented below (Figure 2.4), for each step the problem receiving a + (positive answer to the respective column) or a – (negative answer) depending on the results of the evaluation, which shall lead to a pathway that ends in a score from the 16 presented in the last column. This method considers the lowest score as identifying the problem with the highest priority.

**Figure 2.4**  
Problem

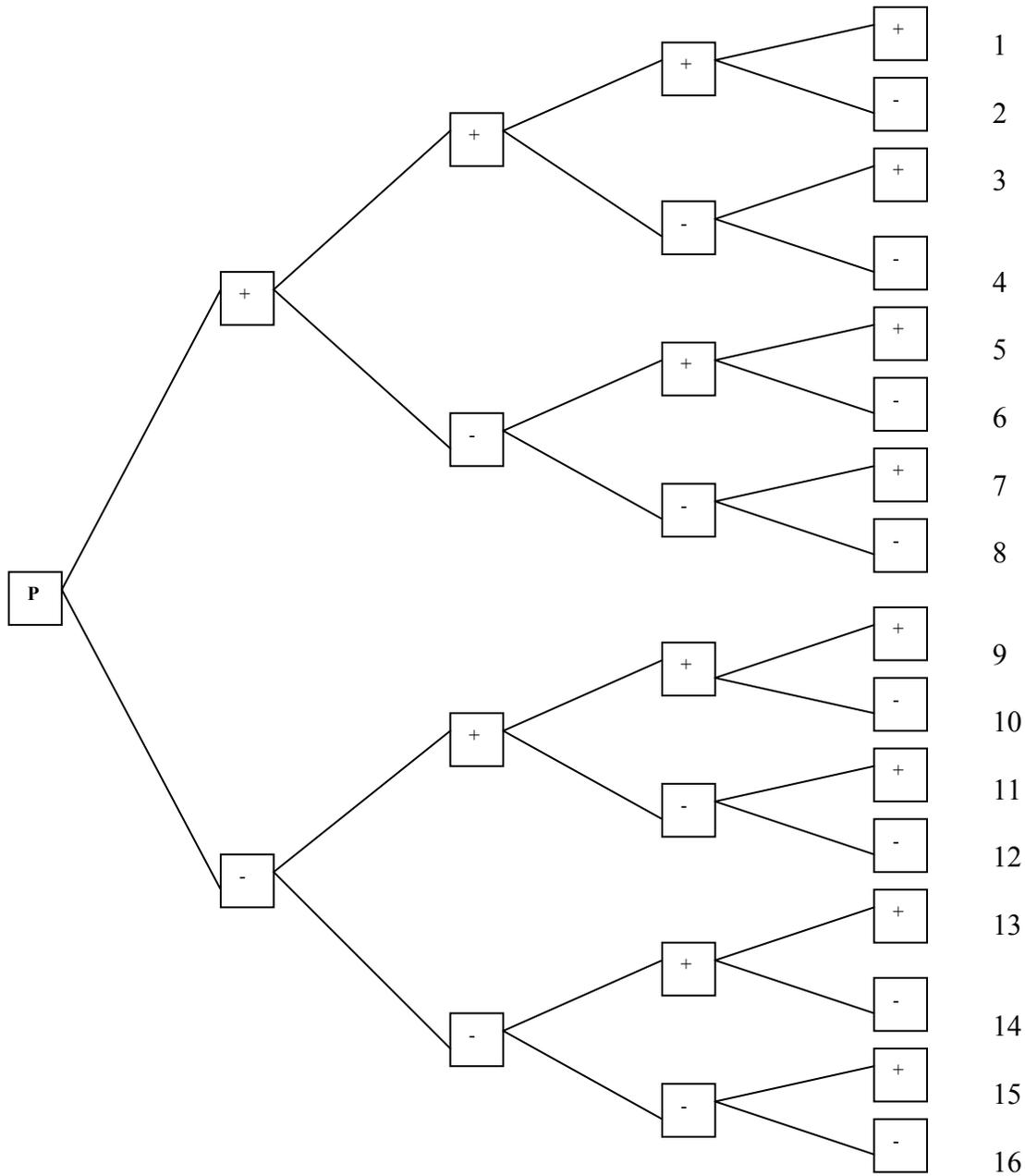
**Analysis Grid**  
Importance of  
the problem

Relation between  
the risk factor  
and the problem,  
scientifically  
proven

Technical  
capacity for  
intervention

Feasibility

Recommendation



Example = lung cancer (problem)

Importance of the problem	- very high (high and increasing frequency)	+
Relation with the risk factor	- proven (smoking)	+
Capacity of intervention	- in primary prophylaxis	+

Feasibility - difficult to change the prevalence of smoking -

The recommendation for primary prophylaxis of lung cancer: **priority 2**

The results of this method can be summarized in a table as follows:

**Figure 2.5 Results of the analysis grid**

	Importance of the problem	Relation between risk factors and problem, scientifically proven	Technical capacity of the intervention	Feasibility	Recommendation of the analysis grid
Problem 1	+	+	+	-	2
Problem 2	-	+	+	+	9
.					
.					
.					
Problem n	-	+	+	-	10

*b. Paired comparison*

Among the general prioritization problems, only “Paired Comparison” shall be described as follows. Problems are compared 2 by 2. Each problem is compared with every one of the other problems. In each comparison, the most important problem is outlined. Eventually, the situations where a problem is bigger than the other ones are summed up.

For instance, if 5 problems are judged (A, B, C, D, E) in order to be prioritized, the method can be summarized in the following table:

**Figure 2.6 Results of the Paired Comparison**

Problem	Paired comparison (the most important problem is checked)				The final score or %
A	A B√	A C√	A√ D	A E√	A=1 or 10%
B		B√ C	B√ D	B E√	B=3 or 30%
C			C√ D	C E√	C=2 or 20%
D				D E√	D=0 or 0%
E					E=4 or 40%

*Example*

To continue the above-mentioned exercise, after making the list of health problems in the county of Bistrita-Nasaud, the nominal group technique was used to define, prioritize, and establish the intervention priorities. The paired comparison technique was used on 5 of the identified problems taking into account the previously mentioned criteria. Figure 2.7 illustrates the results of this exercise.

**Figure 2.7 Results of the priority setting exercise, using the paired comparison method**

<b>Problem</b>	<b>Paired comparison (the most important problem is checked)</b>				<b>The final score or %</b>
A. Insufficient information and education on prevention and control of type II diabetes mellitus	A B√	A C√	A√ D	A E√	A=1 or 10%
B. Deficiencies in the medical-social system for the elderly; high number of institutionalized elderly persons		B√ C	B√ D	B E√	B=3 or 30%
C. Poor institutional capacity to develop health policies and programs, adapted to the population's needs			C√ D	C E√	C=2 or 20%
D. Uneven access of the population to health services				D E√	D=0 or 0%
E. Lack of an integrated information system for the medical-social, educational and administrative issues, to serve as a support for an informed decision making process					E=4 or 40%

The outcome of this exercise was the prioritization of the assessed problems, the first 4 linked to the goals of the health policies developed in the county of Bistrita-Nasaud. The hierarchy was as follows:

1. Lack of an integrated information system for the medical-social, educational and administrative issues, to serve as a support for an informed decision making process
2. Deficiencies in the medical-social system for the elderly; high number of institutionalized elderly persons
3. Poor institutional capacity to develop health policies and programs, adapted to the population's needs

4. Insufficient information and education for the prevention and control of type II diabetes mellitus

There are also certain consensus methods used in priority setting:

- The Nominal Group Technique (described above)
- Brainwriting (described above)

### ***2.3 Potential problems and opportunities***

- Problems:
  - Lack of experience in inter-sectoral and multi-disciplinary cooperation
  - Difficulties in accessing the relevant data from local level, especially data on a certain community (territory)
  - Difficulties in accessing the target population (geographic, ethnic, religious accessibility etc.)
  - Difficulties in maintaining, in the medium term, a multi-disciplinary team that could take action at a certain moment
- Opportunities:
  - The ongoing local administration reform provides the possibility of policy drafting at local level, suitable for specific needs
  - The healthcare reform
  - A higher involvement of the community in identifying problems and making a decision.

### ***2.4 Conclusions***

The healthcare system in Romania is currently under reform, with a special emphasis placed on decentralization of the decision-making process and policy drafting at the local level.

Unfortunately, at present, there is no exercise in substantiating health policies using needs assessment, identification and prioritization of specific problems. This is why certain problems must be brought to the attention of political leaders, as critical issues:

- Highlighting the need of an inter-sectoral approach, given that the healthcare system is not the only sector responsible for the health status of population in Romania.
- Highlighting the need to create multi-disciplinary teams at the local level in order to develop appropriate policies/programs at that level.

- Improving communication between decision makers, service providers and service beneficiaries
- Involving the community in decisions that regard their own health.

It is very important to understand the relationship between causes and their determinants. A good understanding of the causes allows us to put them into a problem tree and to develop, in a further step, a tree of objectives.(see chapter 4).

## CHAPTER 3: POLICY ALTERNATIVES: POLICY DEVELOPMENT SELECTION

### Chapter 3 provides information on:

- Health Sector Policy making process
- Development of health sector policy alternatives
- Policy selection process
- Substantiating the choice of this alternative
- Advocacy
- Challenges and opportunities

### ***3.1. Introduction***

The process of health policy drafting has to undergo several mandatory stages. Chapter 2 gave a description of general and specific techniques that can be used in identifying and prioritizing health issues. For the issues considered to be most important, we must define and analyze possible alternatives for solving or mitigating these problems. Each of the alternatives identified for solving the problem is analyzed based on certain criteria and, in the end, the most appropriate alternative is chosen for solving the priority problem. This chapter will describe the road to be followed until the best alternative is identified.

Every community has health problems and, quite often, these problems surpass the available resources. This is why we have to make choices. Technical tools to help decide among these choices were presented in Chapter 2. Once the most important problem has been selected, possible alternatives are identified. ***The health policy alternatives or options are cost effective technical solutions that solve a specific health policy problem.***

In formulating health policies, the art of negotiation and determining “optimal” solutions to health status issues becomes critical. It is impossible to find a solution that satisfies all the groups. One option considered positive by one group may not be acceptable to another group. Likewise, a policy that is assumed to be cost-effective within the health sector can result in excessive costs (or lost opportunity) for other groups or sectors. The purpose of this chapter is to provide methods for seeking the most optimal and cost-effective alternative not the perfect one.

In examining policy alternatives, decision-makers have several broad choices. For example, choosing the “status quo” (maintaining the current situation) can be a solution. Although the effects of such an option may be limited, this may be the most politically viable option since the “status quo” typically is not met with as much resistance as change. The “status quo” may also be

preferable when the institution/organization involved is not prepared (financially, logistically, etc.) for the implementation of another option or other satisfying options are not identified. However, the policy maker should seek to examine all options considering that a combination between one or several options can represent the key to solving the health policy problem.

### ***3.2. Step by step. The process of health sector policy alternative development.***

#### **3.2.1. Identification of policy alternatives.**

How do we identify health policy alternatives? The activity of identifying health policy alternatives takes place at the level of policy initiator based on specialized studies and analyses. There are several best practices that can be applied to exploring policy options such as models from other parts of Romania or from other countries, and other previous successful experiences at national or local levels. In seeking innovative policy options, it is important to apply past lessons learned, the existing Romanian legal framework, and perhaps most importantly, the creative energy of each partner.

##### **How complicated should the process of defining policy alternatives be?**

There is no universal formula for the level of complexity of the alternative identification process. Simple analyses may be useful starting from very pertinent questions, such as: “What do we have at our disposal for solving this problem?” “What can be done concretely?” “How was this problem solved in another county/country?” “How is the existing legal framework favorable to us?”

##### **How many alternatives do we have to identify?**

There is no definite answer to this question but we should identify at least three alternatives. The list of alternatives should not be very long so as not to waste too much time (and resources) on alternative analyses.

##### **How can alternatives be generated?**

- Within the institution/organization involved: brainstorming, discussions, Delphi technique (as described in previous chapter)
- Consultation with different stakeholders, e.g. individuals, interested groups. This process will not only increase transparency of the institution/organization involved but represents a very good source of information;

- Study the way in which other institutions/organizations/systems have solved similar problems
- Research best practices from other countries

### ***3.2.2. Who is entitled/has to identify the alternatives?***

Stakeholders at the local level are the most appropriate in this respect (for a comprehensive list see Section 2.1.2 ), as they are continuously in touch with the local population and aware of their needs. Also, local stakeholders are most motivated and interested in having the situation improved, as they are going to be directly impacted by results. As discussed in Chapter 2 (Needs Assessment) it is critical that all main “actors” from the community are consulted, informed, and empowered to provide input in selecting policy alternatives (non-governmental organizations, social partners, professional associations, representatives of the private sector, community elites, representatives of local school, church, Mayor’s office etc.). They can have an important contribution in identifying or improving potential alternatives. The consultation process is detailed in the second part of this chapter.

### ***3.2.3. How to select the most appropriate alternative***

How do we choose between different options? Once a listing of potential policy alternatives has been created, each alternative is evaluated according to clearly defined, measurable, standard, specific and relevant criteria. The way we establish the criteria will be the most important factor in carrying out analyses (i.e. feasibility, pertinence and community impact analyses discussed below) that will allow the policy decision-maker to empirically compare and select the most optimal policy. The most frequently used criteria are:

- **Efficiency** – A measure for the projected level of output related to cost should be defined. This includes consideration of how the policy will improve technical (i.e. staff productivity, staffing mix) and allocative (i.e. re-allocating resources to more cost-effective health services such as health centers instead of hospitals).

- Efficacy – This is a measure of the expected technical effectiveness of the policy. For example, if a policy for HIV/AIDS treatment is examined, the decision-makers may project the level of expected success of increasing ARV treatment on improving PWLA longevity.
- Political and administrative feasibility- how easy is it to obtain the agreement of the political actors for a specific option and how easy is it to be implemented afterwards (methods for carrying out feasibility analysis is provided below)?
- Sustainability – How likely is it that the policy will be funded by the public, private or donor community over a long period of time? Will cost sharing amongst sectors and funders be possible?
- Pertinence – The adequacy of the proposed policy to solve the identified needs; methods for carrying out pertinence analysis is provided below.
- Community Impact – The long term effect on the community of the policy alternative; Methods for carrying out community impact analysis is provided below
- Stability –how much the policy objectives will be sustainable no matter what possible malfunctions appear during implementation
- Certainty –what probability exists that the policy will function in any conditions?
- Flexibility – if the policy can serve multiple objectives and/or if it can be adjusted along the way
- Communicability- if the option is easily understood by the others;
- Reversibility –how easy will it be to return to the previous situation if the implementation fails, etc.?
- Equity (See below) – providing access to health services according to health needs rather than one's ability to pay
- Cost-benefit/cost-effectiveness – identification of costs that would be needed to reach the desired result; Methods for carrying out economic analysis is provided below

## **EVALUATING POLICY OPTIONS**

After establishing well defined criteria for evaluating policy alternatives, the policy-maker can choose from several approaches for selecting the most optimal policy. After we choose specific policy options and evaluative criteria, it is recommended to perform deeper analyses to determine very precise impact of the policy costs, risks, and benefits.

There are some constraints when we evaluate different alternatives:

- -time;
- -financial resources;
- -limited available information;
- -limited expertise

## **THE POLICY SELECTION PROCESS**

The following sections provide four approaches to carrying out the policy selection process. These include: Carrying out research of each option; developing an “option model”; carrying out a feasibility, pertinence or impact (economic, social and environmental) analysis; and carrying out a consultative process. Any of these approaches can be applied independently or combined. For example, your team may decide to carry out detailed research and analysis but complete the process by presenting findings to a consultative group of community stakeholders for final decision-making.

I. Carrying out research study and analysis that-provide information on:

- The opportunity to solve that problem;
- Presentation of alternatives;
- The budge estimate for each alternative;
- The anticipated impact for each alternative;
- The criteria for assessing the alternatives and for selecting the one that is recommended for implementation.

## II. An option model

Below you can find a simple model to choose between different options applying several of the above criteria. The decision-maker can draw from the list above to add other criteria that may be significant to his/her community. On the row are presented different options and the columns include criteria selected. Each option receives points (on a scale from 1 to 5) based on each evaluation criteria. A total score is derived and the option with the highest score will be selected.

For example if we want to improve health services in hospitals we can choose a solution based on the following model:

Example:

**Fig. 3.1. – An optional model to judge different alternatives**

Options	Criteria no. 1 efficiency	No. 2 feasibility	No. 3 efficacy	No. 4 flexibility	No. 5 Equity	No. 6 Sustainability	total
No.1 Maintaining public system but developing performance based contracts for managers	2	4	2	3	3	4	18
No.2 Public- private partnerships	3	4	4	5	4	4	24
No.3 Hospital privatization	4	3	3	2	1	3	16

## III. Carrying out analyses applying three specific approaches:

- Feasibility;
- Pertinence;
- Economic, social and environmental impact.

### ***a) Feasibility analysis***

***Feasibility*** answers the following question: “Is this alternative feasible at this moment, at the community level?” In order to find an answer to this question, we must consider the following aspects:

- ***political feasibility*** – namely if the political actors from that community/county are favorable. If they oppose us, we have to be aware of this and find the best arguments to persuade them to support us or to no longer oppose us.

- ***legal feasibility*** – namely if the selected alternative is not contrary to the existing legislation. If there is no legal framework regulating the activity in this field, we have to be aware that it is not impossible to promote regulations, but this is a long and winding road for which we need to have national echo.

- ***resource feasibility*** – namely if we have enough qualified human resources to implement the alternative and if the material resources suffice. This analysis is based on estimates of the resources necessary for implementing the respective alternative and on the comparative analysis of costs and results pertaining to different alternatives.

### ***b) Pertinence analysis***

***Pertinence*** answers questions such as: Is this alternative appropriate for the target population? Does it correspond to the cultural model and its components? Could it be accepted by the beneficiaries? What about the authorities?

### ***c) Impact analysis***

The impact analysis has several dimensions: economic, social and environmental.

***A. The economic impact*** is calculated by estimating the costs necessary for the implementation of each alternative. A more sophisticated approach would be a cost-benefit analysis. The cost-benefit analysis is a quantitative method for estimating the level of desirability of a project or of a governmental policy based on calculating and assessing the relationship between future costs and benefits, expressed in monetary value. The method has an advantage resulting from the fact that, by expressing both costs and benefits, it creates a common denominator for comparing any treatments, programs or investments.

**The cost-benefit analysis is used for:**

- Analyzing the opportunity of a project (the project will be realized if the benefits outweigh the costs)
- Analyzing and selecting from several problem solving alternatives (we select the alternative that has the highest cost/benefit ratio value)

**Steps of the cost-benefit analysis:**

- Detailed analysis and substantiation of the costs and benefits entailed in a health policy alternative;
- Quantifying the cost-benefit value or estimating it in monetary units;
- Calculating the net value for each individual alternative;
- Presenting the risks and the uncertainties that, in time, can lead to variations in the estimated values.

**Limitations of the cost-benefit analysis:**

- It is focused on costs and benefits and less on objectives of that health policy;
- It has a very limited applicability for social policies;
- Sometimes there is a shortage of information and statistical data.
- It involves the existence of applied expertise.

***B. The social impact***

The assessment of the social impact of a health policy is aimed at identifying the consequences of a health policy solution on human capital, human rights, employment, as well as labour quality, gender equality, social exclusion and poverty, health, citizen safety (crimes and terrorism), consumers' rights, social capital, education, culture etc..

The social impact can be identified by going through several stages, from collecting information to comparing and analyzing this information. Thus, there are several methods that can be used during each of these stages such as focus groups, interviews, case studies etc.

For a better view of the types of social impact on a group or a community, see the following example which summarizes the information obtained after using the methods described above. This table exemplifies the impact identification coordinates, which can vary depending on the health policy type.

**Example:**

**Fig. 3.2. Health policy alternative: Program for improving health care for the elderly**

<b>Components of the health policy solution (health policy alternative)</b>	<b>Impact (impacted group)</b>			
	<i>Social integration</i>	<i>Level of health care system costs</i>	<i>Benefits for target population</i>	<i>....</i>
1) care for the elderly in acute hospitals	_____			
2) medical care for the elderly				
3) social care for the elderly				
4) community based integrated medical-social care for the elderly				

**C. Environmental impact**

The assessment of the environmental impact of the policy refers to the level of impact a certain health policy solution could have on the environment, and is especially relevant for big infrastructure projects. The environmental impact assessment is aimed to identify, as accurately as possible, the positive or negative impact associated to measures that lead to climatic changes; air, water and soil pollution, biodiversity lost, as well as public health impairment. For example, the environmental impact of the hospital biological waste. The methods for identifying this kind of impact are of a technical nature and depend on the field in which the health policy is elaborated.

The general impact assessment in the case of a health policy as well as the impact analysis, can include information obtained after the application of methods specific to the three types of impact presented above.

If the aim is to have a summary of the information obtained from the health policy alternative impact assessment based on the three perspectives mentioned above, namely economic, social and environmental, the following synoptic information table can be used.

**Name of the health policy:**

(For each of the types of impact, we can introduce indicators specific to each type of health policy)

**Fig. 3.3. Impact analyses for alternatives**

	Economic Impact			Social Impact			Environmental Impact	
	Estimated costs	Estimated benefits	..	Social integration	Employment level	.	Pollution	...
<b>Alternative 1</b>								
<b>Alternative 2</b>								
<b>Alternative 3</b> (recommended)								

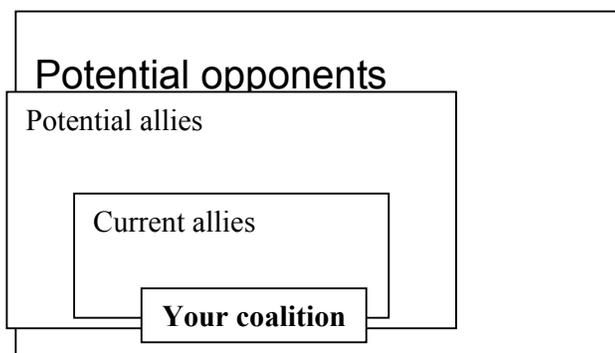
**3.3. The consultation process: Analysis and consultation of key actors/institutions involved in defining the alternatives (stakeholder analysis)**

**3.3.1. Goal and utility of the consultation process**

The consultation process is designed to increase the level of transparency in the decision making process, but, at the same time, it also allows for the accumulation of useful information on that health policy proposal, including suggestions for possible solutions, benefits and costs or risks associated with the implementation of a certain alternative.

It is extremely useful to consult the main actors and political beneficiaries during the early stages of policy selection to ensure commitment and political will. This will ensure that policy selection and implementation take place in the best conditions possible and with the lowest possible number of subsequent objections.

**Fig. 3.4: The consultation process**



### 3.3.2. Analysis of consulted groups/organizations

**Figure 1 above** illustrates a first step in the consultative process - to carry out a “political mapping” or “social assessment analysis”. This will help to identify potential policy opponents and supporters.

This process includes an analysis of all organizations, political institutions and groups that are involved and have an interest, can benefit or are affected by that policy. This analysis is used in the process of drafting a health policy in order to identify:

- The interests of various groups that could benefit or could be affected by a certain health policy;
- The risks or possible unpredicted consequences that could impact the groups or could be triggered by them;
- Possible roles the groups may play during the policy drafting and implementation stages.

A useful tool in analyzing the groups/organizations involved in drafting a health policy is the **stakeholder matrix**, which offers means of assessing the importance and potential impact of various actors interests in a certain health policy issue. The main factors to consider here are:

- Stakeholders. The list of stakeholders has to be as extensive as possible during this initial stage;
- Type and extent of resources of these groups/organizations;
- The capacity to mobilize these resources;
- The position adopted by the group regarding the policy in question.

**Fig. 3.4. The stakeholder matrix**

Group	Interest of the group in that policy	Available resources	Capacity to mobilize the resources	Position of the group regarding that issue
Name of the group	Estimating the level of interest of the group (could vary, from very high to very low)  Here we can also mention those specific interests	Total resources of the stakeholder (e.g.: financial information, status, legitimacy, coercion)	Estimating the way in which the group can mobilize its resources.  (Estimation could vary, from very high to very low; or quantitative	Estimating the group’s position regarding this issue  (May be positive or, on the contrary, negative; or quantitative indicators could be

			indicators could be used: +5, -5 etc.)	used: +5, -5 etc.)
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### 3.3.3. Consultation methods

- Asking for comments, suggestions, opinions, in writing. This can be done after having sent relevant documents via mail or email. In this case, in order to avoid any vague, general answers, it is recommended to send a questionnaire as guidance in elaborating the answers.
- Video presentations. Debates and seminars can be organized, during which people can discuss the partial or final results of the health policy making process.
- Meetings and discussions. These can have an informal nature and can be organized at the headquarters of the initiating institution or that of the consulted organizations or can have one of the following forms (part of these methods are presented in detail in the chapter on social impact):
  - Public debates;
  - Interviews ;
  - Focus groups etc.
- Public opinion surveys (see the chapter on the social impact). When enough time and financial resources are available, but also in the case of public policies with a major impact on large population groups, it is recommended to use opinion surveys and, sometimes, referendums.

### 3.4. *Cross cutting issues that ensure optimal policy solutions*

Once the general information on each alternative is collected, a comparison is made, based on the initially selected criteria, namely feasibility, pertinence, cost and impact on the community. Then, we choose the policy alternative with the most favorable economic, social and environmental impact on the community that is both feasible and accepted by beneficiaries and authorities alike.

### 3.5. *Advocacy*

#### **Policy analysis and advocacy**

Advocacy, a term used in literature for defining actions of pleading, arguing a cause, idea or policy, is also used in Romanian language accordingly. Advocacy is an active process which requires a thorough analysis, strategy (*game plan*) and tactics (*players and games*).

Key to successful advocacy are:

- Know what you want (*be specific*);
- Know *who* can give you that (who are the people with real power and influence);
- Know what they want (favorable media coverage, public recognition, votes, publicity);
- Know *what you can and cannot offer them* (recognition vs. contributions);
- Know who are going to be your *allies* and *opponents*;
- Know what is needed for success.

Good **political advocacy** requires a strategy that includes the following:

- Very good knowledge of the problem;
- Data and arguments;
- Approach it so that it becomes *their problem*;
- Good knowledge of the system and the actors;
- Present the problem at *high levels*;
- *Organize*;
- One voice is not sufficient so use the best arguments in order to support the objective and also the best arguments against your opponents' position and;
- Good political advocacy requires sound tactics including letters, facsimiles and emails (once is not enough), phone calls (emergencies have to be communicated immediately), face-to-face meetings whenever possible as these are the most productive, public education via the media, building a coalition: getting other people and organizations involved, and *building power*.

### ***3.6. Challenges and opportunities for success***

Generating health policy alternatives that answer all relevant problems gives the decision makers the opportunity to have varied perspectives on the questions about who, how, when and with what resources to approach a certain problem.

The health policy initiator is confronted with an important challenge: *time*. Time planning depends, in principle, on the needs that have been identified, the type of selected interventions and circumstantial factors that influence the process.

**Possible constraints and barriers:**

- Insufficient data arguments;
- Proposed interventions with highly technical, specialized character;
- Insufficient knowledge or consideration of environmental and political factors;

- Communication malfunctions;
- Reaching consensus, integration with other health and social policies;
- Difficulties in determining the efficacy of policies and interventions;
- Administrative, bureaucratic barriers;
- Limited available resources – financial, informational, technological, time;
- Difficulty in estimating the impact of that policy and intervention;
- Unstable economic and political environment;
- Emergence of unpredicted limitations and difficulties.

An opportune health care policy has to answer people's needs and minimize emergency situations. This is possible only by using technical data and knowledge and by knowing the system and the political process. The success depends on the ability to use political leveraging and organizational resources in order to obtain the envisaged result. Flexibility is required during all the stages of policy preparation, elaboration, implementation, integration and assessment. Besides the inherent challenges and constraints, we can also identify opportunities and factors for success, such as:

- a favorable context of concerns and interests;
- coalitions;
- similar priorities set in neighboring regions or at regional/national level;
- including the identified problem in the scope or strategy of the government or local administration;
- national health care and social policies;
- attracting the support of the nonprofit private sector;
- attracting the support (financial and influence) of business people;
- precedents, similar initiatives;
- use of successful, good practice models;
- obtaining access to several intervention sources;
- use of the most appropriate communication channels and means;
- involvement of opinion leaders;
- organizing special events or using cultural and media events for disseminating information on and publicizing the policy/intervention;
- national, international collaborations.

### ***3.7. Conclusions***

The key element in health policy making is the research done for testing and defining all the necessary alternatives. In Romania, the minimum standard imposed by the legislation is three alternatives. Alternative identification methods, the depth each testing should have, and the alternatives for the implementation of a local health policy in the health care system, are the tools necessary for developing a competitive policy. The policies should be feasible and should stand up to a series of tests such as the cost-benefit analysis, the social impact analysis and – whenever necessary – the environmental impact analysis, which helps determine the level of feasibility. The health policy initiators should consider the political climate in order to determine if their efforts can be successful. Once all the options have been analyzed, the most feasible of the alternatives, from a technical and political point of view, is selected and prepared for implementation.

## CHAPTER 4: POLICY IMPLEMENTATION THROUGH PROJECT DEVELOPMENT

### Chapter 4 shall meet the following learning objectives:

- Moving policies to implementation phase
- Gaining the necessary skills for policy implementation: defining the goal and objectives of a health policy
- Designing and drafting the action plan for policy implementation
- Formulating monitoring and evaluation indicators
- Developing the technical skills for proposal writing as a main tool for resource mobilization

### 4.1 Introduction

This chapter provides the passage from the stage of policy drafting, outlined in the previous chapters, to policy implementation. Its purpose is to develop planning skills, project management and resource mobilization means needed for the implementation of health policies. It is useful to have a clearly defined conceptual framework that differentiates between:

**Policy:** consensus on priority measures to be adopted in order to achieve a desired result or change;

**Program:** a set of coherent projects / services implemented to reach the established objectives regarding a specific population and an identified problem; and

**Project:** a number of related activities aimed at meeting certain defined objectives, over a given period of time and with a specific budget.

This chapter is specifically meant for those who manage the policy implementation process, as well as for policy makers and decision makers. It provides aids for developing projects, identifying sources for funding, writing project proposals and monitoring the intervention's progress. The main sources of funding that we will focus on are public funds from the National government as well as the upcoming European Structural Funds.

The preceding chapters have provided skills for developing effective policies. Next, we need to consider how we will use the information gathered to determine how to implement policies that improve health status. An important part of the implementation planning stage will be to determine how we will measure the achievement of the project outputs, results and impact. It is important that

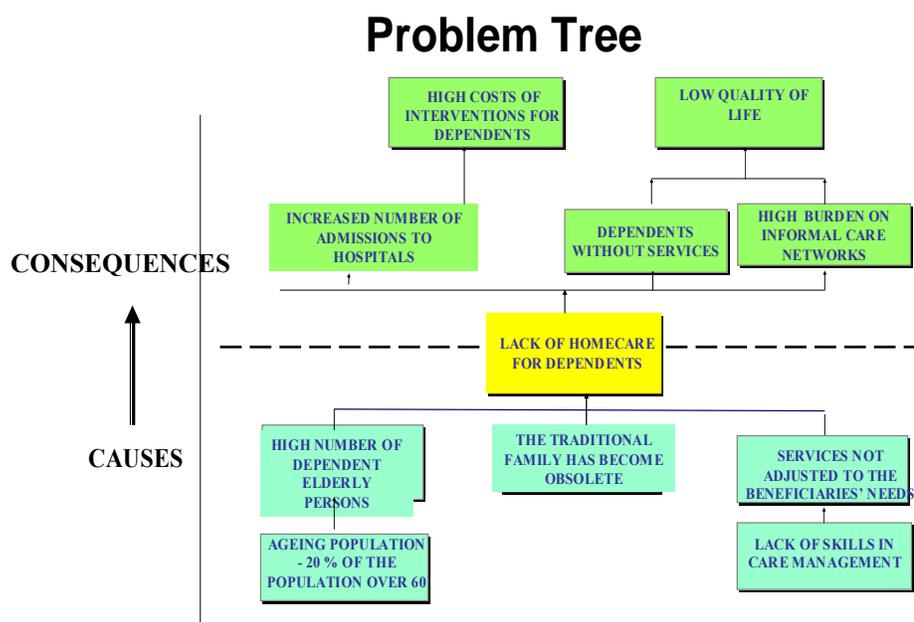
the indicators used to evaluate policy implementation be able to match our health improvement expectations.

## 4.2 Step by step –program implementation and mobilization of resources

### 4.2.1 Problem analysis

Formulation of project objectives needs a prior understanding of the issue to be solved. Problem analysis implies several steps (defined in chapter 2):

1. Listing the problem determinants and the links between them
2. Identification of the core issue (problem)
3. Listing the effects of the identified core problem and the links between them



Romanian Health Care Reform Program

2

### 4.2.2 Setting the project's goal and objectives

*The goal* expresses the final result expected from project. It must aim at sustainable outcomes for the target population and other beneficiaries. The policy's goal may concern long-term changes, such as behavioral or health status changes.

**In order to better establish a policy goal, the following questions must be answered:**

- What are the specific health status problems related to the population in the respective community? (See chapter 2.)
- Which are the determinants of these causes?
- Which ones of these problems can be solved by the local administration/healthcare unit/other organizations involved? (See Chapter 3)
- What are the alternatives to solve these problems? (See Chapter 3)
- Are these alternatives possible, achievable, pertinent and feasible? (See Chapter 3).

**In order to properly describe the goal, it must:**

- concern a major health issue that reflects the technical analysis described in (Chapter 2)
- concern the target population and a certain geographic area

**Example:** The goal of a health policy related to increasing the quality of life of dependent persons: “To improve the quality of life of dependent persons through the increase of integrated health and social home care in Suceava County”;

**The general (overall) objectives** represent the desired result to be obtained by conducting a specific intervention. The general objectives are less broad than goals and must be capable of measuring the progress made for reaching the goal. They need to be realistic, clear and quantifiable.

**Example:** The general objective of a health policy related to increasing the quality of life of dependent persons: “To reduce by 30% the number of unassisted dependent persons through the increase of integrated health and social home care in Suceava county”;

**The specific objectives** concern intermediate results in the target population, and describe the expected results. They are specific, they relate to a geographically defined location, over a certain period of time, for a population with pre-established features. The objectives need to be determined during the planning stages of implementation. Reaching the expected results established through the specific objectives is monitored during project implementation.

**Example:** A specific objective of a health policy related to increasing the quality of life of dependent persons may be: “To create 5 rural integrated medical and social units for the dependent persons in Suceava county” in 2007-2008;

In order to draft the objectives correctly, the following must be identified:

- what will be achieved;

- to what extent will the change occur
- when (over what period of time) is the result expected
- where (in what location) is the result expected
- who are the ones to benefit from the change

Thus, a well established objective corresponds to the following SMART characteristics: (S- specific, M – measurable, A- achievable, R- realistic, T– timely).

As a general principle for increasing the chances of reaching stated objectives, the recommendation is to draft a limited number of specific objectives. The verbs used in this respect must be expressed in the active voice, and the appropriate verbs are: “decrease”, “increase”, “improve”, etc.; while the inappropriate ones to be used for the objectives are: “train”, “provide”, “establish”, “conduct”, “produce”.

In complex projects, the objectives are formulated on several levels. They are inter-dependent and sequential.

#### **4.2.3 The intervention logic (the logical matrix)**

The logical matrix is a useful tool for describing the project’s goal and objectives, providing visual details on how the objectives shall be reached and it will indicate whether they have been reached.

The intervention logic may include the following:

- goal (what problem will the project solve?)
- objectives (what is to be achieved?)
- the project’s expected results
- activities (how will the objectives be reached?)
- process and result indicators (how can be proved that the results were achieved?)
- data sources
- collection frequency
- person/department in charge
- pre-conditions/assumptions (external factors, major project-related factors that might considerably influence its success)

The intervention logic must be the result of an iterative, repetitive process of consultation and refining, conducted during all stages of the project: analysis of the actors, problem analysis, objective setting, strategy selection, activity planning, and resource allocation.

The intervention logic is used to define two important concepts for project management:

**Vertical logic** – indicates what is to be achieved through the project, clarifies the cause and effect relations and outlines the assumptions (pre-conditions – aspects external to the project that cannot be controlled by the implementation team);

**Horizontal logic** – tracks the effects of the project and the resources used during the implementation phase, by specifying indicators that help verify the objectives and the sources that allow the identification of these indicators.

### The intervention logic

Project description	Indicators	Verification sources	Pre-conditions
Overall objectives (the project's contribution to the respective policy - impact)	How will the overall objective be measured (quantitative, qualitative, time horizon)	How will the information be collected, when and by whom?	
Specific objectives (tangible results provided by the project)	How will the results be measured (quantitatively, qualitatively, in terms of time)	idem	What are the conditions to be met in order to achieve the objectives
Activities (tasks to be realized in order to provide the desired results)	Means	idem	What are the conditions to be met in order to realize the activities

#### 4.2.4 Planning the activities, setting responsibilities and deadlines

Activities represent the tasks of the partner organizations that must be conducted to meet each objective. The partner organization's capacity is important when choosing the activities. Making use of previous experiences from other organizations in similar projects is extremely valuable. Usually it starts with listing and numbering the activities, by following the chronological sequence of the activities to be developed.

Examples of project activities:

- 1.1 making a list of experts in Integrated Health Management Information Systems (HMIS) as well as decision makers in the health and social related fields;
- 1.2 organize a 3 hour workshop on HMIS for the above identified interdisciplinary group in order to reach a shared definition on the needs of a desired HMIS.

***In order to decide which are the necessary interventions (activities), the following questions must be answered:***

- What activities have to be conducted in order to obtain the planned objectives?
- Why do we think our activities will trigger the planned changes?
- How long will each activity take?
- What do we need for each activity in terms of human, material and financial resources?

The action plan specifies what, where, when, how much and by whom it must be done, taking into consideration the linking of stated objectives to practical activities. While objectives reflect the expected final and intermediary results, the action plans are similar to the means used for reaching these results.

***At this stage, it is important to decide who is in charge of the activities and the period of time necessary for achieving them.*** There are several techniques that can be used in activity planning, such as the Gantt Chart, the Critical Path Method, or the Pert Chart.

***The budget for conducting the activities is also estimated during this stage.*** The experience of other organizations in similar programs can be used for this estimation, but the national legislation or the funder's requirements must be observed in setting the project's budget.

#### **4.2.5 Policy implementation**

If the previous phases have been properly conducted, the implementation of activities can be carried out smoothly.

Essential factors for proper implementation:

- A stable project manager and project team, with previous experience;
- Political support and consistency in the sectoral policy
- Adequate human and material resources
- Sufficient office and communication technologies

Implementation implies:

- Creating the legitimacy of the identified solution and informing all stakeholders
- Gathering of resources – negotiations, building partnerships, hiring new staff
- Changing the organizational structure – creating new organizations, introducing new responsibilities in old organizations, inter-institutional cooperation
- Mobilization of resources and activities – implementing activity plans, communicating best practices
- Impact monitoring – following realistic performance indicators

A successful implementation of a public policy option implies a realistic implementation plan. The activities must be presented in a logical sequence and the allocation of responsibilities for conducting the activities must be done at the level of the structures (institutions or departments) to maximize the efficiency and effectiveness.

In order to have precise monitoring and evaluation and obtain the best results, the recommendation is to split activities into sub-activities, and keep responsibilities and implementation costs explicit for each sub-activity.

The action plan must specify clearly:

- what needs to be done
- where an activity is to be conducted
- the period of time for conducting the activity
- the persons / institutions involved in that activity
- the person in charge of the respective activity

An **operational action plan** answers the following questions:

- Is this tool realistic enough to lead to the implementation of the selected public policy solution? Does it provide sufficient benchmarks so as not to promote arbitrary decisions that can clearly influence the implementation process?
- Are the responsibilities and attributions of the structures involved in the implementation presented in a sufficiently clear manner?

- Are the structures and departments in charge of the coordination of each activity specified?
- Are the deadlines for the activities realistic?
- Is the language used in presenting the action plan clear and understandable both for those in charge of implementation in the implementing institutions and for the target group?

The institutional framework used to implement the public policy must be specified in the action plan's structure. This is why identifying the persons in charge is very important, as it determines the success or failure of the public policy. Both the coordinating teams and the action plan makers must consider a number of issues extremely important in action planning:

- The policy's objectives must be clearly formulated and the definition of the intermediate and final results must be precise;
- The team selected for the implementation of a certain activity must be adequate (considering the personnel structure, the knowledge of its members, their experience in similar projects, and the employment level during the period when the respective activity is implemented);
- The correlation between the activities must be clearly established, also considering how quality implementation of a certain activity influences the implementation of another activity;
- The communication mechanism used by the departments implementing the policy must be coherent so as to allow for an efficient monitoring.

The logical conditions for a sound policy / program implementation are the following:

- The circumstances outside the implementation agency (structure) must not impose paralyzing constraints.
- The program must be allotted a sufficient period of time and adequate resources.
- The resources must be available in the necessary combination.
- The dependency relations must be minimal.
- There must be common understanding and consensus regarding the objectives.
- The tasks must be specified in detail and in the correct sequence.
- The communication should be excellent.
- The coordination should be well done.
- The persons with authority must be treated with respect.
- Compliance with the requirements for implementation activities must be achieved.

The budget chapter presents the cost of each activity, underlining certain expense categories including:

- Personnel costs;
- Investments/equipment costs;
- Travel costs;
- Training costs;
- Utility costs;
- Unexpected costs.

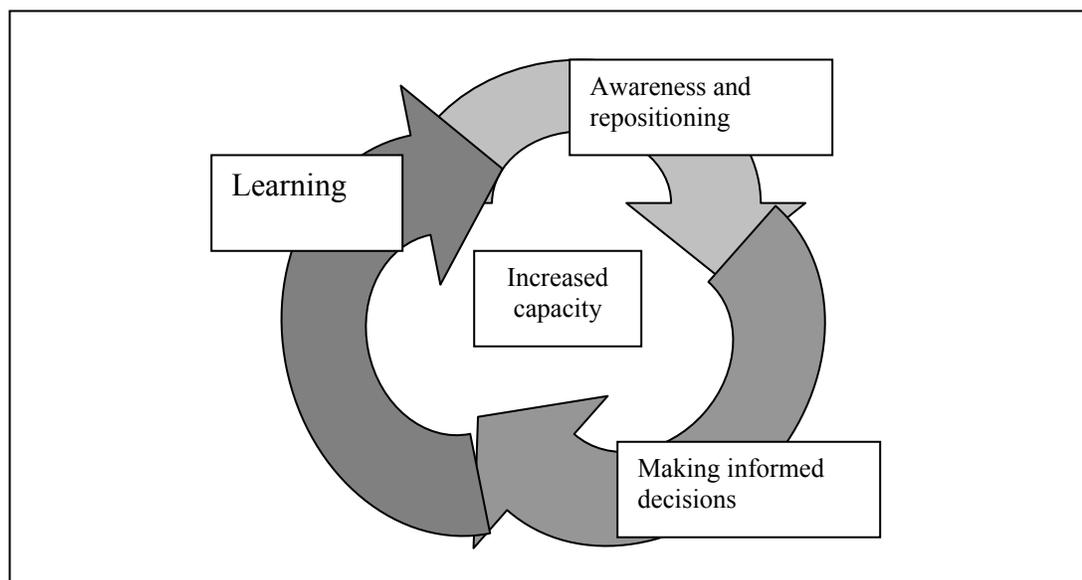
It is important to have a realistic estimate of the implementation expenses for each activity, especially in the context of introducing program-based budgeting and in the case of a public policy implemented over a longer period of time. The budgetary allocations have precise destinations that must be taken into consideration.

**The deadlines** for drafting the reports and conducting the monitoring and evaluation activities are mentioned in the action plan. It is recommended for this planning to underline a series of major results anticipated by the respective policy. The frequency of the monitoring reports must follow the policy implementation stage in relation to a series of intermediary objectives that can decisively influence the public policy implementation quality. The monitoring reports are aimed at assessing the results and the stage of public policy implementation from the perspective of the specific objectives, obtained results and performance indicators related to each activity. This information is extremely important for the team coordinating the implementation, since it allows the intervention and correction in due time of potential difficulties or deviations in implementation.

## 4.2.6 Monitoring and evaluation

The monitoring and evaluation processes (for definitions of terms, see Annex 4.1) are extremely helpful in improving performance and reaching objectives. In fact, their purpose is to measure and assess performance for a more efficient management of the results and outcomes of an intervention. The major monitoring and evaluation objectives are summarized in figure 4.1.

**Figure 4.1** The monitoring and evaluation objectives



Source: according to UNDP [2]

Monitoring and evaluation of an intervention provide the government, the managers and the civil society the possibility to know if their goals and objectives have been achieved, to learn from past experiences, to improve the provision of services, to better plan and allocate resources and, last but not least, to account for the obtained results to the groups of interest.

Recently, the emphasis has been placed more and more on obtaining visible and sustainable results as a consequence of an intervention, thus the monitoring and the evaluation are aimed especially at measuring these results.

**Monitoring refers to the outputs whereas evaluation refers to outcomes and impacts.** Monitoring indicators need to be collected and reported throughout the program whereas (for evaluation purposes) baselines indicators, mid –term and expost evaluation are usually obtained through special surveys and studies – based on data analysis and reporting.

Monitoring and evaluation are management tools, helping managers to follow closely the progress made, provide evidence for the results and take corrective measures whenever necessary. The participation of all stakeholders in defining the indicators is crucial as they will probably better understand and use the indicators when making a decision, and reach a shared vision on the progress achieved.

According to what they measure, indicators are classified as follows:

- *Structure indicators (input)* concern the accessibility and availability (of certain services)
- *Process indicators* concern the activities conducted, the use of resources, service quality (i.e. use of standard guidelines)
- *Result indicators* can be:
  - immediate, tangible results (output), i.e. number of day centers refurbished
  - outcome indicators, i.e. number of patients with access to services
- *Impact indicators* relate to effectiveness (the extent to which the intervention has reached the expected or planned results)

There are 2 classical types of indicators:

#### QUANTITATIVE

- absolute number (for instance, the number of services of a certain type, costs per unit, per patient/bed/hospital day/service)
- structure (percentage of the elderly population)
- rate (mortality, incidence/prevalence)
- ratio (lethality)

#### QUALITATIVE

- compliance (to treatment)
- quality (of services)
- degree of satisfaction

Numerous projects require the specific definition of the change to occur, namely the formulation of specific indicators for the different levels of project objectives and project activities. In such situations, the baseline indicators must be known. Indicators must be carefully defined; a poor definition of indicators can be interpreted as failure, although the obtained results can be impressive, and the error could be caused only by a wrongly formulated basic benchmark.

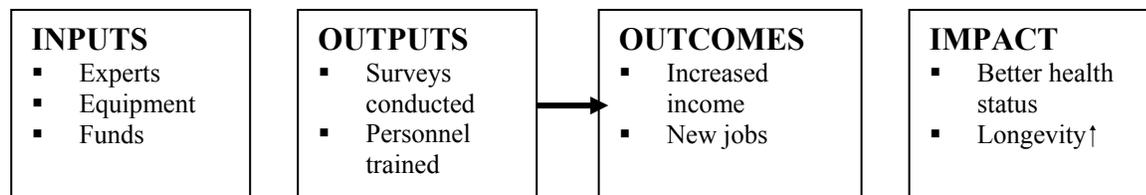
The link between the intervention logic and the indicators is shown in the table below:

<b>Overall objective</b>	<b>Impact indicators</b>
<b>Specific Objectives</b>	<b>Results / short and medium term effects</b>
<b>Activities</b>	<b>Outputs</b>

As you can see, this is the core of a Logical Framework Matrix and ensuring coherence amongst all these levels is in fact ensuring coherence and robustness of the proposed project/ programme.

Further on, there is interaction between the outputs and the outcomes in the process of reaching the results.

**Figure 4.2 Results chain**



Source: according to UNDP [2]

For measuring the **outputs** of an intervention, the indicators are easy to create because the initial situation and the targets to reach are well known. The issue becomes relatively complicated when **impact** and **outcomes** are to be measured.

Principles in selecting a set of relevant indicators for monitoring and evaluation of an intervention:

- Establishing the initial situation from the moment the intervention starts and the targets to be reached (the expected situation at the end of the intervention)
- Using proximity indicators when there are no direct indicators (for instance “efficient management of the healthcare system” is often estimated through “level of the population’s confidence in the system”)

- Analytical – non-aggregated data are extremely useful (data that specifies, for instance, the geographic location, the environment of residence, the gender, the level of education or income etc.)
- Involvement of all partners and stakeholders in planning the monitoring and evaluation indicators, while setting the responsibilities
- Quantitative indicators (especially to measure efficiency), as well qualitative indicators (especially to measure changes in attitudes/behaviors) must be used
- It is better to select a limited number of relevant indicators

In **planning a monitoring and evaluation system** for the outcomes of an intervention, the recommendation is to follow several essential steps:

**1. Assess the information requirements and select the appropriate indicators** – what information is needed in order to assess the output, outcome and impact? Which are the most important elements to track? What can indicate the progress/success?

**2. Assess the monitoring and evaluation tools** and choose the most cost effective ones that give the best information – which are the most commonly used tools for data collection and data analysis in other programs? Do these tools provide the information needed by the program? Are all partners involved? What is the cost incurred by the different data collection and analysis?

**3. Review the purpose of monitoring and evaluation** – Is it necessary to have specific tools adjusted to the respective program? Is the needed information captured accurately? How do we verify the reporting accuracy (validation)

**5. Adjust and/or institutionalize monitoring and evaluation mechanisms** – Enabling stakeholders participation in monitoring and evaluation, for instance, case steering committees for monitoring, making sure that all partners are included. Or, if obtaining an outcome involves a large number of partners, specific monitoring tools can be added, such as meetings of stakeholders. These groups or committees should include end beneficiaries of the health care services.

Figure 4.3 contains a list of monitoring mechanisms, ranked in 3 categories, according to their predominant feature.

**Figure 4.3 Selecting the appropriate mechanisms**

<b>REPORTING AND ANALYSIS</b>	<b>VALIDATION</b>	<b>PARTICIPATION</b>
<ul style="list-style-type: none"> <li>• The annual report</li> <li>• Intermediate reports (quarterly)</li> <li>• Work plans</li> <li>• Program documentation</li> </ul>	<ul style="list-style-type: none"> <li>• Working visits</li> <li>• External evaluations</li> <li>• Customer satisfaction surveys</li> </ul>	<ul style="list-style-type: none"> <li>• Groups of beneficiaries</li> <li>• Steering Committees</li> <li>• Meetings of stakeholders</li> <li>• Focus-groups</li> </ul>

Source: according to UNDP [2]

A monitoring plan should be written at the beginning of the program and cover:

- the outcomes described by the indicators;
- the result indicators;
- the data source;
- the methods and frequency of data collection and analysis.

Figure 4.4 proposes a format for a monitoring plan.

**Figure 4.4 The monitoring plan**

<b>Output/ Outcome/ Impact</b>	<b>indicator</b>	<b>Data sources</b>	<b>Methods of data collection/ analysis</b>	<b>Frequency of data collection/ analysis</b>	<b>Person/ institution in charge</b>	<b>Who shall use the information</b>
<b>Social expenditures lower</b>	<b>% of population over 65 y.o. receiving home care</b>	<b>Current reporting health system</b>	<b>Current reports of the suppliers to the health authority</b>	<b>quarterly</b>	<b>County health authority</b>	<b>Decisions makers from local level</b>

Source: according to UNDP [2]

Alternative methods for data collection when data is missing:

- surveys and questionnaires for raising awareness/attitudes;
- expert panels;
- interviews with key informants;
- focus-groups;

### ***4.3 Mobilization of resources through drafting project proposals***

Financial resources are indispensable for the implementation of a reform process. Generally speaking, such sources can come from the state budget, from external loans or international financing institutions or from non-governmental organizations. It is crucial that the government fosters cooperation with international and non-governmental organizations and facilitates the building of networks without which it is very difficult to get adequate funding.

Given the major shift in organizational culture that is taking place within Romanian Governmental Institutions during these last years of preaccession and now accession into the European Union, most of the public national funding as well as European structural funding shall be provided to public institutions on program based criteria, following appropriate program and project development. Mobilising resources for health policies and programs will hence require a thorough multiannual programming and planning, including a multiannual financial projection from the part of the main decision makers involved as well as important programming and project development skills.

An essential step in defining a public policy and an implementation program, is identifying and mobilizing the resources needed for its appropriate implementation.

“Market research” for potential funders can be extremely useful. In principle, the following funding sources should be targeted - the state budget, the local budget, international donors, and EU funds.

In most of the cases, a project proposal must be drafted and sent to the funder. A competition for awarding the funds shall be organized in almost all cases. In order to draft a successful proposal, the principles regarding the important stages in preparing a project, must be observed, as well as the correct drafting of the specific documentation requested by the potential funder.

Usually, once the project is identified, potential financiers can be considered. Donors who supported similar projects in the past may be interested in the present proposal.

So it is useful to know the intervention areas of these donors, their priorities and specific interest in a certain health problem, geographical area, organisation or unit type proposed by the project, and eligibility criteria for their funds. Consulting potential donors' official publications and sites (to understand their programmes and priorities) is an information source for guiding and justifying the project.

The proposal must prove that the project fits the financier's programmes and priorities, compliments other projects from the area and does not overlap with previous projects.

In general, donors organise competitions for selecting projects. To be a success, the proposal should persuade the donor of the necessity for financing the project through a concise and clear description of the issues tackled. Many times, co-financing is required. Identifying and demonstrating the interest of other organisations in project, is a strong argument for success because the donors are interested in supporting a project with broad interest. Donors require the completion of specific forms and correctness and clarity in filling out the forms and respecting the dead-line for presenting the proposal are essential.

Traditional donors for national and local health projects have been the national health budget, local budgets, UNICEF, USAID, FNUAP, WHO, PHARE, UNAIDS, BIRD, BERD, Global Fund for HIV/AIDS, TB and malaria, Swiss Government, Great Britain, private donors, NGOs and others. Starting in 2007, Romania has access to post-adhesion EU funds. Projects that seek these funds should fulfil the specific requests based on the type of financing, e.g. structural funds, adhesion funds, or other funds.

***The general specifications which have to be fulfilled by the projects which access EU funds are:***

***1. Clear and achievable goal and objectives:***

- a. a clear distinction between objectives and activities;
- b. involve beneficiaries, target groups, interested groups
- c. assumptions and pre-conditions are realistic
- d. have lasting benefits

**2. *Quality factors which strengthen the long-term benefits:***

- a. Strategies assumed by the country for sectoral and regional policies
- b. Choose the proper solutions for resolving the issue
- c. Respect the socio-cultural values of the involved groups
- d. Increase the management capacity of the private and public institutions which implement the project
- e. Project's economical and financial viability and the durability of the generated benefits
- f. Gender considerations
- g. Integration of environmental protection aspects

**3. *Consistency with, and contribution to accomplishing the EU's objectives for 2007-2013***

- a. Economical and social convergence
- b. Regional competitiveness
- c. Territorial cooperation

The Romania National Development Plan and National Reference Framework represent the country institutional framework in the EU and define the main intervention areas which will benefit from structural and adhesion funds.

***The checklist for identifying the potential donor for the proposed project:***

- Which is the policy and which are the donor's priorities?
- What projects did finance and where?
- What part of the project is eligible?
- Is Co-financing required?
- Which is the specific form for the proposal?
- What is the deadline for submitting the proposal?

Beginning in 2007, Romania has access to Structural Operations (Structural and Cohesion Fund), as well as to other types of European financing, such as Communion Funds (eg. FP 7).

The strategic planning and multiannual financing scheduling document is The National Development Programme (NDP) which has as its general objective a fast reduction of the socio-economical differences between Romania and other EU states.

**The NDP has the following priorities:**

- Increase the economical competitive and economical development based on knowledge (Lisabona Agenda)
- Develop and modernize the transportation infrastructure
- Protect and improve the environment
- Develop human resources, promote occupation and social inclusion and strenghten administrative capacity
- Develop rural economy and increase the agriculture productivity
- Reduce the differences between country's regions

**Essential principles for writing a successful proposal when applying to EU funds:**

- Identify the national and EU program under which the proposal is placed (OP, sectorial programme etc)
- Adjust the project to fit the national and EU's programmes priorities
- Assign a competent team for writing the project
- Careful study and completion of proposal documents
- Co-financing – where required
- Durable partnerships and division of tasks
- Demonstrate the allocation principles of the strucutral funds:
  - Additionality
  - Subsidiary
  - Equal chances
  - Disemination and innovation

- Applying for community funds (eg: FP 7):
  - European dimension
  - Innovation
  - Multiplier effect
  - Visibility
  - Assessment
- Study and follow the financing selection and winning criteria

The allocation of the structural funds is made through the Operational Programmes, which detail the financing areas which correspond with national and EU priorities. At present, the Program Complement and the Application Guidelines for each of the Operational Program are under negotiation and need to be actively followed as conditions of eligibility, co-financing, etc shall be different from Operational programs.

#### ***4.4 Specific problems and opportunities***

The most important challenge in moving from policy drafting to policy implementation is an adequate assigning of human resources for the management, monitoring and feedback to decision-makers during the process. The institutional development programs that provide project management training to the local administration represent an opportunity for developing sustainable interventions.

#### ***4.5 Conclusions***

Planning represents the application of a process that leads to “deciding what to do, how to do it, and how to assess before taking action”. It is a process that concerns the future, involves a causality relation between actions taken and expected results; it applies the principle of determinism; it involves action (the end result is change); is an ongoing and dynamic process with a multi-disciplinary nature involving collaboration between physicians, economists, legal advisors, engineers, biologists, sociologists, psychologists, and statisticians. Appropriate planning is the most important prerequisite for good program proposal writing and program (project) implementation.

The successful health program brings together in a coherent manner the 3 main elements that determine an effective health care intervention, objectives, activities and resources. The essential task of the persons involved is to draft plans and secure funding for designing the future.

## ANNEXES

## Annex 1: Glossary of Terms

**Health** is defined as complete physical, psychological and social welfare, not only the absence of diseases and disabilities. Thus, it is a positive concept focused both on social and personal resources and on physical ability. This implies actual ability as well as the individuals' perception of their abilities to perform their activities according to their social role, to function and relate with the physical and social environment, as well as with the specific diseases and life in general<sup>1</sup>.

**Health status represents** a summary of individual health statuses, considered as a whole, overall vision. It is not simply a sum of the individual health of the members in a community.

**Health determinants** are factors or any conditions with an impact on the individual's health or, in quantitative terms, with an impact on health status<sup>2</sup>.

**Health need** represents a person's ability, under given physical and psychological conditions, to conduct their activity in the society.

**Need for healthcare services** represent the ability to benefit from a service/treatment.

**Establishing the health need** is a systematic method of reviewing the health problems of a population, leading to priority setting and resource allocation for the purpose of improving health and reducing gaps<sup>3</sup>.

**Target population** can be defined as the population where one or several diseases have a high incidence, or as the population that is the subject of a certain intervention/study/health policies.

**Health system** – the personnel, the institutions and the resources committed, together with the strategy and the policies, aimed at improving the population's health, answering their hopes and protecting them through a variety of activities with a main purpose of improving health<sup>4</sup>. The term covers both the medical care system and other activities from other sectors whose main purpose is to promote, recover or maintain health (for instance, environmental safety, food safety etc.).

**Health care system** – a formal structure for a defined population whose funding, management, aim and content are defined by law and regulations. It provides healthcare services to the population (in various locations, such as at home, education institutions, public spaces, communities, practices, hospitals, clinics)<sup>4</sup>.

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<sup>1</sup> Beaglehole R., Bonita R. Basic epidemiology. OMS, Geneva, 1993

<sup>2</sup> Donals L.P, Erickson P. Health-Related Quality of Life – Outcomes of Health Care Organization and Delivery. Medical Care. Vol 35 (11), Supplement, 199

<sup>3</sup> Health Development Agency. Health Needs Assessment: A Practical Guide, 2005. Available at the web address web: [www.nice.org.uk/page.aspx?o=513203](http://www.nice.org.uk/page.aspx?o=513203)

<sup>4</sup> European Observatory on Health Systems and Policies. Glossary of Terms. Available at the web address: <http://www.euro.who.int/observatory/Glossary/TopPage?phrase=Health+system+also> +

## **Annex 2: Indicators proposed by the European Commission – European Core Health Indicators (ECHI - 2)**

### **Main areas for the set of ECHI indicators**

#### **1 The demographic and socio-economic situation**

##### **1.1 Population**

##### **1.2 Socio-economic factors**

#### **2 Health status**

##### **2.1 Mortality**

##### **2.2 Morbidity, on categories of diseases**

##### **2.3 General health status**

##### **2.4 Composite indexes for health status**

#### **3 Health determinants**

##### **3.1 Individual and biological factors**

##### **3.2 Behavioral factors**

##### **3.3 Living and working conditions**

#### **4 Healthcare systems**

##### **4.1 Prevention, protection and promotion of health**

##### **4.2 Resources of the healthcare system**

##### **4.3 Use of healthcare**

##### **4.4 Expenses and funding**

##### **4.5 Quality/performance of healthcare**

### Annex 3: Calculation methodology for potential years of life lost

#### *The classical calculation formula*

The classical formula for calculating potential years of life lost is:

$$PYLL = \sum_{i=1}^{13} d_i(65 - a_i) = \sum d_i W_i$$

where  $i = 1 - 13$  number of age groups, five years each (see the attached table)

$d_i$  = number of deaths within each age group

65 = age limit where a death is considered premature

$a_i$  = center of the age group (semi-sum of the lower limits of 2 adjoining age groups)

The classical age groups are as presented in the table (13 age groups  $i = 13$ , if the age group of under 1 year is not considered, and  $i = 14$  if the age group 0 – 1 year is considered).

No.	Age group	$a_i$	$W_i = 65 - a_i$	$d_i$	$d_i \times W_i$
0	1	2	3	4	$5 = 3 \times 4$
1	under 1	0.5	$64.5 = 65 - 0.5$		
2	1 – 4	3	62		
3	5 – 9	7.5	57.5		
4	10 – 14	12.5	52.5		
5	15 – 19	17.5	47.5		
6	20 – 24	22.5	42.5		
7	25 – 29	27.5	37.5		
8	30 – 34	32.5	32.5		
9	35 – 39	37.5	27.5		
10	40 – 44	42.5	22.5		
11	45 – 49	47.5	17.5		
12	50 – 54	52.5	12.5		
13	55 – 59	57.5	7.5		
14	60 – 64	62.5	2.5		
					$\Sigma =$

Age is a continuous quantitative characteristic, therefore  $a_i$  is calculated:

$$a_i = \frac{\text{lower\_limit\_of\_class\_i} + \text{lower\_limit\_of\_class\_i+1}}{2}$$

### *Several aspects related to the situation in Romania*

**Absolute number of PYLL** during 1994 - 2004 decreased continuously (see table no.1). The value of losses for men is double that of women.

Table no. 1. Potential years of life lost in Romania, 1994 – 2004

Absolute figures – number individual – years

<b>Year</b>	<b>Total</b>	<b>Male</b>	<b>Female</b>
1994	1,737,416.0	1,153,971.5	583,444.5
1996	1,703,585.0	1,140,037.5	563,547.5
1998	1,562,282.5	1,039,775.0	522,507.5
2000	1,415,609.0	938,576.5	477,032.5
2002	1,309,118.0	880,802.5	428,315.0
2004	1,246,969.5	838,740.5	408,229

Data source - Marcu Aurelia et al. – Premature death in Romania, paper written in ISPB, 2006

The decrease (assessed by the method of the decrease rate in the baseline, the baseline being the year 1994) is more considerable in women, as compared to men; the percentage of the decrease in 2002, in relation with 1994 was of 23.7% in men and 26.6% in women (see table no. 2)

Table no. 2. Decrease in the number of potential years of life lost in Romania, 1994 – 2004

<b>Year</b>	<b>Total</b>	<b>Male</b>	<b>Female</b>
1994	100.0	100.0	100.0
1996	98.05	98.79	96.58
1998	89.91	90.10	89.55
2000	81.47	81.33	81.76
2002	75.35	76.32	73.43
2004	71.77	72.75	69.97

Data source - Marcu Aurelia et al. – Premature death in Romania, paper written in ISPB, 2006

### **The PYLL index for 1,000 inhabitants**

- The PYLL index to 1,000 inhabitants is a reliable reflection of the impact of premature deaths on the population's health status
- The characteristic of "sex" is an important element in establishing the level of premature deaths. Thus:
- The average value of the PYLL index to 1,000 inhabitants is constantly more than twice as high in men, compared to women
- The PYLL index to 1,000 inhabitants dropped by 22% for the total population, with 24% in women and 20% in men (see table no. 3).

Table no. 3. Evolution of the PYLL for 1,000 inhabitants

<b>Year</b>	<b>Total</b>	<b>Male</b>	<b>Female</b>
1994	76.43	103.43	50.41
1996	75.35	102.88	48.89
1998	69.42	94.42	45.47
2000	63.09	85.56	41.6
2002	60.06	82.76	38.40

- The amplitude of the **inter-county oscillations** is visibly larger in men than in women; the ratio between the 2 amplitudes has a value of over 5, an element that suggests a very wide distribution of values among counties. The value of the amplitude in men is almost equal to the minimum value (see table no. 4).

Table no. 4. Characteristics of the values for index APVP for 1,000 in 2002

<b>Characteristic</b>	<b>Male</b>	<b>Female</b>	<b>Urban</b>	<b>Rural</b>
Average value	82.76	38.41	55.63	65.58
Minimum value	63.46 M. of Bucharest	30.35 M. of Bucharest	45.73 M. of Bucharest	46.76 Hunedoara

#### Annex 4: DALY values for the county of Brasov, 1998

Group of disease	Code <sup>x)</sup>	DALY no.	%	DALY no./1000 inh.
Total		103410		
Infectious diseases	1 – 79	2141	2.07	3.42
Malignant tumors	80 - 176	13804	13.35	22.07
Blood diseases + hematology	203 - 233	629	0.61	1.01
Thyroid diseases	234 - 240	-	-	-
Diabetes	241 - 245	931	0.90	1.49
Endocrinology diseases	246 - 298	3427	3.31	5.48
Organic mental disorder	299 - 305	1234	1.19	1.97
Behavioral disorder	306 - 355	4812	4.65	7.69
CNS diseases	356 - 397	12073	11.67	19.30
Cardio-vascular diseases	445 - 497	31078	30.05	49.69
Respiratory diseases	498 - 542	5014	4.85	8.02
Digestive diseases	543 - 591	6375	6.16	10.19
Diseases of the subcutaneous tissue	592 - 625	36	0.03	0.06
Osteo/joint diseases	626 - 669	1444	1.39	2.31
Genital/urinary diseases	670 - 732	957	0.92	1.53
Pregnancy, birth, post partum	733 - 776	551	0.53	0.88
Perinatal diseases	778 - 820	1799	1.74	2.88
Malformations	821 - 878	2133	2.06	3.41
Accidents	879 - 975	11204	10.83	17.91

\* I.C.D., the 9<sup>th</sup> revised edition

## **Annex 5: Example of using the key informant technique**

**Topic** – Assessment of the health information system in Romania (study conducted upon the request and with the technical support of WHO – EURO)

**Key informants used** – categories of personnel

1. Directors / directors general from the Ministry of Health
2. Director of the IT and Information Center of the Ministry of Health
3. Representatives from other ministries relevant for health, holding information related to certain health status determinants (National Institute of Statistics, Ministry of Agriculture, Ministry of Transportation etc.)
4. Representatives of the National Health Insurance House / County Health Insurance House
5. Coordinators / country directors for health programs
6. Heads of offices for health statistics from the county directorates of public health
7. Family doctors
8. Coordinators on health statistics issues from the parallel health networks

**Questions they answered**

1. What data and information can be found in the institutions they represent?
2. What is the data flow – who sends them the data and to whom they send the data?
3. What is the aggregation level for the data?
4. What are the strengths and weaknesses in data generation and transmission?
5. What pieces of legislation regulate the data flow, its strengths and weaknesses?
6. Which are the mechanisms for data quality control?
7. Which are the mechanisms that ensure data confidentiality?
8. How are the available data and information used in the decision-making process?
9. Have they used the WHO databases in their activity?

**Result** – a report on the organization and functioning of the information system in healthcare in Romania and recommendations for improvement.

## Annex 6: Socio-Economic Indicators Useful for the Assessment of the Population's Health Needs

- Percentage of persons living in rural areas, in the total population<sup>5</sup>
- Population density per km<sup>2</sup>
- Ethnic and religious structure of the population<sup>6</sup>
- Literacy rate
- Drop-out rate
- Percentage of persons with secondary education in the total population  $\geq 15$  years<sup>1</sup>
- Percentage of persons with higher education in the total population  $\geq 25$  years<sup>1</sup>
- Proportion of the socially assisted population, in total and per category
- Poverty rate (% of the population living below the minimum poverty threshold)
- Unemployment rate
- Total and active workforce, % of the total population
- Structure of the economy: % income from agriculture, industry, services
- Population migration rate
- Delinquency incidence rate
- Annual inflation rate (%)
- The population's actual individual use<sup>2</sup>
- Minimum and average gross salary per economy
- Gross average income per person and per household
- Average monthly salary of a hospital physician
- Average monthly income of a family doctor
- Gross Domestic Product (GDP) per capita and growth rate GDP (economic growth)<sup>2</sup>
- Total health expenditure, in percentage from GDP<sup>1</sup>
- Total health expenditure as average annual amount per capita<sup>1</sup>
- Percentage of public expenditure in the total health expenditure<sup>1</sup>
- Percentage of hospital expenses in the total health expenditure<sup>1</sup>
- Average amount spent annually on drugs, per capita<sup>1</sup>
- Direct payments made by the population for healthcare services (% *out of pocket payments* in the total health expenditure and average amount per capita)
- Informal payments (*under the table payments*) made by the population for healthcare services (average amount per capita)
- Average fees applied for healthcare services, drugs and medical devices
- Human Development Index<sup>1</sup>
- GINI coefficient – for the distribution of welfare.

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<sup>5</sup> World Health Organization. Regional Office for Europe. Health for all database. <http://data.euro.who.int/hfad/>, accessed in January 2007

<sup>6</sup> Ministry of European Integration. Regional Operational Program 2007-2013, document drafted based on the Analysis of Areas for the National Regional Development Plan

## Annex 7: Definitions

**Monitoring** can be defined as a *continuous* process having as essential goal the provision of information for the managers and groups of interest on the progress made or on the failure that occurred during the implementation of an intervention, in order to reach certain objectives. The monitoring is based on a systematic collection of data and information, used to build specific indicators. [1]

**Evaluation is defined as a judgment of value made with regard to an intervention, a service or any component within a program or project.** It represents a *selective* exercise that tries to measure systematically and objectively the progress made in order to obtain an outcome. Evaluation is not conducted only once, it can be done at various moments in time during the implementation of an intervention in order to achieve certain objectives and can continue even after the completion of the intervention, for impact assessment. [1]

**Reporting** is an integral part of the monitoring and evaluation processes. Reporting is the systematic and timely provision of essential information, at certain well-defined time intervals. [1]

**Feedback** is a process by which, as a result of monitoring and evaluation, the results, the conclusions and the recommendations are disseminated and used to improve performance and form a basis in making a decision promoting the lessons learned during the implementation. [1]

**The outputs** represent the products, services or other concrete results (or events) generated by the completion of activities included in an intervention (project, program, strategy). [1]

**The outcomes** represent short or medium term effects, expected or realized as a result of an intervention, usually meaning the collective effort of partners. Examples of outcomes for individuals or groups: new knowledge, better skills, change in attitude, change in values, behavioral change, improvement of certain conditions, development of certain abilities and a healthy lifestyle. [1]

**The impact** represents the overall and long-term effect of an intervention. [1]

## **ANNEX 8: Indicators proposed by WHO for assessing the HFA strategy**

### Objective:

- A. Reducing morbidity and incapacitation
  - 1. Number of days with incapacitation
  - 2. Percentage of the population with various levels of incapacitation
  - 3. Incidence of TB
  - 4. Incidence of digestive infections
  - 5. Incidence of viral hepatitis
  - 6. Incidence of sexually transmitted diseases
  - 7. Temporary incapacitation for work
  - 8. Prevalence of chronic diseases
  - 9. Life expectancy without incapacitation
  - 10. Average number of cavities, missing or obturated teeth in 12 years old children
- B. Elimination of certain diseases
  - 11. Incidence of measles
  - 12. Incidence of poliomyelitis
  - 13. Incidence of tetanus
  - 14. Incidence of tetanus in the newborn
  - 15. Incidence of congenital rubella
  - 16. Incidence of diphtheria
  - 17. Incidence of congenital syphilis
- C. Life expectancy
  - 18. Life expectancy at birth
  - 19. Life expectancy at various ages (1, 15, 35, 65 years of age)
  - 20. Potential years of life lost (PYLL)
- D. Child mortality (21)
- E. Maternal mortality (22)
- F. Cardio-vascular diseases
  - 23. Mortality caused by cardio-vascular diseases, per age groups and sex
  - 24. Mortality caused by ischemic heart diseases
  - 25. Mortality caused by cerebral-vascular diseases
- G. Cancer
  - 26. Mortality per age groups and sex, according to malignant tumors
  - 27. Mortality per age groups and sex, caused by tracheal and lung cancer
  - 28. Mortality caused by cervical cancer

## Annex 9: Health Indicators and their main data sources

In time, different international bodies/agencies proposed sets of key indicators that characterize the health status of a population.

- The World Health Organization – proposes in 1981 a set of indicators that monitor the program “Health for everyone by the year 2000” (see annex 4.2)
- The European Union – proposes in 2005 a short list of community health indicators – ECHI (European Core Health Indicators) (see annex in chapter 2)
- The Government of USA, under the coordination of CDC Atlanta – proposes in 1991 a set of indicators to monitor the “Healthy People 2000” strategy. [4]

The main data sources for routine indicators (reported systematically) used in the healthcare system are as follows:

- *Population* – taken from the census data or from population estimates for the years between censuses. Institution: The National Institute for Statistics
- *Mortality* – taken from death certificates, in the County Offices for Statistics, then aggregated at national level. Institution: The National Institute for Statistics
- *Morbidity* – taken from various sources: national registries of diseases (cancer, diabetes), systems for the control of communicable and non-communicable diseases, the health insurance system. Institutions: The National Center for the Organization and Provision of the Information and IT System in Health, The National Health Insurance House
- *Health services* – taken especially from hospitals (the DRG system). Institutions: The National Health Insurance House

There is also a series of special studies, conducted at certain time intervals, that produces relevant indicators for health monitoring and evaluation, while adding to the information missing from the routine sources:

- *Prevalence surveys* – assess the prevalence at the moment of the interview (the Health status survey conducted regularly by the National Center for the Organization and Provision of the Information and IT System in Health)
- *Longitudinal surveys* – follow an evolving phenomenon (the Household Survey, conducted annually by the National Institute for Statistics)
- *Health status survey through interviews* – assesses the population perception of their own health status, a survey to be conducted at the European Union level and based on a set of standardized questions, produced by EUROSTAT. It will be conducted by the National Institute for Statistics.

These surveys are based on representative population samples and on a validated questionnaire. The main disadvantages: they are costly and use numerous resources (financial, human and time).

## **Annex 10: Proposal Preparation**

### **Writing the proposal**

Generally, the proposal's dimensions vary between 5 to 10 pages for projects with 1-2 year period or can be longer for the long time projects. Usually, the donor specifies this requirement in the proposal form.

#### ***Main sections of an application form:***

1. First page - presentation;
2. Contents;
3. Executive summary;
4. Introduction and justification;
5. Goal and objectives
6. Activities;
7. Monitoring and evaluation;
8. Key personnel;
9. Strengths and innovations;
10. Sustainability
11. Budget
12. Annexes

1. ***First page*** – usually contains key informations as: name and contact informations of the organisation/ institution; project's name; name of the potential donor, date of the proposal, project's length and requested budget.
2. ***Contents*** – is useful especially for larger proposals, for an easy orientation of the donor;
3. ***Executive summary*** - it should not be longer than 1 page and to be a summary of the proposal, and to have each sections' key elements:
  - What is the organisation that requires the financing?
  - Why is it requested?
  - What are the issues addressed by the project?
  - How long is it going to take? What are the goals and objectives?
  - How will the goals and objectives be achieved?
  - What are the expected results?
  - What is the budget?

- What are the co-financing funds?
- How will the activity continue after the end of financing?

4. **Introduction and justification** – should present in 2-3 pages what is the issue addressed by the project and what is the organisational/institutional capacity to realize the project.
  - a. In the description of the problem is proving the emergency and importance of tackling this issue and is providing relevant international and national statistical data from credible sources. Also is included the area's theories and programmes, other organisations' experience, positive and negative results, the necessity for the project's specific intervention. A short description of the project and the expected results is also included.
  - b. Is justifying why the organisation/ institution is interested by the project, which is the organisation/ institution's mission, experience and personnel's experience, which were the partners in the previous projects.
5. **Goal and objectives** – usually are presented in a ½ a page, considering that the goal has to prove the durability of the intervention for the target population and the objectives to accomplish tangible results on short or medium term. Donors like World Bank, European Bank for Investments, European Union require the project to be in a specific framework (eg. National Development Plan, strategic area eligible for the financing, priority axis, general objective), the project's relevance for that framework, the project's contribution in accomplishing national and European specific objectives. Also the logical framework can be explained here. Also include the discussion regarding the pre-conditions and assumptions.
6. **Activities** – will demonstrate the accomplishment of the objectives through indicators. Key issues to present are how the activities will be fulfilled, why there were chosen, who will perform them, who are the beneficiaries, when they will begin and when finished, what are the needs for carrying out the activities, and who are the partners. The workplan with all the activities will be discussed.
7. **Monitoring and evaluation** – include the indicators and their description, source of data, who will collect the data and the collecting frequency. Including a monitoring and evaluation plan is useful for facilitating the project's functioning mode and for taking the right decisions during implementation.
8. **Key personnel** – in this section will be specified the human resources used in the project – who will work and what tasks they will have, how long they will work on the project, what skills they have, and use volunteers, etc.

- 9. *Strengths and innovations*** - The section allows emphasizing the organisation/institution's abilities in tackling the problem or the involvement of experienced partners for minimize the risks. Also the project's originality in tackling themes, populations, neglected aspects, organising or implementing the project will be discussed.
- 10. *Sustainability*** - refers to the project's ability to continue after the end of the financing period. The project should be integrated in the organisation/ institution/ community's future budget for continuing the intervention and assuring that the target population, general population, beneficiaries will receive long term benefits. Community and policy-makers' involvement, offering the earned experience, reducing costs etc are ways to ensure the continuity.
- 11. *Budget*** – is a vital aspect of the proposal. It should reflect all the personnel, material, trainings, consultancies, travels' costs or other activities mentioned in the proposal' costs and indispensable monitoring and evaluation costs. Usually is presented in a table and narrative report in a form specified by the donor. A total and detailed budget is presented. The EU requires mentioning the budgets by activity, partners, financing categories, eligible percents. The co-financing requirements are very clearly specified.
- 12. *Annex*** – includes the logical framework, workplan, supporting letters from partners, other donors., ownership documents, proofs of co-financing participation, etc

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