
10 Years
of Health Systems
Transition in Central and
Eastern Europe and Eurasia



Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia

July 28-31, 2002

Please visit the Conference Website:
www.eurasiahealthtransitionconference.org

AIHA Emergency Contact Information
AIHA Staff Cellular Phone: 202-345-2113
Toll-Free Phone Number: 1-877-SOS-AIHA

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I. Welcome



U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

The Administrator

July 28, 2002

Dear Conference Participants:

On behalf of the United States Agency for International Development (USAID) and our partners that have made this gathering possible, I am pleased to welcome you to the Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia Conference.

This conference comes at a challenging time. For ten years, the region has struggled to maintain health systems that have been de-capitalized by worsening economic conditions. Now, it is also facing new health challenges, including the rapidly growing threats of HIV/AIDS, TB, and the chronic diseases of aging populations. With new problems also come new opportunities such as we see in new and improved diagnostics and treatments, a worldwide communications revolution, a vast expansion of public private partnerships and last, but not least, the public commitments of world leaders to solve health problems. Your exchanges of ideas this week on how to strengthen organizing and financing of health care, improve the quality of health services, mobilize citizens and communities for better health, and advance public health will contribute to realizing these opportunities.

USAID welcomes this opportunity to learn and build upon our last ten years of experience in improving health and healthcare in Europe and Eurasia. We and our conference partners appreciate the time that each of you is giving to this effort through your participation. I thank you for coming and wish you well in the deliberations over the next three days.

Sincerely,

A handwritten signature in black ink that reads "Andrew S. Natsios". The signature is written in a cursive, flowing style.

Andrew S. Natsios

II. Conference Agenda At-a-Glance

USAID Conference Agenda: July 28-31, 2002

Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia

Tracks:

- | | |
|--|--|
| 1: Facing the Challenges of Healthcare Financing | 4: Mobilizing Citizens and Communities for Better Health |
| 2: Improving the Continuum of Care | 5: Advancing Public Health |
| 3: Improving the Quality of Health Services | |

Sunday, July 28											
18:00	Opening Reception										
Monday, July 29											
9:00-10:30	Welcome Addresses: United States Agency for International Development, United States Department of Health and Human Services, Ministers of Health										
10:30-11:00	Coffee Break										
11:00-12:30	Plenary Addresses: USAID, WHO, The World Bank Regional Overview: European Observatory on Health Care Systems Conference Charge: USAID										
12:30-14:00	Lunch										
14:00-14:30	Breakout Sessions: Introduction to the Tracks										
14:30-16:00	Concurrent sessions <table border="1"> <thead> <tr> <th>Track 1: Room: Georgetown</th> <th>Track 2: Room: Jefferson West</th> <th>Track 3: Room: Jefferson East</th> <th>Track 4: Room: Lincoln West</th> <th>Track 5: Room: Lincoln East</th> </tr> </thead> <tbody> <tr> <td>1A: National Health Insurance Financing</td> <td>2A: Improved Hospital Management/ Downsizing Hospital Sector</td> <td>3A: Facility and Professional Standards Development</td> <td>4A: Building Stakeholder Support for Health Reforms</td> <td>5A: HIV Risk Reduction 1</td> </tr> </tbody> </table>	Track 1: Room: Georgetown	Track 2: Room: Jefferson West	Track 3: Room: Jefferson East	Track 4: Room: Lincoln West	Track 5: Room: Lincoln East	1A: National Health Insurance Financing	2A: Improved Hospital Management/ Downsizing Hospital Sector	3A: Facility and Professional Standards Development	4A: Building Stakeholder Support for Health Reforms	5A: HIV Risk Reduction 1
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Tuesday, July 30											
8:30-10:00	Concurrent Sessions <table border="1"> <tbody> <tr> <td>1B: Integrating Multiple Sources of Financing</td> <td>2B: Strengthening Primary Care</td> <td>3B: Health Professions Education – Focus on Primary Care</td> <td>4B: Building Healthier Communities Through the Healthy Communities/ Healthy Cities Process</td> <td>5B: HIV Risk Reduction 2</td> </tr> </tbody> </table>	1B: Integrating Multiple Sources of Financing	2B: Strengthening Primary Care	3B: Health Professions Education – Focus on Primary Care	4B: Building Healthier Communities Through the Healthy Communities/ Healthy Cities Process	5B: HIV Risk Reduction 2					
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Wednesday, July 31											
8:30-10:00	Plenary: Track Summaries by Track Leadership Teams										
10:00-10:30	Coffee Break										
10:30-12:30	Dialogue with Policy Makers and Donors										
12:30-12:45	Conference Closing										
1:00-2:00	Lunch										

III. Acknowledgements

A major international conference of this magnitude requires thousands of hours of work on the part of many people from multiple organizations. The US Agency for International Development (USAID) gratefully acknowledges the contributions of the organizations named below for their support. Especially appreciated is the hard work of the conference planning committee, composed of members from the American International Health Alliance (AIHA), USAID, the US Department of Health and Human Services (DHHS), the World Bank, the World Health Organization (WHO), and the European Observatory on Health Care Systems. The Agency also recognizes the contributions of the following organizations and their field offices for their time and effort in identifying, preparing, and funding speakers for the conference: Aga Khan Foundation, AIHA, the Canadian International Development Agency, DHHS, Humana Foundation, Open Society Institute, TACIS, U.K. Department for International Development, USAID, WHO/EURO, and the World Bank. Special thanks also to AIHA and DHHS for their valuable logistical and coordination support, and to AIHA and Eli Lilly Company for their support with the conference opening reception.

IV. Post-Conference Evaluation and Website

Conference participants typically complete evaluation forms to provide feedback on the quality of presentations, conference facilities, etc. Instead, participants are invited to provide comments, through the conference website, on the quality of the conference program and how you were able to apply what you learned after the conference ends. We will be sending you follow-up email messages in three months and six months to invite you to share how you applied the new and improved ideas and approaches you took home from the conference.

Remember the Lessons You Learned from Ten Years of Health Systems Transition in CEE and Eurasia.

Please Visit the Conference Website:

www.eurasiahealthtransitionconference.org

for Quick Access to :

- Conference Proceedings
 - Text and Audio of Speeches
 - Photos of Conference Sessions
 - Panel Slide Presentations
 - Abstracts of Presentations
 - Contact Information of Conference Attendees
-

V. Biographies of Plenary Speakers

Frederick Schieck

Deputy Administrator of the US Agency for International Development (USAID)

Mr. Schieck has had a long and successful career in international development both at USAID and other institutions. He was a USAID Foreign Service Officer for more than 25 years before retiring in 1990 with the rank of Career Minister. He has served as a member of the Board of Trustees and Vice President of the Executive Committee of the Pan-American Development Foundation. During his Foreign Service career at USAID, Schieck held senior positions in Washington, D.C., including Acting Assistant Administrator and Deputy Assistant Administrator for Latin America and the Caribbean, Deputy Assistant Administrator for Program and Policy Coordination, and Deputy Assistant Administrator for Asia.

Tommy G. Thompson

Secretary of the US Department of Health and Human Services

Secretary Thompson has dedicated his professional life to public service, most recently serving as governor of Wisconsin since 1987. Secretary Thompson made state history when he was re-elected to office for a third term in 1994 and a fourth term in 1998. During his 14 years as governor, Secretary Thompson focused on revitalizing Wisconsin's economy. He also gained national attention for his leadership on welfare reform, expanded access to health care for low-income people, and education.

Yuri L. Shevchenko, MD, PhD

Minister of Public Health, Russian Federation

Dr. Yuri Leonidovich Shevchenko has served as the Minister of Public Health of Russian Federation since July 6, 1999. He is a doctor of medical sciences, professor, and academician. Minister Shevchenko is Vice President of the Russian Academy of Natural Sciences, 1st Vice President of Petrovskaya Academy of Sciences and Arts of Russia, Chairman of the Nikolai Pirogov Surgical Society and Academic Board of the Russian Military Medical Academy. Minister Shevchenko is the recipient of several outstanding awards, including the Michael E. DeBakey International Military Physician's award, Honorable Degree of the Russian Military Medical Academy and Honored Scientist of the Russian Federation award. He has published 12 monographs and over 360 scientific papers.

Daniela Bartos, MD, PhD

Minister of Health and Family, Romania

Dr. Daniela Bartos has served as Minister of Health and Family in Romania since December 2000. She is a doctor of medical science, senior lecturer at the University of Medicine and Pharmacy "Carol Davilla," Bucharest and was part of Global Healthcare-Innovation in Medicine, Harvard Medical International. Minister Bartos is a member and vice president of the Society for Education on Contraception and Sexuality and an honorary member of the White-Yellow Cross of Romania Home Healthcare Delivery. She received the Award of the Alliance for Reproductive Health for supporting women's health action in Romania.

E. Anne Peterson, MD

Assistant Administrator, Bureau for Global Health, USAID

Dr. E. Anne Peterson is the assistant administrator of the Bureau for Global Health for the US Agency for International Development (USAID).

The Bureau for Global Health is tasked with technical and program support to field interventions as part of USAID's foreign aid in health system reform, HIV/AIDS, infectious disease control, reproductive health, child and maternal health, environmental health, and nutrition. Dr. Peterson has an extensive background in both US and international public health and medical practice. She has served as a consultant to the Centers for Disease Control and Prevention and the World Health Organization in Haiti and Brazil, designing elephantiasis treatment training materials and evaluations of educational interventions. She has spent almost six years in sub-Saharan Africa (Kenya and Zimbabwe) doing community development work, public health training and AIDS prevention, as well as performing US-based research in chronic disease prevention, outbreak investigations and food safety.

Marc Danzon, MD

Director, WHO Regional Office for Europe

Dr. Danzon has 25 years of experience in public health at national and international levels. He is a medical doctor who has specialized in public health, psychiatry and health management and economics. He has considerable experience working for WHO in the past. Dr. Danzon was in charge of communication and public information at the European Regional Office from 1985 to 1989. At the time, he was responsible for the first European Conference on Tobacco Policies held in Madrid in 1988. In 1992, he returned to Health Development. He was also Director of the Health Promotion and Disease Prevention Department. Before standing for the post of the WHO Regional Director for Europe in 2000, he was Director of the National Federation of Mutual Insurance Societies, a non-profit health insurance organization covering 35 million people and managing 1500 health and social establishments in France.

Christopher Lovelace, PhD

Director, Health, Nutrition and Population, Human Development Network, The World Bank Group

Chris Lovelace is a Bank expert on health, nutrition and population (HNP). In his current position he is responsible for providing strategic leadership for the HNP sector and building effective relationships and collaboration with key external partners. Previously, he was director of human development in Europe and Central Asia Region (ECA) and also served as HNP sector manager, responsible for providing strategic direction for HNP activities within the region. He joined the Bank in 1996 as a senior health specialist in ECA.

Prior to coming to the Bank, Mr. Lovelace worked with the British Columbia Ministry of Health, Canada, in various capacities including assistant deputy minister of management operations (1985-88), assistant deputy minister of care services (1988-92), special consultant (1995), and assistant deputy minister of strategic programs (1995-96). He was also director general and chief executive of the New Zealand Ministry of Health (1992-95).

Martin McKee, MD, MSc, FRCP

European Observatory on Health Care Systems (data/demographics and trends of the past decade)

Martin McKee is a professor of European public health at the London School of Hygiene and Tropical Medicine. He manages a large research program focused on health and health policy in Europe, and in particular Central and Eastern Europe and the former Soviet Union. Dr. McKee is co-director of the School's European Centre on Health of Societies in Transition, a WHO Collaborating Centre specializing in health and health care in the countries of Central and Eastern Europe. He is also editor-in-chief of the European Journal of Public Health.

Josep Figueras, MD, PhD, MSc

European Observatory on Health Care Systems (the nature of health care reform in the past decade)

Josep Figueras is the Head of the Secretariat and a Research Director of the European Observatory on Health Care Systems. He is the regional advisor for Health Systems Analysis at the WHO Regional Office for Europe in Copenhagen. He holds an honorary lectureship in Health Policy and Management at the London School of Hygiene & Tropical Medicine.

Dr. Figueras was co-project leader for the WHO Regional Office for Europe's study of health care reforms, which published the book, *European Health Care Reform: An Analysis of Current Strategies* (WHO 1997) as well as *Critical Challenges for Health Care Reforms in Europe* (edited with Richard Saltman and Constantino Sakellarides; Open University Press, 1998). He is also the author of the book, *Choices in Health Policy: An Agenda for the European Union* (with Abel Smith et al; Dartmouth, 1996).

Kenneth I. Shine, MD

Director, RAND, Center for Domestic and International Health Security

Kenneth I. Shine, MD, former President of the Institute of Medicine (IOM) of the National Academy of Sciences, has been recently named as the founding Director of a new multidisciplinary Center for Domestic and International Health Security at RAND.

Under Dr. Shine's leadership from 1992-2002, the IOM played an important and visible role in addressing key issues in medicine and healthcare. IOM reports on quality of care and patient safety heightened national awareness of these issues. IOM researchers led studies on nutrition, food safety, and child development, and examined availability and side effects of vaccines. Dr. Shine also focused attention on meeting the healthcare needs of all Americans: he organized symposia to underscore the importance of cultural sensitivity in healthcare and supported programs to increase immunization rates, decrease use of tobacco among adolescents, and improve care of the dying.

Dr. Shine is Professor of Medicine Emeritus at the University of California, Los Angeles (UCLA) School of Medicine. A cardiologist and physiologist, he received his M.D. from Harvard Medical School in 1961. Before becoming president of the IOM, he was Dean and Provost for Medical Sciences at UCLA. He served as Chairman of the Council of Deans of the Association of American Medical Colleges from 1991-1992, and was President of the American Heart Association from 1985-1986.

VI. Agenda

USAID Conference: Ten Years of Health System Transition in CEE and Eurasia

	Sunday, July 28
6:00 p.m.	Opening Reception Gazebo Area, Washington Hilton
	Monday, July 29, morning
9:00 – 10:30 am International Ballroom Center	<p>Welcome</p> <p>Paula Feeney, MPH Conference Moderator, Bureau for Europe and Eurasia US Agency for International Development</p> <p>Frederick Schieck Deputy Administrator, US Agency for International Development</p> <p>Tommy G. Thompson Secretary of the US Department of Health and Human Services</p> <p>Yuri L. Shevchenko, MD, PhD Minister of Health, Russian Federation</p> <p>Daniela Bartos, MD, PhD Minister of Health, Romania</p> <p>Plenary Address I</p> <p>E. Anne Peterson, MD, MPH Assistant Administrator, Bureau for Global Health, US Agency for International Development</p>
10:30 – 11:00 am	Coffee Break (Concourse)
11:00 – 12:30 p.m. International Ballroom Center	<p>Plenary Address II</p> <p>Marc Danzon, MD Director, WHO Regional Office for Europe</p> <p>Plenary Address III</p> <p>Christopher Lovelace, PhD, Director, Health, Nutrition, and Population, Human Development Network, The World Bank Group (introduced by Dr. Armin Fidler, Health Sector Manager, Europe and Central Asia Program, The World Bank Group)</p> <p>Overview: Ten Years of Health Systems Transition in CEE and NIS</p> <p>Martin McKee, PhD European Observatory on Health Care Systems: (data/demographics and trends of the past decade)</p> <p>Josep Figueras, PhD Director, European Observatory on Health Care Systems: (the nature of health care reform in the past decade)</p> <p>Conference Charge</p> <p>Mary Ann Micka, MD Chief, Health Reform and Humanitarian Assistance Division, Bureau for Europe and Eurasia, US Agency for International Development</p>
12:30 – 2:00 p.m. International Ballroom East and International Ballroom West	Lunch

Monday, July 29, afternoon

2:00 – 2:30 p.m.
Introduction to the
Conference Tracks

Track 1: Georgetown
Facing the Challenges of Health Care Financing

Introduction to Track: Jack Langenbrunner, The World Bank; Mitalip Mamytov, Minister of Health of Kyrgyzstan; Tim Johnston, The World Bank

The way funds flow through a health care system is one of the most important determinants of the system's ability to meet its goals of sustainability, access, equity, quality and cost effectiveness. We will look first at some of the different ways that funds have been collected and pooled to create national health insurance programs and the issues that have arisen in the process. Since few systems can be totally dependent on health insurance for their funding, we will then hear about innovative approaches to combining different sources of public and private financing to influence the availability and organization of health care services.

Following the discussion of health care financing, panel sessions will address the mixed experience of countries in their attempts to use purchasing policies to influence the cost and utilization of hospital and primary care services. Following these four panel sessions, conferees have a choice of two sessions to top off their examination of financing issues. The first session will be a case study of a country whose experience illustrates the many components to be addressed and integrated when attempting to change the rules of the financing system. The second session is a discussion of the benefits and pitfalls of market-based health care and strategies to address the lessons learned. Among the topics discussed will be the need to legislate and effectively enforce new governance principles.

Track 2: Jefferson West
Improving the Continuum of Care

Introduction to Track: Martin McKee, European Observatory on Health Care Systems; Armin Fidler, The World Bank; Amiran Gamkrelidze, Minister of Health of Georgia; Nata Menabde, WHO

Underpinning the economics of a viable health care system is the appropriate allocation of resources across levels of care and within each level. Reformers in CEE and Eurasia recognized that the re-orientation of health care away from the hospital sector was an important first step in freeing resources to address the broad range of health care needs of the population. Leading the track discussions will be a session on management strategies to improve hospital efficiency. Panels will then examine efforts to strengthen and modernize services at the other end of the continuum - primary care. Initiatives to reorganize systems and develop regional approaches to service delivery demonstrate that by taking a creative look at how best to match resources with needs, care can be streamlined to better serve the population. Conferees will hear numerous examples of how disease management methods in new care settings have both reduced treatment costs for each episode of illness and improved the effectiveness of care. Finally, an enhanced perception of the diversity of special needs in the population has led to initiatives to fill gaps in the continuum of care and to enable more non-governmental organizations to participate in care giving.

2:30 - 4:00 pm

Panel A: National Health Insurance Financing
Moderator: Jan Bultman, The World Bank

- **Organization of Federal Health Insurance in Russia**, Andrei Taranov, director of the Federal Health Insurance Fund
- **Hungarian Health Care Financing Reform: Managing the Change**, Tivadar Miko, professor and head, Department of Histopathology, Faculty of General Medicine, University of Szeged, and former Director General of Health Insurance Fund, Hungary
- **The Challenges of Implementing Health Insurance Policies**, Eva Andrejčaková, vice-director, General Health Insurance Company, Slovakia
- **Implementation of a Health Insurance System in Estonia**, Maris Jesse, chair, Management Board, Estonian Health Insurance Fund
- **Private Health Insurance as a Supplement to the Publicly Funded Health System**, Paul Lenz, president, Managed Care Consulting International

Panel A: Improved Hospital Management/
Downsizing Hospital Sector
Moderator: Laura Rose, The World Bank

- **Moldova Hospital Reform**, James Cercone, president, Sanigest International
- **Downsizing the Hospital Sector in Issyk-Kul and Chui Oblasts**, Damira Salieva, director, Issyk-Kul Oblast General Hospital, Kyrgyzstan
- **The Changing Role of Nurses Along the Continuum of Care**, Valentina Sarkisova, president, All Russia Nurses Association, Russia
- **Municipal Hospital Management Under Health Insurance**, Jan Mlcak, director, Jindrichuv Hradec Hospital, Czech Republic
- **The Rational Use of State Financing and Commercial Activity in a State-Owned Medical Institution**, Iakov Nakatis, CEO, Sokolov Hospital #122, St. Petersburg, Russia

Track 3: Jefferson East
Improving the Quality of Health Services

Introduction to Track: Rashad Massoud, University Research Company; Michael Borowitz, UK Department for International Development; Igor Denisov, Vice Rector, Moscow Medical Academy

The quality of health care is determined in part by the capacity of professionals and institutions to deliver services that are timely, appropriate, acceptable and effective. Capacity building reforms that will be discussed at the conference include educational programs, professional self-regulation initiatives and the development of new practice protocols in line with international standards of practice. The first session will provide examples of programs that were initiated to formalize quality measurement in health care facilities as well as in the health care professions. Conferees will then learn about reform efforts that have centered on retraining and enhancing the effectiveness of health professionals by increasing educational opportunities for modern clinical training in primary care. Dramatic changes in the healthcare delivery system have created a need for new clinical professions and for a cadre of professional health care managers trained to make personnel, financial and other administrative decisions, the topic of our third panel. Finally, two panels will present new models for managing health care through quality measurement techniques and use of evidence-based medicine.

Panel A: Facility and Professional Standards Development
 Moderator: James Heiby, US Agency for International Development

- **Implementation of Quality Improvement in the Czech Republic**, David Marx, senior lecturer, Charles University, Czech Republic; physician advisor and former director of Quality, Ministry of Health, Czech Republic
- **Medical Education Development: The Role of the Council of Rectors and Nursing Council in Central Asia**, Zhamilya Nugmanova, regional director, AIHA/Central Asia
- **Improving Hospital Quality of Care through Implementation of a Magnet Nursing Program in Selected Hospitals in Russia and Armenia**, Linda Aiken, Professor, director of the Center for Health Outcomes and Policy Research, University of Pennsylvania
- **Implementation of a Hospital Clinical Indicator and CQI Program**, Marina Ugrumova, head, International Patient Department, Central Clinical Hospital of the President of the Russian Federation, Moscow, Russia
- **Facility Accreditation in Poland**, Rafal Nizankowski, associate professor, Accreditation Council, Poland, and former director, Polish National Committee for Quality Assurance

Track 4: Lincoln West
Mobilizing Citizens and Communities for Better Health

Introduction to Track: Ilona Kickbusch, Yale University; Mihaly Kokeny, Secretary of State, Ministry of Health of Hungary; Mary Ann Micka, USAID

Health is not a benefit that can be delivered to a population. To achieve improved health in a country or community, reformers have found that representatives of all stakeholders (from across many sectors) must become involved in a process that enables them to take ownership of the problem and feel empowered to implement the solutions.

The first panel session illustrates the importance of identifying who the stakeholders are and building their support. Lessons learned from those seeking major legislative change as well as those pursuing more specific opportunities to better the quality of life will be presented. The healthy communities/healthy cities program has given citizens the tools needed to take part in the community development process. Methods used to mobilize citizens and communities through this program and some of the notable success stories will be examined by the second panel.

Citizens' efforts to mobilize resources to benefit vulnerable populations are testimonials to the emerging role of advocacy and civil society in the region. The third and fourth panels will describe how programs were developed to respond to the social and medical needs of children and elderly, followed by a special look at complex community problems that impact women in particular, such as trafficking and domestic violence. Finally, conferees are invited to join Track 1 for the discussion of a case study on managing the change to diagnosis related groups (DRGs), the new hospital payment system in Romania. The strategic planning for this transition recognized that the concerns of all the political and professional stakeholders had to be addressed in order to achieve acceptance of changes that had broad ramifications.

Panel A: Building Stakeholder Support for Health Reforms
 Moderator: Susan Raymond, Consultant

- **Building Support for Reforms that Transcend Political Change**, Mihaly Kokeny, secretary of state, Ministry of Health, Social and Family Affairs, Hungary
- **The Role of Training Stakeholders in Building Support for Health Reforms**, Tamas Evetovits, director of International Programs, Health Services Management Training Center, Semmelweis University, Hungary
- **Patient's Rights in Bulgaria**, Svetla Tsolova, project manager, Index Foundation, Bulgaria
- **Turning a Prosthetic Rehabilitation Partnership into an International Sports Program**, Mark Pitkin, director, IPRLS, Research Associate Professor of Rehabilitation Medicine, Tufts University School of Medicine
- **Scaling up Health Care Quality in Russia: Building Stakeholder Support**, Anna Korotkova, chief of Methodological Center for Quality, Central Public Health Research Institute, Russia
- **Links to all Stakeholders: The Management Strategy of Bulgaria's Social Insurance Reform**, Atanas Shterev, chairman, Committee of Health, National Assembly, Bulgaria

Track 5: Lincoln East
Advancing Public Health

Introduction to Track: Martin Bobak, University College London; Daniela Bartos, Minister of Health of Romania; Nina Schwalbe, Open Society Institute

Improvements in health status are the fundamental goal of a health care system. However, many social and economic factors which are outside the realm of the health care system contribute to poor health. During the past ten years, CEE and Eurasia have endured social and economic hardships which have led to unhealthy lifestyles and more stress-related conditions. As a result, life expectancy has declined in most countries in the region and chronic diseases are the primary cause of death and disability in the region. Over the same period, the HIV/AIDS pandemic has taken root in the region while much of the capacity for preventing, identifying and controlling the spread of infectious diseases has been lost due to the transition.

The first two panel sessions will address the measures underway to reduce the risk of HIV/AIDS. Preventing and controlling HIV/AIDS in high risk groups, particularly injecting drug users, will be discussed in the first session. In the second session, measures to establish an infrastructure to address the emerging threat of HIV/AIDS will be described. A range of strategies to build capacity for promoting public health through education, community-based organizations and national initiatives are discussed in the third session. The last two sessions are devoted to the important topic of health promotion and disease prevention. Both sessions begin with examples of comprehensive national initiatives of health promotion followed by discussions of preventive measures to protect women's health in the fourth panel, and health promotion related to lifestyle changes in the final session.

Panel A: HIV Risk Reduction 1
 Moderator: Sue Simon, Open Society Institute

- **Prevention of HIV Among Injection Drug Users**, Iraida Sivacheva, chairman, Pskov Anti-AIDS Initiative, Russia
- **The Way Home Charity Fund: HIV Prevention Among Drug Users**, Sergei Kostin, director, "The Way Home" Charitable Foundation, Ukraine
- **Laboratory and Integrated Behavioral Assessment of Risk Factors of STD/HIV Among High Risk Groups in Moscow, Russia**, Lali Dubovskaya, director, SANAM Russian Association for STI Prevention
- **STD and HIV Prevention Efforts in the Russian Federation**, Anna Shakarishvili, Division of STD Prevention, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention
- **USAID's Partnerships in HIV/AIDS Control and Prevention in Central Asia: The Drug Situation in Central Asia and USAID's Response to the Drug-Related HIV/AIDS Epidemic**, Jennifer Adams, director, Office of Health and Population, USAID Kazakhstan

Tuesday, July 30, morning

8:30 – 10:00 am	<p>Track 1 continued: Georgetown Panel B: Integrating Multiple Sources of Financing Moderator: Alex Preker, The World Bank</p> <ul style="list-style-type: none"> • Single Payer Health Financing Model: Budgeting for Universal Coverage, Mitalip Mamytov, Minister of Health, Kyrgyzstan • Four-Party Agreements to Strengthen Delivery of the Program of State Guarantees in the Russian Federation, David Johnson, director, Project Management, Health and Life Sciences Partnership Consulting • Provider's Perspective: Financing Community Health Care Programs with Funds from National Health Insurance – The Misszio Experience, Imre Somody, founder, Misszio Health Center, Hungary • Provider's Perspective: Financing Private Sector Health Care – The Successful Financing of a Private Polyclinic, Marie Horakova, director of SPEA Clinic, Olomouc, Czech Republic • Community Philanthropy as a Source of Funding: How to Involve the Community in Financing Hospital Improvements, Adam Jelonek, executive director, Friends of Litewska Children's Hospital, Poland 	<p>Track 2 continued: Jefferson West Panel B: Strengthening Primary Care Moderator: John Petersen, Milwaukee International Health Training Center</p> <ul style="list-style-type: none"> • Case Study in Restructuring Primary Health Services at the District Level, Katayon Faramuzova, deputy health program manager, Aga Khan Foundation, Tajikistan • Developing the Role of Nursing to Strengthen Primary Care at the Institutional and District Level, Saadat Mahmudova, head, Narimanov District Health Administration, Azerbaijan • Free Choice of Primary Health Care Practice and Enrollment as a Behavior Change Factor in Central Asia, Elvira Nabokova, marketing coordinator, ZdravPlus Project, Kazakhstan • The Ferghana Experience: Bottom-Up Reform, Maria Vannari, task manager, The Information for Development Program, The World Bank • The Development of Family Medicine, Yevhen Latyshev, deputy head physician, Information Coordinator, Donetsk City Hospital #25, Ukraine • Collaboration with a Corporate Donor: Sustainable Pediatric Training Programs with Measurable Results, Mircea Nanulescu, director, Pediatric Clinic #3, Children's Hospital, Cluj, Romania
10:00 – 10:30 am	Coffee Break (Concourse)	
10:30 – 12:00 pm	<p>Panel C: Paying for Hospital Services Moderator: Susan Matthies, KPMG Consulting</p> <ul style="list-style-type: none"> • Hospital Payments in Russia: Lessons Learned, Igor Sheiman, director of ZdravConsult Foundation, Russia • Hospital Payment in Georgia, Akaki Zoidze, deputy state minister, Georgia • Implementing DRGs in Czech Republic, Marcela Ambrozova, head of Department of Mathematical and Statistical Analysis in General Health Insurance Company • The Impact of DRGs in Hungary: Hospital Utilization Rates Have Not Changed, Csaba Dozsa, head, Department for Preventive and Curative Care, National Health Insurance Fund, Hungary • The Estonian Experience: How Financing Systems Encourage a Public/Private Mix of Ownership, Toomas Palu, member, Management Board of Estonian Health Insurance Fund 	<p>Panel C: Reorganizing Systems and Developing Regional Approaches Moderator: James A. Rice, International Health Summit</p> <ul style="list-style-type: none"> • Restructuring EMS Services in Poland, Andrzej Rys, senior consultant, Health and Management Limited and Former Deputy Minister of Health, Poland • Addressing Infant Mortality and Morbidity through a Regional Perinatal Network in Kosice, Slovakia, Peter Krcho, Perinatal Center NICU Faculty Hospital, Slovakia • Restructuring Regional Rural Health Services to Enhance the Role of Primary Care, Lyudmila Patoka, deputy head, Kharkiv Oblast Health Administration, Ukraine • Restructuring Health Delivery Systems in Central Asia, Sheila O'Dougherty, regional project director, ZdravPlus Project, Kazakhstan • Health Care System Reform in Samara, Russia: Development of New Approaches to Funding and Care Provision, Olga Chertukhina, Health Department, Samara, Russia
12:00 – 1:30 pm	Lunch (International Ballroom East and International Ballroom West)	

Track 3 continued: Jefferson East

Panel B: Health Professions Education – Focus on Primary Care

Moderator: Neal Vanselow, former chancellor, Tulane Medical School

- **The Development of Family Medicine in Central Asia**, Damila Nugmanova, clinical training director, ZdravPlus Project USAID, Abt Associates, Kazakhstan
- **Integration of a Skills-Based Primary Care Training and Continuing Family Medicine Education**, Zuhra Mirzoeva, head, Department of Health Reform, Tajikistan
- **Skills-Based Primary Care Training Program to Upgrade Skills and Build Physician-Nurse Practice Teams**, Shirin Berkelieva, physician, Family Medicine Training Center, Health House #1, Turkmenistan
- **Primary Health Care Continuing Medical Education in Macedonia**, Fimka Tozija, associate professor, International Project Unit, Ministry of Health, Macedonia
- **Clinical Primary Care Training**, Nancy Fitch, Physician Advisor, Armenia Social Transition Program
- **Family Medicine Development in Bosnia and Herzegovina: A Seven-Year Retrospective**, Geoffrey Hodgetts, director, Family Medicine Development Program for Balkans, Queen's University, Kingston, Canada

Track 4 continued: Lincoln West

Panel B: Building Healthier Communities Through the Healthy Communities/Healthy Cities Process

Moderator: Bernice Bennett, American International Health Alliance

- **Lessons Learned from WHO's Healthy Cities/Healthy Communities Initiatives in the NIS and CEE**, Leah Janss Lafond, Centre for Regional Economic and Social Research, Sheffield Hallam University
- **Improving the Community's Health in Dubna: Lessons Learned**, Sergei Ryabov, head of the City Health Department, Dubna, Russia
- **Using the Healthy Cities Collaborative Planning Process to Implement Occupational and Environmental Health Programs in Banska Bystrica**, Eleonora Fabianova, director, State Health Institute, Slovak Republic
- **Youth Drug Prevention: Creating Healthy Lifestyles in Vac**, Laszlo Ujhelyi, pediatrician, Primary Health Care Service, Vac Public Health Institute, Hungary
- **Mobilizing a Community Through the Community Process to Address Domestic Violence and Other Women's Health Issues**, Daniel Verma, head, Health Promotion Department, Constanta Health Authority, Romania; representative from the Romanian Ministry of Health and former inspectorate for Public Health, Public Health Directorate of Constanta, Romania
- **Lessons Learned from WHO's Healthy Cities/Healthy Communities Initiatives in Hungary**, Antonio deBlasio, secretary general, Hungarian Association of Healthy Cities

Track 5 continued: Lincoln East

Panel B: HIV Risk Reduction 2

Moderator: Paul Delay, US Agency for International Development

- **Essential National Efforts Toward Structural Reform and Securing Cross-Border Collaboration in the Fight Against HIV/AIDS**, Zaza Tsereteli, international technical advisor for HIV/AIDS/ STIs, Task Force on Communicable Disease Control for CBSS
- **The 1995 Federal HIV Law, Related Statutes, and Current Practice in Russia**, Frank Feeley, clinical associate professor of Public Health, School of Public Health, Boston University
- **AIDS Infoshare: Getting Out the Message to Risk Groups and Health Professionals**, Alena Peryshkina, program director, AIDS Infoshare, Russia
- **A Regional Approach to Preventing Mother-to-Child Transmission of HIV in Odessa, Ukraine**, Natalie Nizova, professor, Department of Post-Graduate Education, Odessa State Medical University
- **Securing the Blood Supply: Development of a Model Blood Bank**, Levan Avalishvili, director, Polyhaema Blood Bank, Georgia

Panel C: Health Professions Education 2 – Focus on New Professions, New Training, and Modalities

Moderator: Mary Ellen Stanton, US Agency for International Development

- **Training a New Generation of Health Managers**, Roman Prymula, vice president, Purkyne Military Medical Academy, Czech Republic
- **Nursing Education: Creating Four-Year Bachelors Programs for Nursing**, Alina Kushkyan, Erebuni Nursing College, Armenia
- **Health Education Link Project in the Context of Nursing Reform in Russia**, Galina Perfilieva, dean, Faculty for Higher Nursing Education, Sechenov Medical Academy, Moscow, Russia
- **Improving Quality Through Nurse Managers: Development of Advanced Management Training for Nursing Administrators**, Jana Mareckova, senior lecturer, Institute for Theory and Practice of Nursing, Olomouc University, Czech Republic
- **Improving the Quality of Emergency Medicine and Disaster Response: Region-Wide Models for Continuing Education**, Georgiy Chebanu, chief physician, Chisinau Emergency Hospital and Chair, Department for Emergency Medicine, Moldova State Medical University

Panel C: Creating More Responsive Community Services: Focus on the Vulnerable (Children & Elderly)

Moderator: Aleksandra Posarac, The World Bank

- **Deinstitutionalization of Children**, Aleksandra Posarac, The World Bank
- **Mobilizing Community-Based Services for Disabled Children**, Klara Frecerova, National Institute for TB and Respiratory Diseases, Slovakia
- **Providing Services to Specific Population Groups (Children and Elderly)**, Paikarmo Aliyorova, Roshkala District chief doctor, Department of Health, Tajikistan
- **Maternal and Child Health Initiative in Turkmenistan**, Yazgylch Charyev, country director, Counterpart International, Turkmenistan
- **After the Conflict: Developing a Post-Traumatic Stress Disorder Program**, Ante Gilic, head of Psychiatry Department, Zadar General Hospital
- **Changing Health Provider Roles to Meet Community Needs: Addressing the Special Needs of the Elderly Through Community-Based Primary Care**, Rosa Abzalova, chief physician, Model Family Medicine Center "Demeu", Astana, Kazakhstan

Panel C: Building Capacity for Public Health
Moderator: Daniel Miller, The World Bank

- **Reallocation of Resources from Curative to Preventive Programs**, Pagbajav Nymadawa, minister of health, Mongolia
- **Developing Monitoring and Surveillance Systems to Address Lead and Environmental Health in Russian Cities**, Boris Revich, senior researcher, Center for Demography and Human Ecology, Institute for Forecasting of the Russian Academy of Sciences, Russia
- **Developing Community Skills in Community Assessment, Mobilization, and Communication**, Selma Sogoric, Croatian Healthy Cities Network Support Center located at Andrija Stampar School of Public Health, Medical School, University of Zagreb, Croatia
- **Building Health NGO Capacity to Make Health Impacts: Counterpart Consortium and Abt Associates in Central Asia**, Zafar Oripov, grants manager, ZdravPlus Project, Uzbekistan
- **Educating for Public Health in Central Asia**, Maksut Kulzhanov, rector, Almaty School of Public Health, Kazakhstan
- **Challenges of Training in Public Health and Health Management in Lithuania**, Ramune Kalediene, dean, Public Health Faculty, Kaunas University of Medicine, Lithuania

Tuesday, July 30, afternoon

<p>1:30 - 3:00 pm</p>	<p>Track 1 continued: Georgetown Panel D: Primary Care Financing Moderator: Forest Duncan, US Agency for International Development</p> <ul style="list-style-type: none"> • Per Capita Payment for Primary Health Care in Central Asia, Cheryl Cashin, deputy director, ZdravPlus Program, Abt Associates • Attempting Capitation When Data are Limited: Results and Lessons from Bosnia and Herzegovina/Republika Srpska, Tatyana Makarova, senior program associate, Management Sciences for Health • Primary Healthcare Rehabilitation Project, Lapsuna District, Moldova, Viorel Soltan, Public Health program director, Soros Foundation, Moldova • The Trade-Off Between Access and Sustainability for Bulgaria's National Health Insurance Fund: Is Financial Independence a Real and Achievable Goal?, Christian Tanushev, director, Budget Directorate, National Health Insurance Fund, Bulgaria 	<p>Track 2 continued: Jefferson West Panel D: Infectious/Chronic Disease Management Moderator: Olusoji Adeyi, The World Bank</p> <ul style="list-style-type: none"> • Integrating Infectious Disease Management into Primary Care: The Cost of Managing Cases of Hepatitis A in an Outpatient Setting Relative to a Hospital Setting in Kazakhstan, Michael Favorov, Central Asia program director, US Centers for Disease Control and Prevention • DOTS Implementation in Central Asia, Indira Aitmagambetova, health program management specialist, Office of Health and Population, USAID Kazakhstan • Implementation of WHO TB Control Strategy in Pilot Regions of Russia as a Factor in Improving Continuum of Care for TB Patients, Olga Demikhova, deputy director, Central Tuberculosis Research Institute, Russia • Diabetes Disease Management Programs in Moscow Oblast, Svetlana Bertash, deputy minister, Moscow Oblast Ministry of Health, Russia
<p>3:00 - 3:30 pm</p>	<p>Coffee Break (Concourse)</p>	
<p>3:30 - 5:00 pm</p>	<p>Panel E: Bringing the Pieces Together: The Romania Experience Moderator: Jugna Shah, Nimit Consulting</p> <ul style="list-style-type: none"> • Leaping from a "Project" to Rollout: Case-Based Financing System, Dana Barduja, project coordinator, National DRG Project, Romania • Building Stakeholder Support for Change, Iulian Popescu, general manager, National Health Insurance House, Romania • Creating Clinical Data Analysis Tools, Daniel Ciurea, coordinator, National DRG Project, Romania • Cost Accounting: Providing Tools to Hospitals, Paul Radu, project coordinator, Institute of Health Services Management, Romania • Creating Incentives to Achieve Results, Aurora Dragomiristeanu, Institute for Health Services Management, Romania • Bringing Leadership to the Vision, Radu Deac, secretary of state, Ministry of Health, Romania <p>OR</p> <p>Panel F: Increasing Market Forces, Transparency and Accountability Moderator: Maureen Lewis, The World Bank (location: Lincoln West)</p> <ul style="list-style-type: none"> • Overview of the Issue of Introducing Market Forces and Privatization in the ECA Region: Positive and Negative Impacts, Maureen Lewis, The World Bank • Attacking Corruption Systematically, Mustafa Khani, minister of health, Albania • Lessons Learned about Privatization and Market Forces during the First 10 Years of Transition, April Harding, senior private development specialist The World Bank • Czech Health Care System Reform, Zuzana Roithova, Chair, Health and Social Care Committee, Senate of the Czech Republic • Public Policy Issues in Privatization: Licensing and Regulation of the Pharmaceutical Industry, Ryszard Petru, economist, The World Bank, and former deputy minister of Finance, Poland 	<p>Panel E: Diversifying the Continuum Moderator: Akiko Maeda, The World Bank</p> <ul style="list-style-type: none"> • NGOs as Health Service Providers in Bulgaria, Georgi Genchev, executive director, Parliamentary Center for European Law Foundation • Addressing the Special Needs of the IDP Community through Home Visits, Rafael Mehdiyev, chief, City Clinical Hospital #6, Binagadi Health District, Baku, Azerbaijan • Making Women's Health Matter: An Integrated Approach, Svetlana Posokhova, deputy chief physician, Odessa Oblast Hospital, Ukraine • Bridging the Gaps in Palliative Services, Anda Jansone, director, Hospice Services, Latvian Children's Hospital, Riga, Latvia • Integrating Mental Health into Primary Care in Ukraine, Yuriy Yudin, Mental Health Department, Kiev City Health Administration, Ukraine

Track 3 continued: Jefferson East

Panel D: Implementing Quality Improvement and Evidence-Based Medicine 1

Moderator: Mary Cummings, Agency for Healthcare Research and Quality

- **Quality Improvements in Primary Care in Romania**, Mary Cummings, health scientist administrator, Agency for Healthcare Research and Quality
- **The Georgia Safe Motherhood Initiative Project Improving Quality Outcomes Through Guidelines and Improved Information Systems**, George Gotsadze, director, Curatio International Foundation, Georgia
- **Responding to the Critical Needs of Newborns**, Olga Detyusk, head, Department of Pediatrics, Lviv Oblast Hospital, Ukraine; Vladislav Romanenko, prorector, head of Emergency Pediatrics and Neonatology Department, Ural State Medical Academy of Postgraduate Education, and director of Chelyabinsk Neonatal Resuscitation Training Center
- **Women and Infant Health Project: A Model for Improving Maternal and Child Health Service in Russia**, Natalia Vartapetova, resident advisor, John Snow Inc.
- **Using Continuous Quality Improvement to Improve Reproductive Health Services in Central Asia**, Gulshara Orazbakova, ZdravPlus Project, Kazakhstan

Track 4 continued: Lincoln West

Panel D: Addressing Complex Community Issues/Case Studies in Preventing Domestic Violence and Trafficking

Moderator: Joyce Hoffeld, US Agency for International Development

- **Prevalence of Domestic Violence in the Region**, Florina Serbanescu, CDC Atlanta
- **A Citizens Foundation Model for Organizing Community Information, Counseling, and Assistance Services to Prevent Domestic Violence and Drug Abuse: The Petzalka Hope Center**, Jana Sturova, president of the Board, Aid to Children at Risk Foundation, Slovakia
- **Prevention of Domestic Violence as an Example of Community Cross-Sectoral Collaboration**, Irina Makarova, deputy chief of Dubna Healthcare Department, Russia
- **Ways to Counteract Trafficking of Women**, Amy Heyden, director, Trafficking Prevention Programs, Winrock International, Ukraine
- **NGO/ Women's Shelter Network**, Marina Pisklakova-Parker, president, Russian Association of Crisis Centers for Women

Track 5 continued: Lincoln East

Panel D: Health Promotion and Disease Prevention 1

Moderator: Debbie Maiese, Department of Health And Human Services

- **A Ten-Year Program of Health Promotion in Hungary**, Andras Javor, general manager, Health of the Nation Program, Hungary
- **Preventing Anemia in Uzbekistan**, Mark McEuen, senior analyst, Abt Associates
- **Mainstreaming Care and Prevention of Birth Defects and Developmental Disorders in Ukraine**, Wladimir Wertelecki, professor and chairman, Department of Medical Genetics, University of South Alabama, and Senior Health Specialist, USAID Ukraine
- **Breast Cancer Screening and Early Detection**, Hranush Hakobyan, member of Parliament, co-president, Armenian-American Wellness, Yerevan, Armenia
- **Improving Family Planning Services in Russia**, Irina Savelieva, head, International Research Program, Research Center for Obstetrics, Gynecology, and Perinatology, Russia

Panel E: Implementing Quality Improvement and Evidence-Based Medicine 2

Moderator: Steven Kairys, Jersey Shore Medical Center

- **A Eurasia-Wide Approach to the Development and Sharing of Clinical Practice Guidelines**, Stephen Kairys, chairman of Pediatrics, Jersey Shore Medical Center
- **Quality Improvement and Evidence-Based Practice in the Prevention of Surgical Infections: Changing the National Prikaz**, Sergei Eremin, Mechnikov Medical Academy, St. Petersburg, Moscow
- **Developing Clinical Practice Guidelines to Improve Primary Care Nationally**, Ruzanna Yuzbashyan, director, Primary Health Care Department, Ministry of Health, Armenia
- **Putting Evidence into the Hands of Practitioners: The Region-Wide Learning Resource Center Approach in Georgia and Throughout the Region**, Zviad Kirtava, director, National Learning Information Center, Tbilisi, Georgia
- **The Financing-Quality Intersection**, Gheorghe Pusta, National DRG Project, Romania

We invite conferees to attend one of the Track 1 sessions at this time.

Track 1, Panel F (*Increasing Market Forces, Transparency, and Accountability*) is being held in this room (Lincoln West).

Please see p.14 for a description of Track 1, Panel F.

Panel E: Health Promotion and Disease Prevention 2

Moderator: Nelle Temple Brown, World Health Organization

- **Challenges in Developing a Local Health Promotion Strategy**, Paata Imnadze, director, National Center for Disease Control, Tbilisi, Georgia
- **Implementing Community-Based Smoking Cessation Programs in Martin, Slovakia**, Elena Kavcova, director, Department of Pulmonary Diseases, Comenius University Teaching Hospital, Slovakia
- **Implementing Cardiovascular Wellness and Health Promotion Minsk, Belarus**, Larisa Plashchinskaya, director, Minsk Wellness Center for Cardiovascular Disease Prevention, Minsk, Belarus
- **Cardiovascular Disease Mortality in the Czech Republic**, Rudolf Poledne, associate professor in Biochemistry, Institute for Clinical and Experimental Medicine, Czech Republic
- **Impact of Reforms on Monitoring and Surveillance Systems for Infectious Diseases for which Immunizations are Available**, Robert Steinglass, Immunization team leader, BASICS

	Wednesday, July 31, morning
8:30 - 10:00 am <i>International Ballroom Center</i>	Plenary Track Summaries by Track Leadership Teams Moderator: Paula Feeney Bureau for Europe and Eurasia, US Agency for International Development
10:00 - 10:30 am	Coffee Break (Concourse)
10:30 am - 12:30 pm <i>International Ballroom Center</i>	Dialogue with Policy Makers and Donors Moderator: Kenneth I. Shine, MD Director, RAND, Center for Domestic and International Health Security
12:30 - 12:45 pm <i>International Ballroom Center</i>	Conference Closing Paula Feeney Conference Moderator, Bureau for Europe and Eurasia, US Agency for International Development
1:00 - 2:00 pm <i>International Ballroom East and International Ballroom West</i>	Lunch

VII. Conference Theme Papers

The first paper in this series is an overview of health sector reform in the NIS and CEE over the last decade. The following five papers introduce the five key system change areas. The papers represent the views of the authors and are not meant to be definitive nor comprehensive surveys on these themes, but rather a conceptual framework for the conference participants. There are many different sub-themes to the issue of health sector reform in the region. The limitations imposed by the time available for conference sessions were such that we had to select a few areas to focus on at the conference. Therefore, the papers do not give a comprehensive analysis of the range of issues that have arisen in the course of the past 10 years. Furthermore, within each sub-theme only a few of the dimensions of the reforms could be addressed. For instance, the scope of the papers often has not touched on some of the issues that will be discussed in panel sessions, reflecting the different priorities of government leaders, local reformers and donor organizations. Most would agree however, that the five tracks do represent important aspects of durable and sustainable reform and also are linked to each other showing the integrated nature of the reform process. USAID gratefully acknowledges the contributions of the European Observatory on Health Care Systems in coordinating and compiling the conference theme papers.

Facing the challenges of health care financing

A background paper prepared for USAID Conference, Washington, DC
29–31 July 2002

Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia

Anna Dixon,

European Observatory on Health Care Systems,
London School of Economics and Political Science

Jack Langenbrunner,

The World Bank

Elias Mossialos,

European Observatory on Health Care Systems,
London School of Economics and Political Science

This draft paper is part of a series commissioned by USAID to provide a conceptual framework and overview of the main thematic topics of the USAID conference "Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia." Following the conference, each team of authors will revise the papers, compiling the final versions in a book by the European Observatory on Health Care Systems, which will be made available to conference participants in early 2003.

Introduction

The financing of health systems was the subject of early and radical reforms in central and eastern Europe (CEE) and the newly independent states of the former Soviet Union (NIS).¹ In most countries the intention of the reforms was to shift away from the centralized integrated state model of Semashko to decentralized and contracted social health insurance. This was modelled in part on the basic features of the Bismarck model found in western Europe, but significant differences also emerged as it was adapted to the particular context of CEE and NIS.

The shift resulted in changes to the way money was both collected and pooled, and created a new relationship between purchasers and providers of care. Legislative reform was, however, not always matched by concrete change on the ground, and in some cases the objectives set out in policy were not fully or even partially attained. The countries of CEE and NIS face a new and challenging environment, in terms not only of total funding for health care but also of the efficiency of their health care services with the funding available and the development of sufficient government and technical capacity.

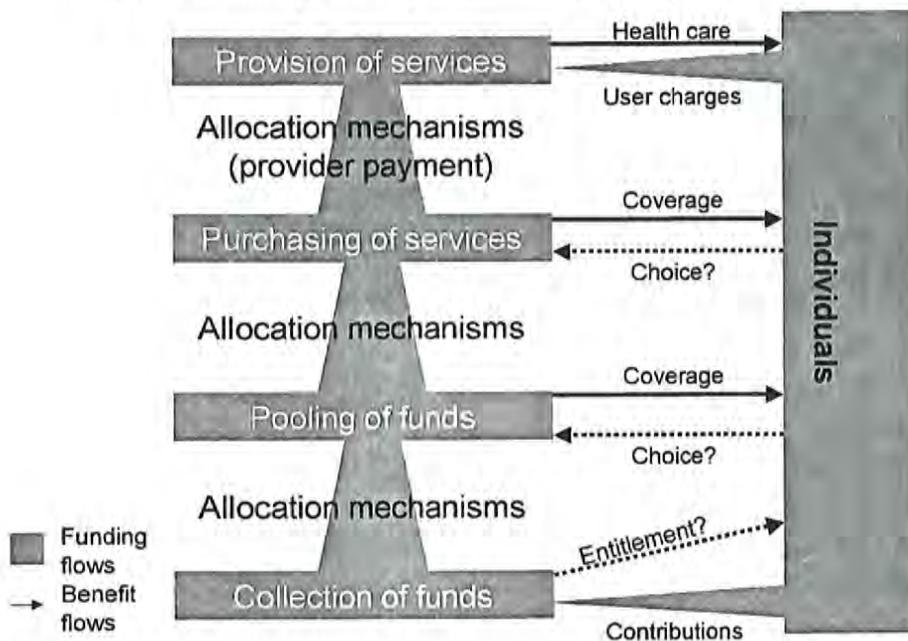
The purpose of this paper is to set out a conceptual framework for understanding the financing of health care, to describe and analyse some of the trends in CEE and NIS, to evaluate the experience and to draw some conclusions. The main body of the paper is organized into three sections: revenue collection, the pooling of financial resources and the purchasing of services.

Conceptual framework

Confusion often arises in debates about health care systems because the systems are crudely defined (e.g. Beveridge, Semashko or Bismarck). The assumption is that the source of funds for health care somehow determines the organizational structure. This traditional thinking is being challenged (Kutzin 2001). A number of tools have been developed to facilitate analysis of health care financing in the region. One of these identifies distinct functions within the health care system: revenue collection, pooling, purchasing and provision (Fig. 1, page 2). Revenue collection refers to the process of mobilizing resources, usually from households or corporate entities but also from external donors. Pooling refers to the spreading of financial risk across the population or a subgroup of the population through the accumulation of prepaid health care revenues. This facilitates solidarity, primarily between the healthy and the sick and, depending on the method of funding, between the rich and the poor. Purchasing is the process of obtaining services from providers on behalf of the covered population. The provision of services, and how these are delivered and by whom, is not within the scope of this paper.

¹The "region" referred to in this analysis covers the countries of central and eastern Europe and the former Soviet Union. Different terms are used to refer to these countries. This paper adopts the WHO terminology of CEE and NIS.

Fig. 1. Functions of health system financing and population links



Source: Kutzin 2001.

For each of these functions it is possible to identify related policy issues. These are outlined in Table 1. Decisions on each of these policy issues will shape the overall structure of the health care financing system. For example, the equity of the financing system will depend both on the level and on the distribution of the contributions. Equity of access will depend on who has access and to what services, as well as on user charges and informal payments. Efficiency will be influenced largely by the extent of pooling and the methods of provider payment. Depending on the extent of decentralization and fragmentation in the system, these functions and the associated decisions may be carried out by different bodies. For example, central government might decide the contribution rate and the proportion to be paid by the employer and the employee, while collection of the contributions might be the responsibility of regional branches of the health insurance fund.

Table 1. Policy issues related to different financing functions

Financing function	Related policy issue
Collection of funds	<ul style="list-style-type: none"> • How much money to collect and from whom? • Who and what to cover?
Pooling of funds	<ul style="list-style-type: none"> • How to pool resources? • How to allocate resources to purchasers?
Purchasing of services	<ul style="list-style-type: none"> • From whom to buy and how to buy? • At what price to buy and how to pay?

Source: Adapted from Preker et al. 2000.

Theoretical issues

Before describing and analysing the systems of health care financing that have been introduced in CEE and NIS, we present a short synopsis of the theoretical debate on the advantages and disadvantages of different funding methods. The extent to which practice reflects these theoretical advantages and disadvantages will depend largely on the country context (politics, economy, culture, history and technical capacity).

The main sources of revenue for health care are taxes, social insurance contributions, voluntary insurance premiums and user charges (formal and informal). Most countries rely on a mix of these sources. Taxes are compulsory for the whole population and are levied by government. Social insurance contributions are compulsory for all or some of the population; they are kept separate from other government revenues and are usually managed by a fund or funds independent of government. In CEE and NIS countries, the term “social insurance” is often used to describe payroll taxes that are in fact levied by government and managed by a fund that government largely controls. Nevertheless, for the purposes of this paper we will use the term social insurance to include payroll taxes.

In terms of equity, direct taxes (i.e. those levied on individuals, households or firms) are usually set progressively — the higher the income the higher the proportion paid. In contrast, indirect taxes (i.e. those levied on goods and services) are regressive because those on lower incomes spend a greater proportion of their income on consumption. Social insurance contributions are usually levied in proportion to income. Where an income ceiling is applied, above which income is exempt from contributions, social health insurance becomes mildly regressive. Furthermore, because contributions are levied only on earned income (not on profits or income from investments and savings) they place a heavier burden on those with lower incomes. In contrast, private health insurance and user charges are higher for those in greatest need, thus relating how much you pay to how ill you are (or are likely to be).

In terms of efficiency, taxation is associated with strong expenditure control; it draws on a broad revenue base and is administratively efficient. Depending on the organization of social insurance, expenditure control might be strong if there is a single fund or government caps the overall budget or sets contribution rates. Social insurance draws only on earned income and therefore adds to the cost of labour with a potentially negative effect on economic growth. If separate systems of collection are implemented, this will add to administrative costs. In theory, both social insurance and taxation are associated with access free at the point of use and near universal coverage, whereas user charges and voluntary health insurance relate access to ability to pay (Mossialos et al. 2002). These issues are summarized in Table 2. Some of the advantages and disadvantages will depend on the perspective taken and the objectives that are being pursued.

Table 2. Summary of the theoretical advantages and disadvantages of different methods of revenue collection

Method of revenue collection	Advantages	Disadvantages
Direct taxation	<ul style="list-style-type: none"> • Wide revenue base (all income) • Administratively simple • Usually progressive and promotes solidarity • Large risk pool • Allows trade-offs with other areas of the public sector • Universal coverage 	<ul style="list-style-type: none"> • Compliance may be difficult • Allocations subject to political negotiation • Potential tax distortions
Indirect taxation	<ul style="list-style-type: none"> • Visible source of revenue (all transactions) • Administratively simple • Compliance easy 	<ul style="list-style-type: none"> • Potential tax distortions • Allocations rely on consumption levels • Usually regressive
Social health insurance	<ul style="list-style-type: none"> • Earmarked for health • Separate from other government revenues • (May) link contribution to benefit • Low resistance to increases • Independent management of funds • May allow choice of insurer 	<ul style="list-style-type: none"> • Compliance difficult • Increases costs of labour and may reduce international competitiveness • Revenue follows economic cycle • Strong regulatory framework • Narrow revenue base (only applies to earned income)
Voluntary health insurance	<ul style="list-style-type: none"> • May allow choice of insurer • May relate payment to utilization 	<ul style="list-style-type: none"> • Strong regulatory framework needed • Adverse selection (results in escalating premiums) • Risk selection (leaves some uninsured) • Access related to insurance cover • Usually regressive
User charges	<ul style="list-style-type: none"> • Relates payment to utilization 	<ul style="list-style-type: none"> • May deter access to necessary services • Access related to ability to pay • Regressive • Limited pooling of funds

The extent of pooling will depend on how much of the revenues collected are pooled through a single fund and whether different sources of funding are pooled or remain separate. For example, tax revenues may be pooled together with social insurance contributions to enable funds to purchase health care services on behalf of all citizens. Alternatively, pooling may be limited if tax revenues are kept separate to provide public services directly for those who do not make insurance contributions.

Where there is decentralization or multiple collection agents, pooling may occur at national level if mechanisms exist to redistribute through a central pool. For example, if regional taxes are levied and retained by local government, pooling operates only at the local level. However, if central taxes are used to compensate regions for the different income levels and/or different health needs of the populations covered, then pooling is extended to a national level. Similarly systems of resource allocation may be used to pool funds between competing insurance funds. Pooling enhances efficiency because it reduces the incentives for risk selection and may break historical patterns of allocation. It also increases equity and solidarity principles by sharing risks across a larger population. Voluntary health insurance may, if it is group-rated, pool risks among the employees of a company or, if it is community-rated, among the residents of a particular area. Usually, however, voluntary health insurance is initially individually risk-rated (and may subsequently be experience-rated) and therefore pooling among subscribers is extremely limited. If user charges are retained by the providers who collect them there is little pooling of funds, but revenues from user charges may be pooled with other revenues to provide services for a specific population.

In theory there are two main models of purchasing: integrated models (under which the providers are owned and managed by the insurer) and contract models (under which the providers are separate from the insurer). Many countries have been moving from integrated command and control models of publicly operated provision towards one or another new form of "purchasing," in which public (or quasi-public) third-party payers are kept more organizationally separate from health service providers. The rationale for this "purchaser-provider split" model (Figueras et al. 2001) has been:

- to improve services by linking plans and priorities to resource allocation, such as to shift resources to more cost-effective interventions and across care boundaries, for example from inpatient to outpatient care (purchasing, in this sense, can be regarded as an alternative way to do some of the things that have been traditionally pursued via planning);
- to better meet population health needs and consumer expectations by building them into purchasing decisions;
- to improve the performance of providers by giving purchasers policy levers, such as contracting or financial incentives or monitoring tools, that can be used to increase provider responsiveness and efficiency;
- to facilitate decentralization of management and the devolution of decision-making by allowing providers to focus on the efficient production of services as determined by the purchaser; and

- to introduce competition or contestability among providers and thereby use market mechanisms to increase efficiency.

In several European countries, the shift to contracting has been accompanied by a shift away from historical or norm-based budgeting to activity- or performance-related pay. The new forms of provider payment are intended to increase productivity and efficiency and ensure the high quality of services provided. However, they rely on good information systems and may be costlier to administer.

In the following sections we review the experience of financing health care in CEE and NIS over the past ten years, describing what has happened and offering some analysis of the implementation process.

Collection of Funds

Prior to the transition to market economies, revenue for health care was generated mainly from state-owned enterprises. Private sources were negligible except for informal payments to providers. As in tax-financed systems, health competed with other areas of public spending, and expenditure on health was the outcome of political negotiations and reflected priorities (these tended not to favour health, which was seen as an “unproductive” sector). During transition two new sources of funding emerged: social health insurance contributions and out-of-pocket payments (both official user charges and informal payments) (Preker et al. 2002). There were a number of reasons why many of the CEE and NIS countries shifted to social health insurance:

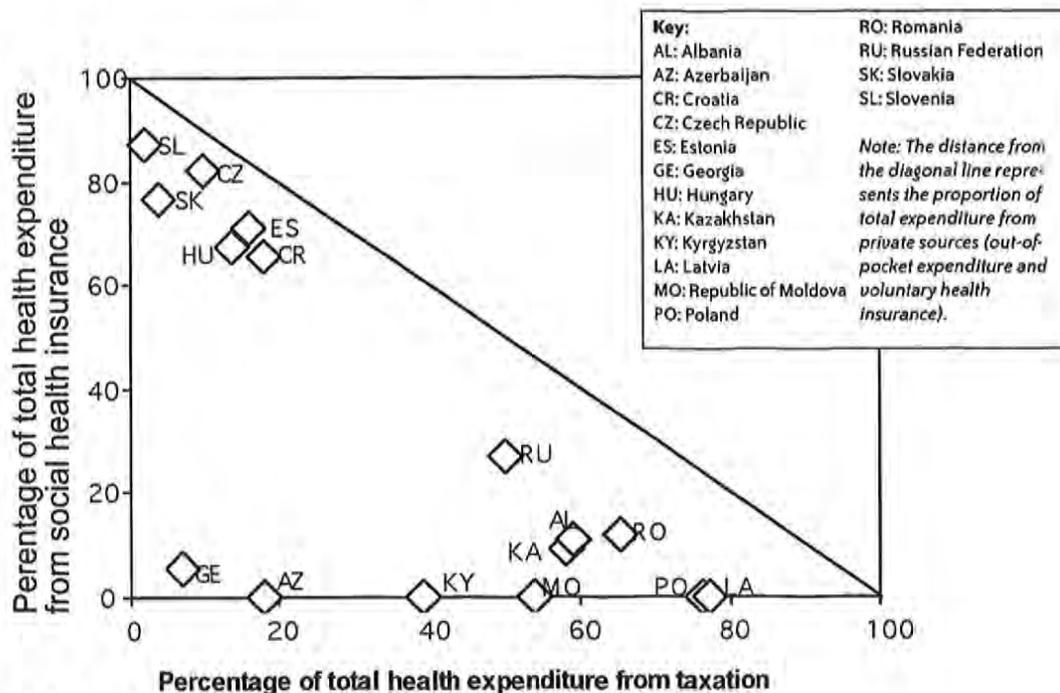
- to break the monopoly of government over the ownership and financing of health services;
- to increase the responsibility of individuals for their own health and the financing of health care;
- to improve efficiency by making health care providers more accountable for the use of resources (Chinitz et al. 1998); and
- to give responsibility for health care to organizations independent of government (this was mainly the result of ideological concerns about the role of the state).

Despite the switch to social insurance contributions, general tax revenues continued to play a significant role in health care funding in many countries. Voluntary health insurance was intended to develop as a supplementary source of revenue. However, the market in private health insurance remains small in most countries and does not contribute significantly to health care expenditure. Private funding, in the form of informal payments for health services within the public health care sector, is much more significant. However, the level and scope of these payments varies significantly between countries (Lewis 2002).

Defining contributions

Total expenditure on health in the region in 1997 ranged from as low as 3.3% of GDP in Albania to 11.3% in the Republic of Moldova. Per capita spending was highest in the Czech Republic, Slovakia and Slovenia and lowest in Albania, Azerbaijan, Georgia and Romania (all less than 100 US \$PPP) (Preker et al. 2002). Fig. 2 shows the relative importance of taxation and social health insurance in the countries of CEE and NIS towards the end of the 1990s.² The distance from the diagonal represents the share of private funding. In the region, there were seven countries that funded health care predominantly from taxation: Albania, Kazakhstan, Latvia, Poland, the Republic of Moldova, Romania and the Russian Federation. Six countries relied predominantly on social insurance contributions: Croatia, the Czech Republic, Estonia, Hungary, Slovakia and Slovenia. In Armenia, Azerbaijan, Georgia and Tajikistan forms of pre-payment almost totally collapsed and health care was predominantly funded by out-of-pocket payments. In Kyrgyzstan and the Republic of Moldova, out-of-pocket payments accounted for more than 40% of total expenditure on health.

Fig. 2. Percentage of total expenditure on health from taxation, social health insurance and other sources (includes voluntary health insurance and out-of-pocket payments) in selected CEE and NIS countries, 1997 or latest available year



Source: Preker et al. 2002.

² These data are likely to have changed. For example, since 1998 Poland has had a 7.5% social health insurance contribution.

Table 3. Contribution rates, employer-employee share and income ceiling in selected CEE and NIS countries

Country	Contribution rate for salaried workers	Employer-employee share
Croatia	18%	100:0
Czech Republic	13.5%	66:33
Estonia	13%	100:0
Georgia	4%	75:25
Hungary	14%	79:21
Kazakhstan	3%	100:0
Kyrgyzstan	2%	100:0
Romania	14%	50:50
Russian Federation	3.6%	100:0
Slovakia	13.7%	73:27
Slovenia	13.25%	50:50

Source: Preker et al. 2002.

With the shift to social health insurance in many CEE and NIS countries, the burden of contributions has largely fallen on labour costs. The size of the contributions and the respective shares between employers and employees in different countries are shown in Table 3.

Informal payments made by patients and families to supplement formal coverage are common. The estimated frequency of informal payments in the region is typically high (Lewis et al. 2000). The percentage of patients reporting that they had been required to make some payment for a service was 60% in Slovakia, 66% in Tajikistan, 70% in the Republic of Moldova, 74% (of hospital patients) in the Russian Federation, 75% in Kyrgyzstan, 78% (of inpatients) in Poland, 78% in Azerbaijan and 91% in Armenia. Such payments are not high in the Czech Republic, however, where doctors' salaries have increased more than the average rise in wage levels. The level of payments is highest for inpatient care, with drugs and outpatient care subject to lower levels. In relation to household income, out-of-pocket payments for health care can account for as much as 21% of monthly income in Georgia, 9.1% in Albania and 4.1% in Romania. Further survey data are needed to establish more accurately the level and extent of informal payments.

Less well understood or documented are the reasons for the existence and persistence of informal payments. Informal payments take a number of forms and may exist for a number of reasons. They range from the ex post gift to the ex ante cash payment. These payments or gifts may be part of the culture or may be due to the lack of a cash economy, the lack of finances to pay health care workers, the lack of drugs and basic equipment to treat patients, or weak governance. At their worst they may be a form of corruption, undermining official payment systems and reducing access to health services (Ensor & Duran-Moreno 2002; Ensor & Langenbrunner 2002).

Voluntary insurance was conceived in many countries as a complement to social health in-

insurance, covering those services excluded from the benefits of the social health insurance scheme. In practice the boundaries between public and private insurance were not defined, partly because of the failure of many countries to define a basic benefits package (as described in the next session). There was some demand for private insurance to duplicate or supplement social health insurance cover, owing to the inadequacy of access. In most countries the experience with private insurance has been problematic. In Kazakhstan in the mid-1990s, several companies selling private health insurance went out of business owing to lack of regulation or oversight of their solvency. In Uzbekistan, government joint stock companies now sell private health insurance and in the Russian Federation, where there are numerous companies, there appears to be little regulation of their operation. Other countries, such as Slovenia, have taken a more cautious approach, limiting the sale of voluntary insurance to the insurance funds (responsible for social insurance). Unfortunately, these are often supplementary policies that include cover for co-payments under public insurance, thus nullifying their effect, at least for those who can afford supplementary cover. Following accession to the European Union, the market for voluntary insurance in these countries will have to open up to competition from private insurance companies and will be subject to limited regulation. If private health insurance markets are to operate effectively, clear boundaries need to be set between the public and private sectors in terms of benefits and beneficiaries, and there needs to be proper regulation of their activities to protect consumers.

Problems with social health insurance

In practice, health care contributions in most countries are a mix of taxation, social insurance, voluntary insurance and out-of-pocket payments, partly because of the failure of social insurance to generate a significant proportion of health care expenditure. There are a number of reasons for this.

- **Weak macroeconomic context.** Fig. 3 and 4 show per capita GDP for selected countries from the region and the change in GDP over the period 1990-1997, respectively. They provide the macroeconomic context in the region during the 1990s. The countries have been clustered into three groups — A, B and C. There is a high correlation between those countries with low per capita GDP and negative economic growth (Group C) and a high reliance on out-of-pocket expenditure. Except Poland, all countries in Group B have experienced negative growth. These countries are those that, despite introducing social health insurance, continue to rely on general taxation as the main source of funding for health care. Finally the countries that have been more successful in making the transition to social health insurance contributions (accounting for more than 60% of total expenditure on health) are also those with the highest levels of per capita GDP (Group A).
- **Labour market features.** High levels of unemployment mean that the proportion of the population in formal employment is low, thus creating a very narrow revenue base from which to draw contributions. The numbers

of people in formal employment are low and therefore few employers are required to contribute. Many of those in formal employment are public employees, thus the employer share has to be made by government out of tax revenues. In addition, there are large numbers of self-employed and a large agricultural labour force, for whom contribution rates are lower and only levied when a profit is declared (which is not usual)

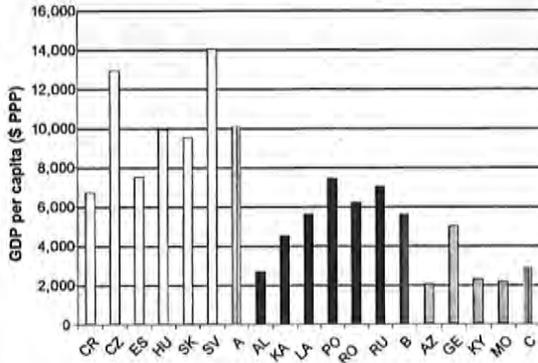
- **Low compliance.** Compliance has been extremely difficult, owing in part to some of the features of the labour market mentioned above. The large informal economy that developed following transition has meant widespread evasion of contributions (and taxes). Corruption in the economy as a whole, and the health care system in particular, may affect the population's ability to pay and may undermine people's acceptance of social insurance if they have to make additional informal payments. Low levels of compliance are further exacerbated because there is often no link between contributions and benefits. Many countries retained the constitutional right to health care for all, which was the historical legacy of the socialist era. Thus from the outset, entitlement to health care benefits under social insurance has been universal and unrelated to contribution status. This contrasts with social health insurance in western Europe during the 20th century, which gradually expanded to different population groups as economic development progressed. It is only very recently that Belgium and France have extended the right to health care benefits to all legal residents. Thus in eastern Europe there are reduced incentives to contribute concurrent with large expenditures for the funds.
- **Lack of transfers to health insurance.** Contributions to the health insurance funds on behalf of the non-working population should, in most countries, have been made through transfers from other social insurance funds, such as unemployment and pension funds, or from government revenues. Owing to chronic deficits across the social security system, however, these transfers were in many cases not made and substantial arrears built up. Health insurance funds were often obliged to provide health services to the whole population, despite the lack of contributory income. The result was large financial deficits in the health insurance funds.

The sustainability of health care systems in the region depends largely on the ability to generate sufficient revenue. This is a key challenge, given the number of contextual and structural problems in the region. Nevertheless, to match funding to benefits and beneficiaries, policy-makers must also take decisions about who and what to cover.

Defining beneficiaries and benefits

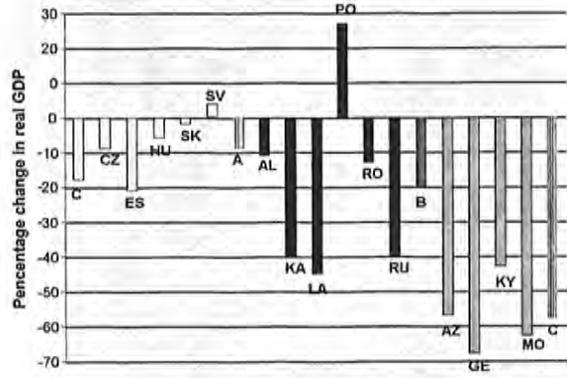
In theory, entitlements to health care benefits have remained universal (100% of the population) in most countries. Anecdotal reports from Kazakhstan and Poland, however, indicate that those who do not pay insurance contributions directly (and there are significant

Fig. 3. GDP per capita in selected CEE and NIS countries, 1997



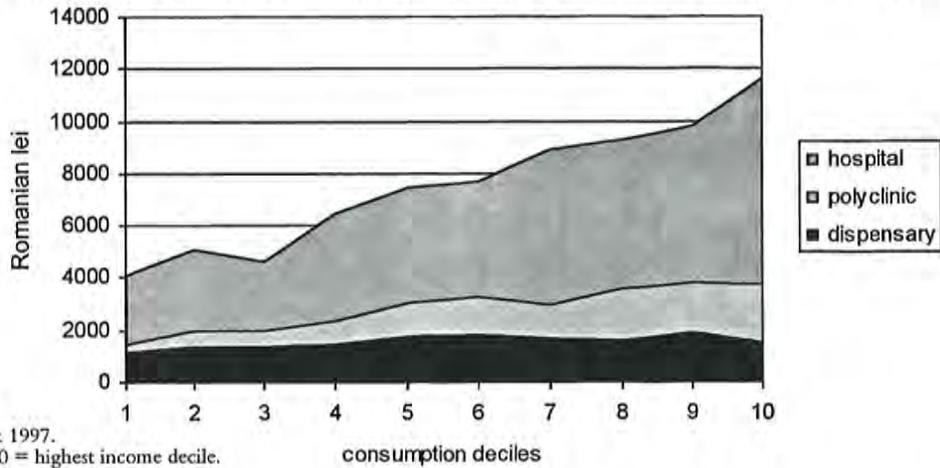
Source: Preker et al. 2002.

Fig. 4. Percentage change in real GDP in selected CEE and NIS countries, 1990-1997



Source: Preker et al. 2002.

Fig. 5. Per capita spending on health care by type of facility and income decile, Romania, 1994



Source: World Bank 1997.
Note: 1 = lowest, 10 = highest income decile.

numbers in the region, such as the self-employed, those in small informal businesses, farmers, the unemployed, students and pensioners) are treated as “uninsured.” This demands either that contributions are subsidized by other public revenues or that people are asked for out-of-pocket payments at the point of service (Chawla 2000; Langenbrunner et al. 1994).

Ethnic minorities make up an important part of the population, whether these be Roma (Gypsies) in some southern and eastern European countries or ethnic minorities in Balkan countries. Coverage and disparities in equity of access have become a bigger issue in some cases over the last few years (Paci 2002).

A few countries have actually rolled back universal coverage to focus on the poor and clinically vulnerable. In Armenia, for example, certain secondary services are available only to the poor.

Historically, most CEE and NIS countries provided comprehensive coverage in theory. In practice services were rationed. Countries in both western Europe and CEE and NIS are attempting to cope with funding the many and expensive medical and health services. Defining a package of benefits (i.e. limiting what is covered) has been seen as one option to cope with the discrepancy between available (public) resources and existing (perceived) demands.

Many countries in the region have attempted to define a more concise or “basic” benefits package, to be financed from the national budget and/or via national health insurance. For a while, Georgia developed and implemented a basic benefits package that covered mostly primary care and some secondary care. Armenia has developed a similar package of outpatient services, with secondary care only for the poor. Kyrgyzstan has developed an innovative package that has shifted drug benefits for outpatients to the supplementary benefits provided only to those who are “insured” through contribution to the social fund (Kutzin et al. in press).

In other cases, however, changes in benefits packages were made in a very incremental way or not at all. In most instances, attempts to develop a systematic “basic package” failed. Why did so many countries in the region initiate the process, yet not succeed? Should the lack of success also mean that countries should stop attempts altogether, or are there other, better ways of addressing this issue?

Many factors/issues made it very difficult to determine a package and implement it. Some of the challenges have been technical, others more political. For example, exhaustive information about the cost-effectiveness of interventions in a particular setting is not available and would be extremely costly to obtain. Where entitlements are defined, they tend to focus on individualized curative interventions rather on the wider population interventions and public health initiatives (McKee in press). On the other hand, citizens and politicians see comprehensive and free health care as a right, and are not ready to accept cuts in benefits. Providers, who depend on the income, similarly oppose it (Bultman 2002).

Those who are entitled to benefits because they contribute may be identical to those covered by the pooled funds. However, the pool may cover a larger population than just those who directly contribute. For example, the social health insurance funds are expected to cover the whole population, including the non-working and therefore non-contributing population, through transfers from tax revenues and transfers from other social insurance funds (e.g. employment and pension funds).

Where there is no explicit entitlement to certain benefits, but the system is in theory comprehensive, purchasers (such as regional authorities or insurance funds) tend to make decisions about what to buy, thus undermining equity of access. Where a basic package of benefits is defined, purchasers may have the freedom to offer supplementary benefits, though this is rare in the CEE and NIS region.

Pooling of Funds

The second important function of health care financing is to pool the resources collected from various sources and to allocate these to purchasers. The two important aspects are the pooling mechanisms and the resource allocation methods.

Pooling mechanisms

A well designed pooling function can be judged by the extent to which multiple revenue streams are integrated or fragmented and the size of the population across which pooling occurs. In smaller countries predominantly funded by social insurance, such as Croatia, Hungary, Slovenia and others, revenue streams are less fragmented (Preker et al. 2002). Problems still persist owing to the lack of pooling of resources for operational expenditures (from social insurance contributions) with capital investment (usually from other sources such as central and local taxation). Some additional funding is also allocated directly from general government revenues to teaching hospitals, thus distorting the pooling.

Decentralization in many countries has included the devolution of revenue collection to regional government or to regional funds (e.g. Bosnia and Herzegovina, Poland, Romania). To ensure adequate pooling between regions, resource allocation methods were designed that aimed to ensure some redistribution according to the health needs of the population covered. However, regional governments, such as those in the Russian Federation, have been reluctant to surrender revenues that they have collected to central government for redistribution to other regions. Similar political tensions exist in Italy, where a similar redistribution mechanism has been introduced (Taroni 2000). With the transition to social health insurance and the creation of multiple insurance funds, pooling of funds has become more fragmented. Similar methods of resource allocation (or reallocation) can be employed to ensure pooling across multiple insurance funds, even where these are not regionally defined. However, these risk-adjustment mechanisms, as implemented in Germany, Israel, the Netherlands and Switzerland, require significant information about individual members of funds. Where allocations have been crudely weighted according to age and sex, there has been increased scope for opportunistic behaviour by funds — namely to select good risks. More sophisticated formulae will generate significant costs and require a certain technical capacity to implement.

Resource allocation

In many CEE and NIS countries the main purchasers of services are insurance funds. In some countries, however, regional authorities are also responsible for purchasing. In some cases funds are collected and retained by the purchaser, in which case there is no allocation mechanism. Where there is pooling, either through a central fund or central government, resource allocation mechanisms are used to allocate resources to purchasers.

Several countries — Kyrgyzstan, Lithuania, Poland, the Republic of Moldova, the Russian

Federation and Tajikistan — have developed new geographical allocation formulae based on per capita or “demand-side” principles rather than the older “supply-side” Semashko-driven norms. One premise in this approach is that it results in reallocation of resources according to population needs, as well as consumer preferences and priorities. In process terms, this involves access to certain technical skills (e.g. public health skills to assess health needs and evaluate outcomes, and access to evidence on the cost and effectiveness of interventions). Often the information and technical expertise required is scarce or nonexistent. Estonia is relatively unusual in having public health involvement in the purchasing and supervision of health services. Mechanisms for needs assessment are conspicuously absent from most countries in the region (Figueras et al. 2001).

Purchasing of Services

The inherited model in most CEE and NIS countries was characterized by an emphasis on supply-side input norms and planning. This was perceived as overly rigid, with structural incentives that encouraged overly expensive specialized care compared with more cost-effective primary and outpatient care. Countries in transition found themselves with too many staff, beds and facilities. There was a related perception of underpayment to individual physicians and nurses, regardless of specialty (Ensor 1993; Sheiman 1993).

As early as 1987, the CEE and NIS countries began testing new organizational and financing models to improve efficiency and assure better funds flows. The “New Economic Mechanism” (NEM), for example, picked a number of geographical demonstration areas, re-organized the polyclinics into family practice groups and initiated fundholding arrangements. The objective was to shift the locus of care to less expensive outpatient and primary services. There were early successes, but also unintended consequences, as in St Petersburg where patients who needed hospital care were never admitted owing to underdeveloped quality assurance mechanisms (Sheiman 1993; Langenbrunner et al. 1994; Schieber 1993).

Contracting mechanisms ³

Concurrent with the shift to social health insurance in CEE and NIS, contracts are increasingly used as a new model of relationships between purchasers and providers. Currently, there is no comprehensive account of contracting or existing evidence on its impact in Europe (Duran et al. in press). CEE and NIS countries have tended to use “soft” agreements rather than selective provider contracts that contain full accountability. Nevertheless, many countries continue to push for contracting that is more performance-based, as in Romania with primary care physicians (see, for example, Vladescu & Radulescu 2001).

One disappointment to date has been the lack of selective contracting from among both public and private sector providers, especially in the case of NIS countries. The Russian Federation, for example, enacted legislation in 1993 but its insurance purchasers have never

³This section draws on some of the discussions found in Duran et al. (in press).

contracted with nongovernmental providers. In other instances, low payment rates have discouraged providers from seeking contracts, as in Poland. Whether purchaser- or provider-driven, this has prevented competition or contestability among providers and thereby not fully utilized possible market mechanisms to increase efficiency.

Contracting for services in CEE and NIS countries has been challenging for a number of reasons.

- **Inadequacy and low predictability of funding.** Since contracts express the clear-cut commitment of a purchaser to reimburse the cost of provided services (contracts in many CEE and NIS countries are regulated by the Civil Code and therefore legally binding), attempts to start contracting require a realistic evaluation of available funding. Experience in Kazakhstan, Kyrgyzstan, the Russian Federation and the Caucasus suggests that, with public funding at 2-4% of GDP, contracting may not be fully viable. Insurers simply cannot pay all providers' bills. Debts increase, payment rates must be adjusted downwards, and providers lose interest in contractual provisions.
- **Low operational autonomy of providers.** To act as contracting parties, providers must have flexibility to respond to purchasers' demands and, in particular, be able to increase or decrease capacity, acquire and dispose of excessive capacity, borrow money within limits, and take financial responsibility for performance. The trend has been to provide facilities with greater rights and responsibilities (Preker & Harding 2001). The Baltic countries have restructured state-owned polyclinics into freestanding practices and independent contractors. In Bulgaria, the Czech Republic, Estonia, Kazakhstan, Latvia and Lithuania, state-owned hospitals have gained the status of public non-profit organizations, with new contracting rights and responsibilities.
- **Lack of timely information and routine information systems.** In both eastern and western Europe, contracting is limited by insufficient information. The minimum information requirements for effective contracting cover patient flow data, cost and utilization information across specialties or diagnostic groups, and demographic and risk groups. Large investments are often required for information systems, including the capacity to process contracts and monitor outcomes.
- **Technical capacity and management skills.** Contracting requires particular skills (e.g. identifying cost-effective medical interventions, negotiating and monitoring providers' performance, communication strategy, etc.) that are not needed under direct public service provision. The corresponding capacity-building exercise has been patchy and discontinuous. Other than some examples in eastern Europe such as Budapest and Krakow, there are few health system management schools in CEE and NIS.

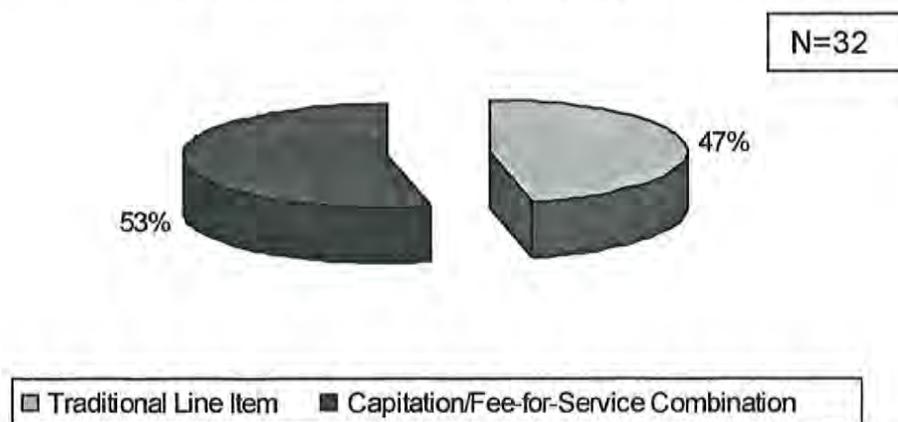
Provider payment

With the former Semashko model, the line-item budgeting system was used in all countries. Line-item budgeting meant that allocation primarily reflected historical budgets plus some inflation factor; that there was limited or no reallocation across categories or from year to year; and that, under difficult economic constraints, salaries, food and medicines took priority.

Health insurance funds and even Ministries of Health now more typically use “performance-based” systems to pay for services. For primary care services, capitation is used more often than not, as seen in Fig. 6. The countries utilizing some variant of this approach include the Baltic countries, Armenia, Croatia, Georgia, Hungary, Kyrgyzstan, Poland, Slovakia, Slovenia and Uzbekistan. Payment can go to the physician directly or to the primary care facility. Some of these models offer the traditional mix of services (e.g. minor surgery) or “carve out” priority services such as immunizations, either using fee-for-service for these (Estonia, Romania) or paying a bonus for rural placement (Georgia, Estonia, Lithuania). This fee-for-service and bonus add-on to the capitation model is important, as some capitation models (e.g. Kazakhstan) have been shown to reduce the utilization of preventive services (Langenbrunner et al. 1994).

Many countries are also developing new hospital payment systems that pay for a defined unit of hospital output. The most popular approaches in the early years of transition were systems based on per-diem and per-case payment. These were most often developed both because they required few data or little capacity to design and implement, but also because they were seen as methods to promote greater productivity by providers and generate increased revenues. Individual countries started at different levels of expertise and interest, and have progressed differently. Most have combined different levels of per-diem and simple case-mix measures, and typically include only recurrent costs rather than capital costs or depreciation. Nevertheless, these steps serve as a developmental framework for examin-

Fig. 6. Percentages of countries in CEE and NIS with traditional line-item budgets and capitation/fee-for-service combinations in paying for primary care



Source: European Observatory on Health Care Systems, 1998-2002

Table 4. Features across countries of per-diem payment systems for hospital services

Country/design features	Case-mix adjuster	Hospital adjuster	Overall expenditure cap ¹	Other features
Croatia		X	X (1999)	Point system for providers
Slovakia		X		
Slovenia	X (high cost cases)		X	
Latvia	N/A			
Estonia	X		X	Fee-for-service for some procedures

¹This is a budget cap set on all hospital services, not just at the level of the facility.

Source: Langenbrunner & Wiley 2002.

Table 5. Features across countries of per case payment systems for hospital services

Country/design features	Payment categories	Payment rate basis	Facility adjusters	Outlier payment feature ¹	Overall spending cap
Georgia	30	Historic budget and throughput norms			
Hungary	758	Historic costs	X	X	X
Kazakhstan	55	Historic budgets	X		
Kyrgyzstan	154	Historic budgets	X	X	
Lithuania	50	Historic bed-days		X	
Poland	9-29	Estimated payroll tax revenues			
Russian Federation	From 50 to 55 000	Varies	X		

¹Additional payments made for statistical outliers (typically 2 standard deviations from the mean), based either on length of stay or on cost per case. In most countries these outliers constitute about 5% of all cases.

Source: Langenbrunner & Wiley 2002.

ing these countries in terms of alternative hospital payment models. A summary of per-diem and per-case systems is provided in Tables 4 and 5.

Providers have responded to these incentives. These per-diem and case-mix systems have driven up the volume of cases admitted and put fiscal pressures on the purchasing organization (e.g. Croatia, Czech Republic, Hungary, Russian Federation). Decreasing numbers of beds and lower average lengths of stay were offset by increasing admissions — a trend that started in the mid-1990s in CEE, and the late 1990s in NIS when these began utilizing new payment methods. Most purchasers have had little capacity or experience of quality assurance or administrative mechanisms to stem the rapid increases in volume driven by the underlying incentives (Healy & McKee 2002).

A number of CEE and NIS countries are now shifting policy objectives, from revenue enhancement and increasing provider income to goals more related to cost containment and efficiency. With this shift, hospital global budgets and capitation are emerging as the “next generation” of payment incentives beyond per-diem and per-case systems. Global budgets are being developed in seven of the countries for which information is available, and already exist in five others (Table 6), with capitation pilot schemes in a number of countries such as Hungary, Poland and the Russian Federation (Langenbrunner & Wiley 2002). Some countries (Croatia, Hungary) face fiscal pressures such that they cannot wait for sophisticated risk-adjusted payment cap systems; instead sub-sectors (primary care, outpatient care, hospital care) are being capped at a national level as a first step to stopping the current haemorrhaging of expenditure.

A summary of countries and hospital payment systems is provided in Table 6.

While the number and types of new payment systems in the region show a clear change from the previous decade, results have been mixed to date. This is due to a number of the issues discussed above, as well as other specific issues that await future policy leadership. The latter include the following.

- **Fragmented public sector pooling and purchasing.** The scope for payment incentives to change behaviour is limited by the disintegration of health finance pooling. Newly emerging insurance systems have often co-existed with the old financing mechanisms through direct (non-contractual) allocation of government resources to providers. In many CEE and NIS countries, too many actors are allocating funds (insurance, central and local treasuries and health authorities, and sometimes commercial insurers), each trying to control its portion of the money.

There are nevertheless successes. In the Baltic countries, the Czech Republic, Hungary, Kyrgyzstan, Slovakia and Slovenia, insurers control most (>70%) of public funds. Purchasing is increasingly integrated, thus facilitating financial planning and planning of medical services delivery (both strategic and operational), with the focus on increased efficiency and predictability of flows of funds. The most recent positive example is Kyrgyzstan, which has started the shift to a single-purchaser model by integrating general budget revenue and mandatory health insurance contributions (Kutzin et al. in press). But in other countries, such as the Russian Federation, numerous health pools exist.

As discussed above, increasing out-of-pocket payments in many CEE and NIS countries further undermine pooling through public channels. Out-of-pocket payments can further influence treatment choice, as patients tend to make larger payments for riskier interventions such as surgery (Lewis 2000; Orosz & Hollo 1999).

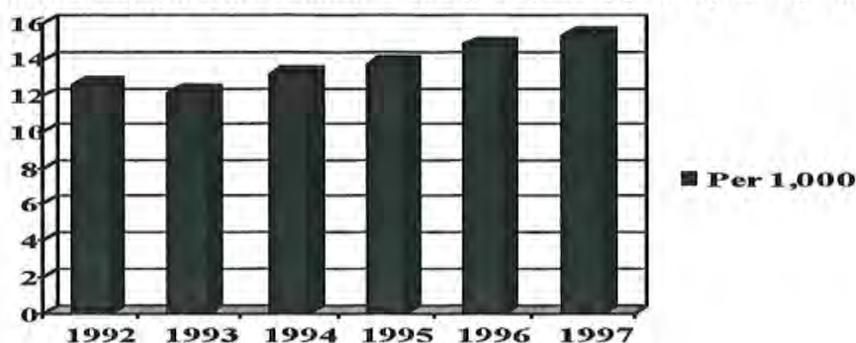
Table 6. Hospital payment systems in NIS and CEE countries

Country	Line item	Per diem	Per case	Global budget
Albania				X
Armenia		X		Developing
Azerbaijan	X			
Bosnia and Herzegovina				Developing
Bulgaria			X	Developing
Croatia		X		Developing
Czech Republic			X	X
Estonia		X	Developing	
Georgia				X
Hungary			X	
Kazakhstan	X		X	
Kyrgyzstan	X		X	
Latvia			X	
Lithuania		X	Developing	
Poland			X	
Romania			X	X
Republic of Moldova	X		X	
Russian Federation				X
Slovakia		X	X	?
Slovenia		X		?
Tajikistan		X		
The former Yugoslav Republic of Macedonia	X			Developing
Turkmenistan	X		X	Developing
Turkey	X			
Ukraine	X			Developing
Uzbekistan	X			

Source: Langenbrunner et al. in press.

- Poor complementarity of design.** Payment reforms across settings often do not complement one another, thus damaging efficiency of allocations. In Croatia, primary care capitation for physicians was “matched” with fee-for-service payments at the specialist referral and inpatient settings. That meant that both primary care physicians and specialists had the incentive to refer up the delivery structure, instead of managing more patients at the primary care level. As a result, the share of inpatient spending (Fig. 7) and hospital admissions increased in Croatia between 1993 and 1997, even as the World Bank loan of nearly US \$50 million was targeted to primary care reform.

Fig. 7. Croatia: increasing hospital admissions during the years of primary care reform



Source: Staines 1999.

Similarly, closed sub-budgets (for primary care, specialist outpatient care and inpatient care) now being applied are important tools for cost-containment, but will these generate adverse incentives for purchasers? Are patients being “dumped” from other sub-sectors? Are there adequate risk-sharing mechanisms and, if not, will this cap only result in a complete shift of all risk on to the providers, which is both inequitable and inefficient?

- **Institutional impediments.** New pilot schemes and payment programmes are often blocked by legal or administrative impediments, such as civil service reform. There are, moreover, significant vested interests concerned with preserving the current system, particularly in those areas that could lose from change.
- **Deficits.** In CEE in the early 1990s, public providers became indebted to their suppliers, and often appealed to the government for subsidies or bailouts. In many of the former Soviet republics, debt has been almost constant, such that much spending occurs not on a cash basis but through a process of mutual debt settlement. A facility wishing to use part of its budget for, say, building maintenance, must first find a contractor with an outstanding debt with the local administration or insurance fund (depending on the source of funding). This debt is then cancelled or reduced in return for repairs to the building to an agreed value. If a debtor cannot be found for the service or commodity required, a facility may be tempted to obtain some other commodity, just to ensure that the budget is spent. This mutual debt-settlement system helps to ensure that services can be provided even in cashless circumstances, but does lead to sub-optimal allocation decisions and is administratively costly to operate (Ensor & Langenbrunner 2002).
- **Monitoring and quality.** Each payment system design brings with it unintended consequences and opportunities for changing levels of quality of care, both

better and worse. The monitoring capabilities of the purchaser are, however, too often underdeveloped. Future directions for purchasers in the region should include providing support to ensure that quality is safeguarded and optimized.

Policy discussion

During the 1990s, CEE and NIS countries undertook sweeping and ambitious reforms to health care financing systems. As key measures, the reforms aimed at:

- switching to social insurance complemented by voluntary insurance, with the concomitant need to define both benefits and beneficiaries;
- decentralization to regional purchasers or insurance funds, with national pooling through the use of needs-based resource allocation such as risk-adjusted capitation; and
- the introduction of performance-related purchasing, such as contracting and new remuneration methods for providers.

Health insurance was expected to eliminate the subordinate role of the socialist health care system and ensure stable, growing resources. Moreover, the autonomy of health insurance funds and performance-related provider payments was expected to make health insurance funds efficient purchasers of health care services. Allowing them to identify and reward high-performance providers was expected to improve the efficiency and quality of the health care services, including improved responsiveness to patients.

In practice, however, revenues generated by social health insurance were limited and governments were often forced to continue funding health care through general tax revenues. Voluntary health insurance developed slowly or failed. The costs of health care in many countries were shifted on to the individual in the form of formal and informal user charges. Mechanisms for pooling resources were inadequate, and in many cases fragmented pools developed with different insurance funds and different regions, and in some cases between taxes and social insurance contributions (with the former controlled by the ministries of health and the latter by the newly created health insurance funds). Purchasers were unable to utilize contracting to elicit efficiency gains or to use incentives to increase the responsiveness of providers.

The expectations of reform have yet to be fulfilled, partly owing to:

- the weak macroeconomic context;
- low levels of employment and formal sector activity;
- low compliance and high levels of corruption;
- the lack of transfers to health insurance from taxation or from other social security funds; the failure to define a core benefits package;
- the maintenance of universal entitlement without sufficient funding;

- decentralization and fragmentation of pooling;
- the inadequacy of information, technical capacity and political will to establish needs based resource allocation mechanisms;
- the inadequacy and low predictability of funding;
- the low operational autonomy of providers;
- the lack of information and of technical and management skills for contracting;
- fragmented public sector pooling and purchasing;
- poor complementarity of design of provider payment methods;
- institutional impediments; and
- financial deficits.

Overall, the reform measures failed to produce the necessary conditions, such as adequate incentives, information and organizational frameworks, that would make the key actors of the health care system accountable for their decisions.

Tackling these issues will not be simple. There are no straightforward alternative policy solutions, nor a linear process for establishing the necessary conditions.

Economic recovery and capacity-building in the region will go some way towards increasing the revenue collected through payroll taxes. In higher-income countries with higher levels of formal employment (Croatia, the Czech Republic, Estonia, Hungary, Slovakia and Slovenia) social insurance appears to have been an effective way of mobilizing resources for the health sector. Lower-income countries in the region such as Albania, Kazakhstan and Romania, with little formal employment, found that insurance contributions were not viable. Further efforts to ensure compliance are necessary. However, the delegation of responsibility for revenue collection to quasi-state agencies or independent insurance funds has created significant challenges for the state in this respect. Lack of compliance in the health sector is likely to be solved only if corruption in the wider economy is reduced.

Another option is to further diversify funding sources, for example through subsidies from other forms of taxation or by pooling out-of-pocket payments. Transfers from other public sources already do or should occur; these need to be transparent and to ensure that funds are not penalized (e.g. by reduced subsidies)⁴ for increasing their revenue and/or efficiency. Where there is a large informal economy, direct taxation (i.e. taxes levied on income or profits) is likely to face problems of compliance similar to those encountered by social health insurance. However, it places less of a direct burden on labour costs and may therefore have less negative consequences for the development of the economy. Indirect taxes (i.e. those levied on goods and services) are more visible and may be less easily evaded, but they are more regressive.

Experience from low- and middle-income countries outside Europe with, for example,

⁴There is some evidence to suggest that those countries that shifted to social health insurance were better able to maintain levels of spending on health care (Preker et al. 2002). Anecdotally, however, social health insurance revenues were simply used by the Ministry of Finance to substitute for general revenues, and overall funding for the health sector did not increase as a result of the introduction of social health insurance contributions.

community health insurance suggests that formalizing out-of-pocket payments and establishing systems of pre-payment (or insurance) will be extremely difficult (Mills & Bennett 2002). Informal payments are partly a response of the health care system, particularly health care providers, to the lack of financial resources and the response of patients to a system that is unable to provide adequate access to basic services. Governments should ensure that the limited resources are targeted more effectively in order to secure access to basic services, for example by shifting resources from secondary and tertiary care to primary care. If there are seen to be clear benefits, and patients are not also expected to pay informally, willingness to contribute to a formal system of pre-payment should be higher.

The commitment to fund both universal coverage and comprehensive benefits is unrealistic and unsustainable in some countries in the region. Despite political and technical difficulties, countries may need to consider defining more limited entitlements to ensure that public revenues are targeted on the most cost-effective interventions and the most needy populations. As revenues increase, so too will the benefits and the levels of coverage, thus providing a motivation to the population and employers to comply. For those countries (Azerbaijan, Georgia, Tajikistan) able to spend less than US \$15 per person per year on health care from the public purse, one important policy option, at least in the short term, could be to change the coverage rules to benefit the poorest and most needy.

Mechanisms for pooling revenues need to be strengthened. Other sources of public expenditure should be pooled with social health insurance contributions to ensure the most effective use of funding. Where multiple funds or regional governments currently collect revenues and are expected to reallocate resources to poorer/high-risk funds or regions, revenue collection could be centralized and resources allocated based on a simple risk-adjusted capitation. This would overcome some of the inefficiencies in having multiple collection agents and the difficulties of establishing national pooling through reallocation.

The technical and administrative capacity of purchasers needs to be strengthened, both through the development of information systems, which can deliver both timely and accurate data from providers, and through the training of personnel. Government regulation and stewardship will also be vital in ensuring that purchasers act in the best interests of the population.

Financing systems are only one among many factors needed to cope effectively with the undoubted inefficiency within the health sector, whatever the context. The multifaceted problems faced in the region demand a well conceived and long-term health sector reform strategy, with specific programmes, a clear governance framework, skilled and committed health care management and administration, and support from health care professionals and the public for the aims and goals of the reforms. Unfortunately, none or few of these elements have been assembled so far in the region to the extent needed. These are but a few of the challenges that lie ahead for the region in the next 10 years, and perhaps beyond.

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Mobilizing citizens and communities for better health:

The civil society context in central and eastern Europe

A background paper prepared for USAID Conference, Washington, DC
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Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia

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Democracy is the work of human beings who comprehend their inalienable rights, who respect human rights and who believe in responsibility for their fellow human beings.

—Vaclav Havel, Prague 1990



Health as citizenship

Hannah Arendt developed three dimensions of being fully human: family life, work life and public life, the *vita activa*. Within these arenas, what connects us as human beings is trust, reciprocity and mutuality, dimensions of what increasingly is being called the social capital of societies. Discussing these issues in terms of health presents several difficulties in former closed socialist societies that are now open to the free market and to increasing individualization. It highlights crucial policy conflicts between what is considered a public and collective good and what is considered a private responsibility. Of course, it is quite inappropriate to try to over-generalize trends in countries that are so inherently different in their historical backgrounds and their present social and economic situations (such as the economic differences between Slovenia and Ukraine). Yet all countries discussed at this conference bear a similar legacy of a highly formalized, state-centred system, with forced participation in certain areas of social and public life. Discussing participation in health as an expression of citizenship needs to take into account this legacy and the new environment of rapid change, social insecurity and extreme inequalities. As many authors have stated, high social capital may well be a prerequisite for economic growth — yet high levels of inequality contribute to reductions in social capital and civic cohesion. This paper therefore tries to look more widely in discussing the interface between civil society and health.

As a principle, the mobilization of citizens and communities for better health embodies both the dimensions of democratization (including joint decision-making and accountability) and of individualization. In the countries of central and eastern Europe, it was (and is being) experienced in all its ambivalence and ambiguity as many countries moved from a collective to an individualistic understanding of health. This is reinforced by moves (and strong pressures from major donors) to reshape the health system and shift responsibilities from the state to other levels of governance, to the private sector and to individuals and families. Any analysis of this process must take into account the political and social contexts within which participatory and collaborative strategies for health are proposed.

For citizens, it includes the ambiguity of gaining a concept of individual human rights or patients' rights yet perhaps losing the collective right to health as a public good and, in the context of the transition, losing access to services. For health professionals, the changes could be seen as a major loss of authority, both towards the general population and towards other sectors with whom they were now called on to cooperate. Nothing had prepared them to work in this new manner. For politicians, it meant accepting voices outside the formal political system, a more open democratic process than that represented by political parties.

The public health premise: health is everybody's business

Mobilizing citizens and communities for better health is a central component of what we now call the "new public health," and health promotion, intersectoral action and community participation have been defined as key public health functions. In the work of the

World Health Organization (WHO), health promotion has been promulgated since the mid-1980s as a democratic and social participatory health strategy, building on the principles first developed in the Declaration of Alma-Ata in 1978. The Ottawa Charter for Health Promotion identifies “healthy public policy” and “community action” as two of the five key action strategies of health promotion, and a recent publication by WHO on evaluating health promotion (Rootman *et al.*, 2001) states: “... we suggest that the primary criterion for determining whether a particular initiative should be considered to be health promoting, ought to be the extent to which it involves the process of enabling or empowering individuals and communities.”

To date, any modern health and development strategy pays at least lip service to a broad participatory approach, and donor agencies and international organizations have included community participation and stakeholder analysis throughout their programmes in the developing world and in central and eastern Europe. Indeed, what started with a focus on community participation has been widened to include a wide range of partnerships in order to solve problems related in particular to prevention, which reach far beyond the health sector and now also include public — private partnerships. With this approach, community participation and intersectoral action moved closer together, as did prevention and treatment such as in the case of HIV/AIDS.

Even before the changes that started in 1989, the WHO Regional Office for Europe — particularly through its health promotion programmes and initiatives such as Healthy Cities — had provided the opportunity for health professionals and local partners and politicians to learn about such approaches. The Healthy Cities project in particular became a conduit for exchange of experiences between local communities in central and eastern Europe and western European democracies, which reached far beyond the health arena. A similar stakeholder approach was initiated by the Safe Communities initiative, which initially focused on injury control. WHO’s health promoting schools programme was deliberately launched first in the countries of central and eastern Europe. It was welcomed by a number of governments, particularly because of its potential to teach democracy at a very local level, for example through the involvement of parents in decision-making — a quite novel concept in many of the countries involved. Other health promotion initiatives in the field of heart health, prevention initiatives such as CINDI, tobacco and alcohol control strategies, family planning, women’s health and later activities in relation to HIV/AIDS also stressed the importance of cooperation, advocacy, participation and community involvement. WHO’s European regional health policy framework, HEALTH21, repeatedly makes the point that health cannot be resolved through the health sector alone but needs to be approached as a joint societal effort: “health is everybody’s business.”

Combining the civil society puzzle with the “health puzzle”

An analysis by the Carnegie Endowment for International Peace (Ottaway & Carothers 2000) makes a forceful point about context and attributes many of the failures of civil society assistance around the world to a lack of understanding of what has been termed the “civil society puzzle.” Too frequently, well-meaning efforts neglect to take into account:

- the existing civic traditions within a country;
- the variety of organizations that have emerged to tackle key issues; and
- the understanding of the role of citizens and organizations, particularly in relation to the state.

Kevin Quigley (2000), in his analysis of the modest results of assisting civil society in central and eastern Europe, points to the existence of two very different mind sets: that of the eastern Europeans, who believed that the mass movements that had spearheaded the change during the 1980s would turn rapidly into a “new society rich in associational life characterized by a more humane politics” and that of the American donors, who attempted to recreate eastern European civil society in the American image. He states bluntly, “Eastern Europeans and their donors did not share a definition of democracy.”

An analysis of the role of the citizen and communities in health and health care in central and eastern Europe needs to be particularly aware of context. In paraphrasing Quigley’s point about democracy, it can be stated just as bluntly that eastern Europeans and their donors (in particular the American donors and the US-based consultants used by many of the international organizations) did not share a basic definition of health and health care. The right to health and health care was part of the constitutional right of citizens in many of the countries of central and eastern Europe and a key defining feature of governments’ “social contract” with their citizens, reaching back to the first constitution of the Soviet Union written by V.I. Lenin. For a significant period of time (roughly into the early 1980s) universal access to health services and a strong commitment to public health were a source of pride in many of the socialist countries, and constituted a central argument frequently put forward in the debate about the respective superiority of the capitalist and socialist systems of governance. Many a debate about more equity in access in western countries was wiped from the table with the argument that its proponents were intending to create a “socialist system of care,” a pattern of response that persists to this day in the United States. It is important to keep in mind that the debate about health care was from the very start a central component of the ideology of the cold war, precisely because the approaches in the United States and the Soviet Union were so diametrically opposed. Consequently, the health sector became a key focus (and in some cases a battleground), in both ideological and economic terms, after the fall of the Berlin Wall.

From the late 1970s, most of the countries of central and eastern Europe were not only losing the arms race but were also less and less able to supply high-quality health care, one of the key “public goods” that was providing legitimacy to the regimes in power. (This

point is analysed in more detail in other background papers to this conference.) In addition, the declining health status (as first presented by the WHO Regional Office for Europe in the 1980s) indicated that a broader range of factors needed to be addressed than had traditionally been considered within the highly hierarchical and medicalized health care systems of these countries. Increasingly, experiences from other countries showed that these “lifestyle” problems could only be resolved through cooperation with partners outside the health sector, including the media, and through a cultural acceptance by the public at large. But many central and eastern European governments did not want to draw attention to these developments (for example the very high level of alcohol use), which they saw would be interpreted not only as a “health systems” failure but also as a failure of the “socialist way of life.”

Addressing health concerns in relation to “lifestyles” would also require a change in the culture of socialist health systems and in the mind-set and behaviour of health professionals, who were slow to accept that authoritarian, top-down approaches were doomed to failure. In addition, any policy or campaign calling on the population to adopt a “healthy lifestyle” lacked credibility in the context of deteriorating living conditions and the crumbling “social contract” between the people and the state. Health targets and the means to implement them were worlds apart. The various recurring attempts in Hungary — starting in 1987 following Hungarian participation in the WHO Ottawa Conference in 1986 — to develop a national health promotion programme document these points very clearly. As an extreme example, lack of access to alcohol and tobacco could prove dangerous in already highly volatile political situations. This was the case in the Gorbachev era in the Soviet Union, when social unrest due to a shortage of cigarettes was averted through a special deal with, and emergency supply by, western tobacco companies.

From 1989 onwards, the rapid social change and “double transition” towards a democratic system of government and a market economy left a deep impact on health and its determinants and on the organization of health care systems. The recent series of interviews with central and eastern European health ministers published in *Eurohealth* highlights the ongoing conflicts they face in finding a balance between collective and privatized systems of health care and in giving appropriate attention to disease prevention and health promotion. Suffice it to say at this point that the interest of donors lay more with the privatization of health care than with its democratization — possibly because the population had little interest in giving up the collective rights to health care, while governments were pressured by professionals from within and donors from outside to embark on “reforms” that basically implied cut-backs in public services and increased privatization. Indeed, it would be worth a detailed analysis to understand what role this lack of involvement, information and consideration of people’s concerns about health and health care has played in bringing political parties that support universal health care back into power throughout central and eastern Europe.

It must also be said that donors (and in the early days even some international organizations, including WHO) were not ready to prioritize health promotion issues, which were

considered less essential than health care reform or were in conflict with the promotion of free markets. This resulted, for example, in a lack of resources to help countries develop strong tobacco legislation or to develop and strengthen HIV/AIDS prevention and advocacy. The price for this failure is being paid now. A well known example is the opposition of the great civil rights advocate, President Vaclav Havel, to strong tobacco legislation, which he sees as running counter to the democratic freedoms gained after 1989.

Not much information is available on how citizen participation and intersectoral action have been systematically fostered in the health sector reforms in central and eastern Europe, or how the existing mind-sets in relation to health and civil society (the respective puzzles of tradition, organizational structure and the relationship between citizens and the state) have structured the response. Also, we know little about the extent to which participatory strategies in the health sector have contributed to the development of civil society. This conference provides an excellent opportunity to attempt a first review and analysis, and perhaps provide an impetus for more detailed research to follow.

Positioning of health in the context of civil society development

As stated above, the mobilization of citizens and communities for better health is part of the broader understanding and organization of civil society within a country or group of countries and cannot be analysed in a vacuum — it is about how policies are made, how priorities are set and how accountability is ensured. This must be underlined, because there is a significant difference in perspective if we speak of individuals as clients or consumers of health care, or as citizens with a voice and a right, or as citizens seeking their rights, such as people living with AIDS. This is particularly important in the field of health promotion, which defines its remit as the process of enabling people (individuals and communities) to increase control over their health and its determinants. Much of this process takes place outside of the health care system in (as the Ottawa Charter states) the “context of everyday life” where health is created.

As a consequence, the organization of civil society, the realms of decision-making and the opportunities for social learning are critical for the new public health. It is for this reason that health promotion has, on the one hand, developed organizational approaches that increase the commitment to health through healthy public policies and participation in health in the settings of everyday life: schools, workplaces and neighbourhoods; and on the other hand has developed and supported grassroots advocacy movements around major health concerns, including equity and human rights. In central and eastern Europe (as elsewhere) it has been difficult for all concerned — politicians, professionals and citizens — to come to terms with a non-medical model of health.

As in any sphere of intellectual and political endeavour, definitions abound. The following definition of civil society can serve as a guide for discussions.

Civil society is the critical space between the individual and the state that creates a geographical landscape for social organization and action. It is also a theoretical cornerstone in local community development, a mechanism through which to reassert local priorities through local democracy.

This definition allows an understanding of a dynamic social and political space, which allows citizens to collaborate for shared interests. Ideally, such a space is inhabited not only by a very broad range of actors and stakeholders (a plurality of organizations) but also by a highly pluralistic set of values, views and approaches (political pluralism). Their organizational format can include formally established, private, non-profit, self-administrative, voluntary types of organization (Salamon 1993) as well as social movements.

Central and eastern Europe has a long and rich tradition of civil society organization reaching back into the nineteenth century, which was destroyed first by the Nazi takeover and then by the communist state monopolies. For example, in the 1930s more than 5000 societies were active in Czechoslovakia just in the field of charitable and humanitarian care (Fric *et al.*, 1997). Under communist rule, quasi civil society organizations (usually called "social organizations" or "mass organizations") were established in fields such as sport, education and culture and controlled by the state. In health, the Red Cross was allowed to continue to work but only in close cooperation with the government-run health services. In the 1980s in many of the countries of central and eastern Europe, civil and opposition movements, grass root circles, ecological movements and human rights groups started to emerge. As the health sector began to erode, self-help groups and voluntary associations, for example for disabled children, were established. The Polish sociologist Ewa Les (1993) states that prior to 1989 the voluntary sector was one of the principal mechanisms for breaking citizens' apathy and promoting solidarity and community. Yet we must remember that in countries such as Albania and Romania even these openings did not exist.

Civil society organizations take on a number of roles, all of which can be of relevance to health development, particularly if we look beyond health services to include the determinants of health:

- strengthening democracy
- promoting social and economic development
- replacing waning social services
- strengthening social cohesion
- promoting equitable development
- promoting the efficient and socially sustainable functioning of market economies.

It is important to highlight this wide variety because the critical analysis developed in the Carnegie publication underscores the danger of a too-narrow, anti-historical and preconceived definition of citizens' action, focusing on supporting only a certain type of non-governmental organization while neglecting the many other forms of social action and organization. Whereas in the promotion of democracy there was a tendency to focus on

policy groups, in the health field there is a tendency to support service-oriented organizations rather than controversial “movement-type” advocacy groups. But particularly with deteriorating living conditions and quality of life and increasing inequity, supporting the mobilization of citizens and communities for better health would imply addressing determinants of health, as many of the environmental groups in central and eastern Europe have done. Or, in view of the spread of HIV/AIDS, the support of controversial groups such as sex workers, drug users and gay or bisexual men gains increasing importance, as has been realized by the Soros Foundation. Also frequently undervalued has been the buffer role of civil society in relation to the stresses of everyday life, which points to the need to support groups and associations that neither provide direct services nor are involved in policy, but that help generate day-to-day social support.

The expansion of civil society organizations was extraordinary in some countries. In Poland in 1989, for example, there were about 5000 nationally registered independent organizations. This grew to about 30 000 by 1997, many of which were tiny organizations involved in service delivery and funded by small individual contributions. A similar trend is true for Hungary, which has about 50 000 civil society organizations, many of them local non-profit bodies created in response to the lack health care, education and social services. One of the strongest areas for activism was the environment, an area of policy that had been severely neglected under communist rule. In her analysis of the civil society sector in the countries of central and eastern Europe, the Hungarian sociologist Elizabeth Vari (1998) shows that while health is still strongly underrepresented it is rapidly increasing. This might be due more to the need to respond at community level to a deterioration of services than to an increase in civic engagement for health per se. Her summary indicates the following (very divergent) percentages for the health field: 7% in Bulgaria, 3-4 % in the Czech Republic, 11% in Hungary and 20% in Poland.

In general, these data indicate that health is still seen as a responsibility of the state and of health professionals, and that explicit health advocacy groups have not yet gained strength and prominence. But what health policy in central and eastern Europe increasingly needs — given the enormity of the problems of morbidity and mortality — is a broad range of civil society coalitions to address major challenges, such as deteriorating living conditions and human costs of the transition, unhealthy products, prevention, control and treatment of HIV/AIDS and premature male mortality, to name but a few. The health crisis is at the very core of eastern European societies, and in some cases is threatening both social cohesion and economic progress. These will not be resolved through a fiscal or medical solution but need broad societal consensus and energy. Donors — as far as they remain active in central and eastern Europe (many of them have been too quick to move out given Ralf Dahrendorf’s estimate of time needed for significant change) — should also take note.

The importance of civil society for health

In the light of this enormous challenge, the examples presented at this conference in rela-

tion to mobilizing citizens and communities for better health in central and eastern Europe could be structured around the following questions.

- What contribution has civil society made with regard to priority health problems?
- How can the role of civil society in health best be enhanced at different levels of governance (national, regional and local)?
- How can health systems facilitate and enable greater civil society involvement?
- What balance is emerging in different countries in addressing policy, advocacy and accountability and service delivery?
- What role can the international and donor communities most usefully play in this context?

The acceptance of the role of civil society in health is related both to understanding the importance of civil society organizations in general and to the contribution it can make in a highly professionalized arena such as health. In central and eastern Europe, a not infrequent claim by the new political elite is that the establishment of democracy and political parties makes grass-root activism and social movements redundant or even illegitimate. Most visible was the conflict between Premier Vaclav Klaus and President Vaclav Havel on the issue of tax relief for voluntary associations in 1994. Also, civil society organizations and social movements experienced a major brain drain, since many of the activists of the 1980s were now running the new political and social institutions and had become active in the new political parties.

It has taken time to understand that a vibrant civil society is a crucial social space of learning and trust building, which helps to mobilize individuals to participate as citizens in the affairs of their societies, and that this also applies to what has been considered a domain for medical professionals. The health sector is still grappling with accepting the role of the empowered citizen, the involvement of other actors and sectors, and new forms of accountability for health outcomes. Both eastern Europeans (politicians, professionals and activists) and western donors have underestimated the time and effort this takes. Ralf Dahrendorf (1990), for example, has stated that while it takes 6 years to build a market society it takes 60 years — at least a generation — to build civil society. Democracy is as much a political practice as it is a culture of social tolerance, and the region as a whole still needs to cope with the legacy of paternalism, suspicion of the government (even if democratically elected) and mutual suspicion of one another. And it needs to deal with a certain amount of disillusionment, as not all promises of democracy and market economy have been realized.

In relation to health, two additional important dimensions have to be considered:

- the impact of a vibrant civil society as a key determinant of health; and
- the contribution of health activism to a democratic society — many health issues have a strong dimension of quality of life and many social issues (such as violence, drug abuse and prostitution) have become part of the health domain.

Robert Putnam (2000) underlines the contribution of social capital not only to “civic health” but also to personal and community health. A large body of research now shows the very strong positive connections between social integration and health, as well as the feeling of empowerment and health. Studies in the United States show that health is better in “high social capital states” or, as Putnam expresses it, “What these studies tell us is that social engagement actually has an independent influence on how long we live.” For the countries of central and eastern Europe, the rapid deterioration in life expectancy has been linked to the (non) functioning of civil society, in particular the low levels of trust, as well as to social isolation and low levels of control over life and control over health. Hertzman & Siddiqi (2000) describe the changes experienced in the societies of central and eastern Europe as “the most comprehensive natural experiment in population-wide stress available, short of war or mass starvation.” A detailed analysis is still outstanding as to what social coping mechanisms have been developed. Boris Genov, in his analysis of Bulgaria, indicates that almost every second citizen over 18 relies on a survival strategy, which does not leave room for forward-looking organized civil engagement. Many donors, according to a recent UNDP analysis (2002), have failed to understand the complexity and painfulness of the transition.

The other dimension is the importance of activist groups to help redefine the health agenda and defend the human rights of vulnerable and disadvantaged people. As is the case throughout the world, government officials in central and eastern Europe are wary of advocacy groups and more easily accept groups willing to be active in service provision, particularly as services are cut and demands rise. For many donors, turning to nongovernmental organizations was also a cheaper way of getting some things done quickly rather than investing in more long-term organizational and administrative change.

For the health sector, this simple division into policy/advocacy-oriented organizations and those oriented towards service provision does not always hold. This proved to be particularly true in the field of HIV/AIDS, where issues of human rights advocacy and service provision in relation to prevention, testing and care were heavily intertwined. Civil society groups were far in advance of government representatives in recognizing the problem and reacting to it. It is perhaps in the area of HIV/AIDS where the interface of democracy, human rights, civil society and health comes to the fore with the greatest clarity. But it is also in this area — as in the field of family planning — where wide differences in opinion and ideology are frequently played out, and where platforms for dialogue and mediation need to be developed.

Where are we today?

Nikolai Genov in his analysis of the present situation in Central and Eastern Europe states, “To put it bluntly, what is going on in the central and eastern European region might be shortly defined as the triumph of individualization at the cost of the common good.” Under a period of rapid transformation and increased social and personal uncertainty “a

typical central and eastern European dilemma” emerges that aims for increased private initiative but wants the security of state-provided services (as in health), yet at the same time mistrusts the state institutions and is disillusioned with the private sector.

The civil society sector continues to be weak. In many countries it still lacks a consistent legal framework. Despite many training workshops and an influx of consultant services from donor countries, most nongovernmental organizations are still managerially inexperienced, have weak communication infrastructures, show a lack of technical expertise and suffer from a severe shortage of money. A recent UNDP conference in Vlora, Albania discussed the failure of nongovernmental organizations to develop greater participatory democracy, stressing that one of the reasons has been the focus on service delivery and humanitarian assistance because of the economic, social and humanitarian crisis in the region. But — similar to the Carnegie report — the conference also highlighted structural factors related to the donors. In particular, it pointed to their tendency to support nongovernmental organizations that were willing to work according to procedures and concepts laid down by the donors, rather than systematically support civil society development at the local level and according to the local societal context. The trend has now moved towards community-based coalitions, a concept spearheaded early on by WHO’s Healthy Cities project and environmental initiatives such as Agenda 21. This includes new approaches to financing: for example, 70% of Hungary’s local governments have established municipal foundations to support social services and health care (Szeman 1997).

In a recent interview, the former Georgian Minister of Labor, Health, and Social Affairs, Mr Avandil Jorbenadze, stated, “Citizens’ poor awareness and participation in the reform process, and the realization of their own rights, also pose additional threats for achieving the reform priorities.” There is an urgent need to explore the social and political mechanisms that support or hinder citizen and community involvement in health in the countries of central and eastern Europe. Too easily, the mobilization of citizens and communities for health is framed only in their adherence to healthy lifestyles or rational use of the health system. No systematic efforts are made to create transparency and accountability, promote health citizenship and increase health literacy and empowerment.

Paying attention to context remains a crucial challenge, and the rapid transformations in the societies of central and eastern Europe seem to reinforce individualization rather than community — in the health arena as elsewhere. The disarray that ensues as institutions are reformed, and the daily experience of lack of institutional capability, erode trust and social capital. The key conflict facing all modern societies is how to balance personal autonomy and community, and the countries of central and eastern Europe face this choice in the extreme. In the face of weak institutions, more than any other challenge in health this must be faced squarely as a priority political task and a governance challenge of the highest order.

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The continuum of care

A background paper prepared for USAID Conference, Washington, DC
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Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia

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This draft paper is part of a series commissioned by USAID to provide a conceptual framework and overview of the main thematic topics of the USAID conference "Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia." Following the conference, each team of authors will revise the papers, compiling the final versions in a book by the European Observatory on Health Care Systems, which will be made available to conference participants in early 2003.

Continuum of Care — Executive summary

This paper is about how to deliver effective and equitable health care in central and eastern Europe (CEE) and the countries of the former Soviet Union (FSU). The inherited systems had many weaknesses and are especially poorly suited to the circumstances of today. The paper sets out a conceptual framework within which health care delivery takes place, stressing the fact that health care delivery involves a complex network of settings, each of with its own role to play but each connected to the others.

Responses require actions at all levels of the system, some at the level of government and some within the health care system. Those acting within the health care system do so within and across facilities, and across boundaries with non-clinical settings such as long-term care, home care and hospice care.

The paper begins by looking at the changing pressures that health systems face. These include changing patterns of health, changes in what health care can do, and changes in public expectations. All have important implications for the types of health care provided.

Policy-makers face four main issues: improving the performance of hospitals, restructuring health care facilities, the interface between primary secondary and tertiary care, and strengthening and modernizing primary care.

Effective hospital performance requires investment to ensure that staff have the appropriate skills, that the facilities are appropriately designed and equipped, and that actions, by both health professionals and managers, are informed by evidence. This will often require new training programmes and replacement of obsolete facilities.

Seeing the reconfiguration of health care delivery simply as closing hospital beds is oversimplistic. Change must take account of the presence or absence of alternative facilities and of social support systems. Many facilities are no longer required, but others that provide alternative models of care are certainly necessary.

The interface between primary care and hospitals has two aspects. One is that many patients admitted to hospital would be more appropriately managed in a different setting, and the challenge is to create appropriate settings for care. The other is that patients who could be discharged are kept long after they have ceased to receive treatment. This, too, requires alternative models of social care.

Finally, it is necessary to strengthen primary care. Under the Soviet system, primary care was the poor relation of the hospital sector. Reform must give primary care professionals new ways to steer patients to the most appropriate care setting, whether in hospital, nursing home or their own home. Where these reforms have been successful, they have enhanced the position of primary care at the centre of the different health care delivery sectors, facilitating a process of "virtual integration". Reform must also expand the range

of services and functions of primary care. These include providing new or enhanced services as well as adopting services previously delivered at other levels of care.

Reform is complex, and the situation is exacerbated when (especially in the FSY) national health ministries are weak. Moreover, many of health ministries remain preoccupied with the day-to-day operation of the health care system rather than moving to a role in which they exercise system oversight: establishing rules for providers, setting health purchasing priorities for insurers, and monitoring the quality of services.

As countries have abandoned the previous system of command and control, they now confront the need to work with a wide range of interest groups. Responsibility is not confined to health ministries; in many cases international agencies also play a part.

The call for simple solutions has little relevance for the health sector. Even advanced industrialized countries continuously struggle to find the right balance between affordability, equity and efficiency in a highly complex health care market in which powerful interest groups dominate the political economy.

The challenges faced differ within countries and between countries. Most obviously, they often face quite specific health needs. Models of care adopted should be consistent with what is affordable in the country concerned.

It is essential that the goals of health care reform are clear and that progress is closely monitored. Too often, change introduced in one part of the health care system creates incentives that are entirely incompatible with those in another part.

Governments must agree, in association with other interest groups, a clear health strategy within which health care providers can work that focuses on promoting health and not just keeping facilities open. They must ensure that the prerequisites for high-quality care are in place, such as effective regulatory systems for professionals, pharmaceuticals and technology, but also systems that will promote involvement in quality assurance activities throughout the health care system.

Introduction

This paper concerns the issues facing health policy-makers in central and eastern Europe (CEE) and the countries of the former Soviet Union (FSU) as they seek to deliver effective and equitable health care. It looks at the challenges they face in an environment of often contracting economies and erratic health budgets and the choices they must make.

The health care delivery and public health systems that these countries inherited had many weaknesses. They reflected a model of care that has become obsolete. Large hospital facilities were designed for patients with diseases that either resolved spontaneously, were quickly cured by basic treatments or were equally rapidly fatal. Staff with few resources to deploy required only basic training. Nevertheless, under-investment in staff development and appropriate technology meant that many were needed. Primary care was especially weak, serving largely as a funnel for directing the sick to secondary care or as a means of controlling absence from work due to sickness. Patients, used to shortages in every area of their lives, grudgingly accepted unresponsive and poor-quality services as inevitable.

This paper looks at how this situation should change. It is in five parts. First, it sets out a conceptual framework within which health care delivery takes place. Second, it examines what has happened in this region in the past decade of transition. Third, it looks at the evidence that should inform change. Fourth, it draws on recent experiences to understand the barriers to and opportunities for successful reform. Finally, it sets out a series of lessons learned from these experiences and recommends policy options for the region.

A conceptual framework

Too often, health policy has taken a reductionist approach, focusing on the individual elements of a health care system. It looks at, for example, hospital reform, primary care, public health or financing. This may be administratively tidy, especially in health ministries that have separate departments dealing with, for example, hospitals or primary care, but it ignores the reality in which health care delivery takes place — a complex network of settings, each with its own role to play but each connected to the others. This is even more important as we increasingly focus on overall health system performance, emphasizing health outcomes, user satisfaction and service quality.

Too often, difficulties with these connections are the reason for problems in health care delivery. In many countries, general practitioners lack the skills and facilities, appropriate economic incentives¹ and the professional ethos to provide treatment for many disorders, with the result that these are unnecessarily referred to hospitals. Other patients, with diseases that are treatable if detected early, are seen by specialists when it is too late to do

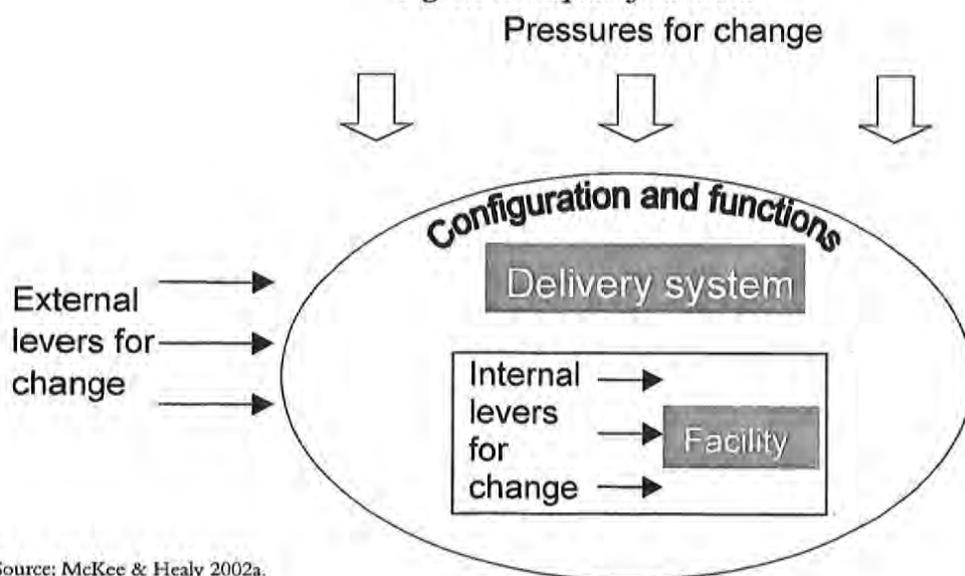
¹ For example, in the case that a general practitioner is remunerated on a capitation basis, the incentive is to attract as many patients as possible but to refer as much as possible to higher levels of care. In turn, if a general practitioner is paid on a fee-for-service basis there is an incentive to over-diagnose and over-treat, resulting in cost escalation. Thus a combination of capitation and fee-for-service with capping may render the most appropriate mix of incentives.

anything. Investigation of many common conditions follows a pathway that can be clearly defined. For example, a woman with a lump in her breast that turns out to be malignant will undergo mammography, biopsy, surgery and rehabilitation, yet a failure to coordinate care pathways can make this journey seem like a pioneering exploration. People with chronic diseases also often follow an unnecessarily complex pathway on the interface between primary and secondary care, seeking the skills of each sector when needed but with little to guide them. And patients often remain in hospital for longer than necessary because of an absence of alternative, more appropriate facilities. The challenge facing health policy-makers is how to design a system that recognizes this interconnectedness. Increasingly in health systems in industrialized countries a family doctor serves not only as a primary care giver, but also as a competent manager who helps the patient negotiate ever more complex choices by interpreting diagnostic and treatment options and offering a focus of continuity.

The interconnectedness of health care delivery is a key element in the conceptual framework used in this paper (Fig. 1) (McKee & Healy 2002a). This sees health care delivery systems responding to many different pressures for change (McKee *et al.* 2002). They respond by changing the way they are configured and how they work. Change is brought about by actions at all levels of the system, some at the level of government and some within the health care system. Those acting within the health care system do so within and across facilities, and across boundaries with non-clinical settings such as long-term care, home care and hospice care.

At the outset, it is important to recognize that health care delivery takes place within a wider context. In particular, the health needs of the population being served are changing. This has important implications for health care delivery.

Fig. 1. A conceptual framework



Source: McKee & Healy 2002a.

Most obviously (although surprisingly frequently overlooked by those who undertake international comparisons of health care expenditures) sicker populations require more health care (Wanless 2002). This highlights the importance of having a health policy that seeks to reduce future demand for care through promotion of health, as well as ensuring that the need for care today is met to the extent possible with the resources available to the health system. However, the main consequence of differing disease patterns is that the types of care provided will also differ. Older populations suffer from chronic conditions and may have more complex disorders, often with multiple disease processes, requiring care from coordinated teams of health professionals with a central role for the primary care physician. Populations that have experienced high rates of smoking have not only high rates of lung cancer and heart disease but are also much less likely to have an uncomplicated recovery from anaesthesia, thus requiring additional post-operative facilities. Populations with low birth rates require fewer obstetric facilities, but those with high rates of teenage pregnancy will have more low-birth-weight babies and so require additional neonatal intensive care facilities. Societies with high rates of violence will require additional trauma facilities.

In some cases, it is the health care system itself that is bringing about change. Inadequate and partial treatment regimes have fuelled a dramatic increase in rates of antibiotic-resistant infection (Dornbusch *et al.* 1998). The most alarming example is multidrug-resistant tuberculosis, a disease that is entirely preventable but that is now reaching alarming levels in many FSU countries (Kammerling & Banatvala 2001). This has been exacerbated with the neglect of the interface between the civil and penitentiary health systems.

In addition, efforts to decentralize services have sometimes jeopardized formerly effective programmes, resulting for example in a breakdown of the vaccine cold chain in many FSU countries. This has resulted in unprotected populations and has led to outbreaks of vaccine-preventable diseases.

Another factor that is changing is public expectations. The consumer society is now firmly in place in many former communist countries, as multinational companies open ever more branches. The new IKEA store close to Moscow airport has the highest takings per square meter of floor space within the IKEA chain. The old-style hotels, with their missing bath plugs and unhelpful staff, are giving way to ones that actually make you feel welcome. People see that service can be provided in comfortable facilities and with a smile, and they are asking why this has yet to happen in many of their health care facilities. Yet in many countries in the region, the humanity with which patients are treated is still far from ideal (Platt & McKee 2000).

The nature of health care and how it is provided is also changing. Advances in technology have made it possible to treat conditions that were once fatal. Again, this has profound consequences for health care delivery. An early example is the discovery of insulin at the beginning of the 20th century. This changed type I diabetes from a rapidly fatal disorder of childhood into a condition involving lifelong treatment by specialists, including endocri-

nologists, ophthalmologists and vascular surgeons. More recently, many cancers have been transformed from growths that surgeons simply removed (while hoping for the best) to systemic diseases requiring integrated teams of surgeons, oncologists, radiotherapists and, if cure is impossible, palliative care specialists. It is not just technology that is changing: health care staff are also changing. They have much higher skills, and thus higher expectations of financial and other rewards. Changes in society mean that there are many other career pathways open to them, especially in the often better-paid private sector, so health services need to compete to retain staff in a way that they previously never needed to.²

An effective response by the health care system to these pressures involves actions at many levels.

Change is required at the level of the individual, as health professionals and others embrace the concept of life-long learning. It was never possible for the knowledge acquired as a medical or nursing student to equip someone to practise effectively until retirement. The increasingly rapid pace of change has reduced the "shelf life" of knowledge ever further. During the past ten years of transition in the CEE and the FSU, the need for change in the paradigm in which medical, paramedical and nursing training is based has received inadequate attention. It may require a generational change coupled with intensive investment in training facilities and curricula to produce professionals who are able to apply evidence-based principles to their professional practice in medicine, nursing or social work.

Change is also required at the level of the facility. Those who provide care must be able to influence the use of resources, while those managing resources must promote quality of care. This means investing in people, facilities and equipment to bring together the many inputs required in ways that promote effective care.

But facilities do not act in isolation. Patients with complex disorders will move between different levels of the system. If given adequate resources, with trained staff and appropriate facilities, much health care can be provided in the primary care setting. In addition to the large number of self-limiting or easily treatable conditions, such as many common infections, primary care teams are increasingly taking on the management of many chronic disorders such as asthma, hypertension and diabetes, with only occasional referrals to specialists when a particular problem arises. In other cases, such as cataract extractions, decisions about definitive treatment may be made in primary care with specialists seeing the patient for the first time in the operating theatre, thus eliminating unnecessary referrals to surgical clinics. At the same time, changing models of rehabilitation mean that those patients who do go into hospital stay for a shorter time, with their primary care team taking a greater responsibility for their recovery.

²The "brain drain" of both nurses and doctors is a severe problem in the CCEE and the FSU countries. The acute nursing shortage in the European Union and the United States provides a powerful incentive for nurses from such countries to seek higher-paid jobs and better living and working environments in these areas. Similarly, many doctors, particularly those with postgraduate degrees from western universities, find attractive employment opportunities within and outside the health sector abroad.

The implications for health care delivery are clear. Much closer links between primary and secondary care are needed to create a seamless interface across which the patient can move with ease. This means revisiting many of the concepts that have too long been taken for granted, such as the optimal configuration of a hospital.

The role of the hospital is changing beyond recognition (Healy & McKee 2002). Shorter stays, and in particular the growth in ambulatory surgery, mean that hospitals must use operating theatres more intensively but need fewer beds. Those patients who do stay in hospital are much sicker, so that each bed needs more staff to support it. At a more mundane level, those staff need more equipment, so the bed needs access to more electrical sockets ... and so on.

Modern health care delivery thus involves much more than just individual general practices and hospitals. Rather, it involves integrated networks of different types of facility, potentially including free-standing, low-risk obstetric and non-urgent surgical facilities, minor injury centres and dedicated rehabilitation centres. This, too, has important implications. It means that there is a need for some structure that has oversight of the range of health facilities serving a defined population, and that is capable of promoting change in both the configuration of services and their ways of working.

Finally, change requires action by those who have an overview of the entire system. The concept of stewardship embraces a range of activities that are necessary if the health care system is to be able to respond effectively to changing circumstances. While the process of change will require actions by many different actors it is the state, acting as a steward for the health care system, that must ultimately be responsible for putting in place the conditions for optimal care.

Increasingly, we realize the state's responsibility for the facilitating environment in which health care exists. These include a clear health strategy, an effective system of regulation and incentives for cooperation between those who can contribute to health care. But other prerequisites outside the health sector must also be in place: a free and informed press will be a better advocate for the consumer; a functioning judicial system is required to enforce the law against abuse, fraud, corruption and malpractice; and the creation of self-help, information and advocacy groups will minimize the discrepancy in information that exists between patients and doctors.

Other sectors of government also play a role. The Ministry of Finance must provide predictable health budgets and appropriate transfers from the budget (or extrabudgetary funds) to health insurance agencies to cover for the uninsured or others such as pensioners or the unemployed. The creation of an appropriate system of financing, insurance and risk pooling, and incentives for access, equity and quality, require close coordination between the Ministry of Finance and the Ministry of Health.

It is also important to work closely with those other ministries responsible for issues that

affect the key inputs into health care, such as trained staff, pharmaceuticals and technology, and knowledge from research and development. Without concerted government action, it is likely that many of these inputs will either be under-produced or inappropriately specified to meet the needs of the health care system or, where imported, inaccessible due to tariff and non-tariff barriers. Government, acting through ministries of education, trade, science and others, has a central role in ensuring that these inputs are available to the health care system and are of appropriate quality.

Comparative overview

Superficially, it may seem easy to describe what has happened to health care delivery systems in this region by looking at the available data on hospitals and other routinely collected statistics. But what is meant by the word “hospital”? Is it somewhere that can provide a wide range of complex and invasive treatments, or is it simply a place where people can rest while they either recover or die. In the Soviet system, hospitals were traditionally required to deal with many social ailments, compensating for the lack of long-term care and an absence of social workers for community outreach, as well as to provide housing of last resort for “social cases” such as the elderly and orphans.

Another commonly used measure is the number of hospital beds. Again, this has very little meaning. A bed is simply an item of furniture. It contributes almost nothing to health care unless it is supported by trained staff and functional equipment and is contained within a coordinated organizational structure. Too many of the hospital beds that are recorded as existing in this region are simply beds. As hospital reimbursement during the communist period was based on the number of beds and the number of staff, it is not surprising that many hospitals established a system of “virtual” beds in order to attract higher allocations from the health budget.

Another approach is to examine policy documents. Space does not permit a comprehensive over-view of the policies adopted since transition, but a few common themes emerge.

Many countries have adopted new provider payment mechanisms. In particular, there has been considerable enthusiasm for systems based on diagnosis related groups (DRGs). Two issues arise, the first being the law of unintended consequences. In Hungary, for example, the introduction of a DRG-based system led (as expected) to a reduction in length of stay, but also to a rise in the number of admissions as hospitals compensated for the lower payments they were receiving for each admission (Orosz & Hollo 2001).³ In several countries, reductions in payments for ambulatory care have led to higher rates of hospital admission. The otherwise successful introduction of DRGs in Austria resulted in patients being

³ Major deviations occurred in Hungary. First, the lack of good internal and external controls as well as an underdeveloped management information systems led to the impossibility of implementing DRGs as intended. Second (and as a result of the first, perhaps) DRG “creep” and/or outright corruption led to inefficiencies and overall cost increases in the system. For example, in a number of hospitals no uncomplicated deliveries were reported – all deliveries were “complicated” owing to the higher reimbursement rate for the latter. A computer program (called Wizard) fraudulently helped to diagnose “up”, leading to higher reimbursement rates.

admitted for day surgery for procedures that had previously been carried out on an outpatient basis, as the latter was not adequately reimbursed in the new system (Hofmarcher & Rack 2001). The second issue is that these systems are often unnecessarily complex. For example, the payment scheme in the Russian Federation was vastly more detailed than that used in the United States, despite being intended for hospitals with extremely basic information systems (Sheiman 2001).

Another theme is that, with a few exceptions, there has been little reduction in hospital capacity or investment in alternative facilities. Here, superficial examination of published data can be confusing. Many of the rural hospitals in some parts of central Asia that have closed in the past decade did not have running water (Kulzhanov & Healy 1999). There may be a need for the care they provide but it is misleading to describe them as hospitals.

Many governments, however, have decentralized ownership. Privatization has largely been restricted to pharmacies, dental and some primary care pharmacies and dental clinics, with few examples of hospital privatization despite much political rhetoric. More frequently, hospitals have been transferred from central to local government. This has proceeded in tandem with the introduction of new management structures within hospitals, supported by new information systems and training programmes. Decentralization has made hospital reform more difficult. In any municipality the hospital is a major employer, and doctors and hospital managers wield more influence over local politicians, making restructuring extremely difficult politically. In some of the FSU, reform of the hospital payment system has also had negative consequences: in Armenia, elimination of the line item budget has given hospital directors more discretion in spending but has also increased corrupt behaviour, rent seeking and misallocation of scarce resources.

Finally, many countries have sought to develop primary care, with innovative training programmes in medical schools, investment in facilities and new methods of payment. Nevertheless, experience shows that this will require a major shift in medical education, not just the retraining of general practitioners. Some countries, such as Georgia and Turkey, have experienced diminishing returns from ever-increasing investment in primary care infrastructure. Logistical challenges in remote areas and high costs of assuring adequate supplies of staff, pharmaceuticals and medical equipment stretch the capacity and budgets of health systems beyond their limits, raising important questions of sustainability. Consequently, countries with dispersed rural populations must explore alternative delivery methods for primary health care, such as mobile outreach services for the most remote populations.

While policy statements are informative, there is often a gap between the intention and the reality. A proper understanding of the changing nature of health care delivery would start with the experiences of those who use it. How has this changed? Unfortunately the evidence remains fragmentary, although there is some relevant research. This suggests, unsurprisingly, that the fortunes of the health care system reflect those of the broader economy, with improvements in those countries that have done well economically and deterioration in those that have not. For example, there have been considerable improvements in

the survival of low-birth-weight babies in the Czech Republic and the territory that was formerly the German Democratic Republic (Koupilová *et al.* 1998), reflecting investment in equipment and facilities. In contrast, deaths from diabetes and some other chronic disorders have increased markedly in some of the FSU, reflecting the breakdown of the previous health care system. Other research looking at the process of care again shows a mixed picture. In particular, the rapid growth in direct payments for care in some countries is a major barrier to access (Delcheva *et al.* 1997).⁴

Options for change

This section examines four issues facing policy-makers as they seek to enhance the quality of health care provided to their populations: improving hospital performance; restructuring health care delivery, the interface between primary care and secondary and tertiary care; and strengthening and modernizing primary care. In the limited space available, it has not been possible to examine these issues in detail. Those wishing to learn more should consult either the references cited or the Observatory products on which this paper is largely based.

Improving hospital performance

Strategies to improve hospital performance must act at many levels. Ultimately, governments retain responsibility for overall health system performance. They, or agencies acting on their behalf, are responsible for ensuring that there is an overall strategy for promoting health that includes the health care sector, and that identifies the resources that the health care sector needs to work effectively. These resources are not simply financial. The health care sector can function effectively only if it has access to trained staff, means of ensuring their optimal distribution, systems for procuring and distributing appropriate technology and pharmaceuticals (while limiting acquisition of inappropriate items), and methods for raising capital for investment in facilities. In addition, the system requires a facilitating environment with functioning financial, regulatory and legal systems.

Similar issues confront those working in hospitals. High-quality care involves attention to inputs (people, facilities and equipment), to processes (linking management of resources to quality assurance) and to the environment, in particular a supportive culture (Healy & McKee 2002).

The most important and the most expensive resource available to a hospital is the staff that work in it. Yet this resource is often extremely poorly trained and managed. This section focuses on two key issues — skill mix and good employment practices.

⁴ In Georgia, for example there is evidence that over 80% of health financing occurs at the point of service, either in the form of official payments, co-payments or illegal payments. This results in huge inequities and leaves the poor fully exposed in the event of a catastrophic illness.

In many countries in this region, the roles adopted by different professional groups, such as doctors and nurses, have changed little despite the enormous changes in medical practice. Responsibilities remain rigidly demarcated. Yet many western European countries have seen major changes in how different health professionals work. One change has been substitution, with nurses in particular taking on many roles previously regarded as requiring a physician (Shum *et al.* 2000). This includes both a greatly extended technical role (for example in intensive care units or performance of endoscopies) but also responsibility for the routine management of common diseases such as asthma and hypertension, including prescribing within guidelines. Another change has been the creation of new occupational groups, such as phlebotomists to take blood samples.

As the attractions of employment in the private sector increase, it will become more difficult to retain skilled staff in the health sector. One issue is, inevitably, money. Unless salaries are competitive, recruitment and retention are bound to be difficult. But people also have other expectations (Grindle & Hildebrand 1995). One is to provide a system of educational development, recognizing the importance of life-long learning. Another is to recognize the changing composition of the workforce in many countries by adopting family-friendly policies, such as workplace crèches and opportunities for part-time work. A third is to create a sense of ownership by involving staff at all levels in decision-making.

There is also increasing recognition in wealthy countries of the ethical dilemma in accepting migrant health professionals (also in the context of European Union accession and the acceptance of free movement of people), who are in search of better living conditions, more opportunities and a better life for their families. This is not only an important "brain drain" from countries in this region but is also an economic hardship for countries that fund the education of health professionals who are then not available to the local health care market.

Management also involves ensuring that those who are employed are actually contributing to the work of the organization. This means tackling abuses, such as unauthorized private work undertaken from public facilities. It also means tackling sickness absence. High levels of sickness absence are more likely to indicate a problem with the organization than the individual and, where they exist, should provoke questions as to why people do not seem to want to come to work.

One reason might be the state of the premises. Many health care facilities were obsolete 20 years ago and have since deteriorated further. They are often totally inappropriate for current models of care. Too many health care facilities do not take account of the fact that many people who use them will be disabled or partially sighted. Their configuration often physically separates departments that should be working together. Conversely, emphasis on the hospital as an institution often acts as a barrier to alternative ways of providing care, such as freestanding facilities for non-urgent surgery or minor injury units. The financing mechanisms in many countries provide a strong disincentive to investment in renewing facilities.

The third input is appropriate technology. Some of the first people to take advantage of the opening of borders in the early 1990s were selling medical technology that was either unaffordable or unnecessary. Partly in response to these excesses, some countries have developed health technology assessment programmes or are drawing on assessments undertaken elsewhere, but there is still much to be done to ensure that the distribution of medical technology supports the development of integrated care. Moreover, some elements of the multinational pharmaceutical industry have taken advantage of the breakdown of continuing medical education and medical ethics, as well as low salaries and the receptiveness to free-market practices. In many countries, these companies provide the only continuing medical education available, resulting in product bias and sales incentives that ultimately hurt the consumer.

Mechanisms to promote quality of care are the subject of an accompanying paper in this series. They will therefore not be examined in detail here, except to make one point. That is that, in many hospitals, management of resources is separate from management of quality. It is essential that the two systems be much more closely linked, so that when problems are identified the resources required to address them can be brought to bear.

The final issue in relation to hospital performance has emerged from research on the relationship between organizational culture and quality of care. This research has found that hospitals that are seen as good places in which to work, with ease of communication between different professional groups and an open process of decision-making, achieve better outcomes. Conversely, major organizational change can have profound implications for the hospital workforce; while hospitals must adapt to their changing environment, radical restructuring may damage staff morale and so adversely affect the quality of patient care (Aiken & Sochalski 1997).

Restructuring health care delivery

Too often, reconfiguring systems of health care delivery is seen simply as a matter of closing hospital beds. The reality is much more complex. As noted above, in the Soviet model of health care the hospital was dominant. Yet hospital care was also highly fragmented. As well as the geographical hierarchy, with the most specialized facilities in capital cities and sometimes extremely basic facilities in rural areas, hospitals were also classified according to the diseases they treated and the occupations of the patients they admitted. Another factor in Warsaw Pact countries was that some hospitals were also built for military purposes, as a strategic reserve in case of war. As a result, many medium-sized cities have inherited many different hospitals with few links between them. Compared with western Europe, hospital capacity seemed excessive. Basic indicators, such as the number of hospital beds per 1000 population, suggest levels of provision that are about 50% higher than in the west. It is, however, too simplistic just to say that this excess capacity should be closed. This argument fails to recognize the very different nature of hospitals in many countries in this region. Unlike those in western Europe, they remain the main providers of social care as well as health services. Nevertheless, this model is rarely the most humane or cost-effective means of serv-

ice provision. Western European countries, which once used this model, now provide most social care through mobile community outreach services or by supporting families through cash transfers. Shortage of appropriate technology, a failure to develop alternatives in the community and lack of knowledge of alternative models of care mean that there are few other options for many patients. Closure will be essential at some stage, but it must proceed in tandem with reconfiguration and the development of more appropriate care packages.

The challenge is to develop a network of facilities that provide care in the setting that is most appropriate. This may mean radically rethinking the nature of the hospital and querying whether the traditional groupings of services are still appropriate. Most of the CEE and FSU have inherited a wasteful duplication of services. In all capitals one finds a network of “republican hospitals” — usually complex tertiary care and teaching hospitals — as well as municipal hospitals essentially providing the same services.⁵ A detailed exploration of these issues has been undertaken elsewhere (Edwards & McKee 2002), and only a brief consideration will be given to some of them here.

Beginning at the front of the hospital, emergency departments typically combine many different functions, such as management of both major and minor trauma, substituting for primary care, observation of patients for whom the diagnosis is in doubt, and acting as a waiting area for those being admitted to wards. In trying to do all of these things, emergency departments often fail to do any of them well (Edwards 2001). It takes little imagination to see how these roles could be separated, with an intermediate structure diverting patients to more appropriate settings. In some cases, such as observation units and minor injury centres, these facilities may need to be created.

As hospitals admit fewer but sicker patients, the demands placed on medical and surgical units are also changing. In addition, in specialties such as gastroenterology, changing technology means that increasing numbers of patients require the combined skills of surgeons and physicians. These developments are leading some hospitals to reconfigure their inpatient facilities in terms of the severity of the condition rather than specialty.

The majority of patients attending an outpatient clinic in one of the major surgical specialties will have with one of perhaps three or four conditions, each requiring a standard set of investigations. There is enormous scope for systematizing their management by creating integrated pathways, such as those in “one-stop clinics” (Waghorn *et al.* 1997).

Looking to the future, developments such as near-patient testing and new forms of imaging will change the way in which laboratory and radiology facilities are provided.

The implication is that hospitals should be designed with inbuilt flexibility. The precise nature of health care delivery in the future may not be predictable. What is certain is that it will be different from what it is now.

⁵ In the case of Chisinau in the Republic of Moldova, this led to the establishment of 17 tertiary care facilities (both republican and municipal) for a total population of about 4 million. The restructuring of this network has been mired in political controversy for the past decade and remains largely unresolved.

The interface between primary care and secondary and tertiary care

Interfaces have two qualities. One is that they provide an opportunity to insert filters so as to limit who crosses them, for example to ensure that referrals are appropriate. Second, they should facilitate movement for those who meet the criteria to cross them, ensuring that not only the patient moves freely but also the information that is required to optimize his or her treatment (Hensher & Edwards 2002).

There are two important interfaces between primary care and hospitals. The first is the inward interface, through which patients are referred to hospital. The second is the outward interface, across which they are discharged. Each raises different issues. In addition, many patients (especially those with chronic diseases) will move repeatedly across both interfaces, raising important problems of coordination.

Turning first to the inward interface, there is evidence from many countries that many patients admitted to hospital would be more appropriately managed in a different setting. These studies also show that, in most cases, a more appropriate setting does not exist (Coast *et al.* 1996). Yet some things can be done. One way is to look at how common diseases are managed and whether more could be undertaken within primary care (see below). Another is to recognize that many patients are admitted to a hospital ward for a period of observation and investigation to decide whether they require further treatment. This has led to the creation of medical assessment units, which enable a coordinated series of investigations to be undertaken without admitting the patient to an acute ward. A third approach relates to non-urgent surgery, where the advent of short-acting anaesthetic agents and new surgical techniques has made it possible to perform many operations without admitting people to hospital.

The outward interface, through which patients are returned to the community, can also be made to work more effectively. Once again, one challenge is to create the appropriate settings for care. These may include a variety of types of residential facility for the most frail, various types of rehabilitation facility, or the strengthening of community support to enable people to remain in their own homes. A second challenge is to place sufficient emphasis on discharge planning. Ideally, this should begin as soon as the patient is admitted to hospital, thus ensuring that all necessary arrangements are put in place for their discharge. Good communication between the hospital and the referring doctor is a crucial aspect of high-quality, cost-effective follow-up after discharge, but this is not yet well developed in most countries in this region.

Developing primary care

The final issue facing policy-makers as they reform health care delivery is the strengthening of primary care. Under the Soviet system, primary care was the "poor relation" of the hospital sector. Staff were poorly paid and of low status, and the inadequacy of their facilities and equipment meant that their role was limited to referring for specialist care or regulating sickness absence.

Almost all countries have accepted that this must change. In some cases progress has been considerable; in others it has only just begun. Reform should focus on two broad areas. The first is organizational reform that will give primary care more power and control over other levels of care. This typically involves giving primary care professionals or institutions new ways of steering patients to the most appropriate care setting, whether in hospital, nursing home or their own home. Where these reforms have been successful they have enhanced the position of primary care at the centre of the different health care delivery sectors, facilitating a process of "virtual integration".

The second area is organizational reform to expand the range of services and functions of primary care. This includes the provision of new or enhanced services as well as the adoption of services previously delivered at other levels of care. New services fall into several categories. Some were either not previously provided (such as rehabilitation) or were often underprovided (some health promotion measures). Others were provided at other levels (hospital or community care), thus reflecting "substitution" by primary care as the new provider. Substitution, in turn, encompasses both total substitution, in which primary care provides the entire service (as in minor surgery or specialized diagnostic services) and partial substitution, in which primary care collaborates with other levels to produce the service (as in shared care programmes). The reform of primary care, with the strengthening of family medicine, will play a key role in achieving these goals.

Successful change requires that certain conditions be in place. These often involve a mix of new mechanisms or related institutional changes. They include changes in technological resources (e.g. telematics) and human resources (e.g. new training and skill-mix arrangements) employed in primary care settings. Change also requires policies that increase the autonomy of primary care, promote teamwork, create incentives for coordination with other levels of care, and increase the quality and responsiveness of service provision. This may require a generational change, since in most countries the current medical education system is poorly suited to the new situation confronting primary care.

Similarly, there is a need to incorporate modern public health concepts at all service levels. A functioning interface is needed with all levels of clinical service and public health. In many countries this will be extremely challenging, as the current SANEPID system operates in virtual isolation from clinical practice, resulting in a costly focus on medicalized interventions and a dependence on technology (much of which is obsolete) at the expense of population-based preventative interventions.

Key factors enabling or obstructing implementation

The previous section indicates the changes that are necessary for effective health care delivery. The next step is to implement them. This section draws on a recent study of the implementation of hospital reform in central and eastern Europe that identified seven key questions for policy-makers (Table 1, page 14) (Healy & McKee in press). That study pro-

Table 1. Seven questions for implementation

What is the context?
Is there agreement?
Who are the stakeholders?
Who will implement it?
How complex is the programme?
Are the resources available?
What are the likely effects (intended and unintended)?

Source: Healy & McKee (in press).

posed “walking through the plan”, using these questions to anticipate potential problems. This approach is equally applicable to other aspects of reform of health care delivery.

The first question is whether we understand the context. Strategies for reforming health care delivery are highly dependent on the context within which they must be implemented. One factor is the nature of the system that has been inherited, with its domination by hospitals and underdevelopment of primary care (Field 2002). Another contextual factor is the legal and financial framework that is in place. Work by development economists has highlighted the importance of issues such as property rights, banking systems and access to funds for investment. For example, an early attempt to privatize some Czech hospitals was unsuccessful because of the lack of legislation governing not-for-profit organizations (Busse *et al.* 2001).⁶

The political context is also important. Major reform requiring primary legislation relies on a combination of skills to design the law and to steer it successfully through the legislative process. It also benefits from a degree of political stability, something that has been rare in health ministries in this region in the past decade (Busse & Dolea 2001; Delcheva & Balabanova 2001).

In some of the FSU, the absence of a functioning legislature has meant that most major reforms have been enacted by presidential decree, a mechanism that has the advantage of speed but the disadvantage of not being subject to legislative scrutiny or requiring stakeholder involvement. Unsurprisingly, such decrees are rarely implemented successfully.

While most of central Europe has recovered to (or in some cases exceeded) the economic levels of 1990, this is not yet true of most of the FSU or Balkan countries. Most of the FSU remain 40–60% below their 1990 economic performance, with profound consequences for health budgets.

Finally, in some countries it is impossible to ignore the consequences of war and civil

⁶ Most attempts to privatize facilities in this region have failed. There are many reasons for this. First, it was recognized too late that only in rare cases is there a good business case for a general hospital. In particular, the conversion of old facilities – with a more than 20-year history of under-investment in infrastructure and equipment – is extremely costly, if not impossible. Most operators would not even be in a position to pay energy costs at market rates. Second, there has been a failure to exploit the full spectrum of the market, as indicated by the resistance of public officials to recognize that the only value for the market may be the land on which a hospital was built.

disorder, often involving large-scale destruction of facilities, loss of skilled professionals and economic collapse (Zwi *et al.* 2001).

A second question is whether we have identified the key stakeholders and how their interests can be addressed. This situation is complicated in those countries that have undertaken administrative decentralization, since the process has often removed the earlier mechanisms of coordination while new ones, which are more attuned to the changed relationships, have yet to emerge. In Hungary, for example, several attempts to rationalize hospital capacity have failed in the face of opposition from hospital management and local politicians (Orosz & Hollo 2001).

Especially in the FSU, national health ministries are often surprisingly weak. Funds are raised and spent within individual regions and any central resources are under the control of the Ministry of Finance rather than the Ministry of Health. Moreover, many health ministries remain preoccupied with the day-to-day operation of the health care system rather than moving to a role in which they exercise system oversight – establishing rules for providers, setting health purchasing priorities for insurers and monitoring the quality of services.

The third question is, having identified the key stakeholders, whether we can achieve agreement among them. As countries have abandoned the previous system of command and control, they now confront the need to work with a wide range of interest groups. In many cases, old ways of working have persisted. Idealistic national plans continue to be produced with little consideration as to how they will be implemented. Responsibility is not confined to health ministries; in many cases international agencies have also played a part.

A fourth question is whether we have made the policy too complex. Complex plans are always difficult to implement, even when agreement has been reached with stakeholders (Pressman & Wildavsky 1973). Many reform programmes have been remarkably complicated, such as the new provider payment systems described earlier.

On the other hand, the call for simple solutions has little relevance for the health sector. It is evident that even advanced industrialized countries are continuously struggling to find the right balance between affordability, equity and efficiency in a highly complex health care market in which powerful interest groups dominate the political economy.

One cause of complexity is the existence of multiple lines of accountability and, with them, funding streams. In Poland, hospitals obtain recurrent revenue from insurance funds, major capital investment from central government, and maintenance from local government (Kozierkiewicz & Karski 2001). Effective change requires coordination between all of these groups. This problem is increasingly recognized in western Europe, and recent reforms in France have created regional hospital agencies, linking the planning function with the social insurance funds in structures that have successfully introduced major changes in the configuration of hospital services (McKee & Healy 2002b). A debt crisis facing municipal hospitals in Austria led to the establishment of provincial holding companies, whereby municipalities give up ownership of hospitals to state holdings. They thus created efficien-

cies through consolidated management and purchasing and the ability to restructure an entire network as opposed to a single facility. The introduction of an internal market in health care in the United Kingdom failed to tackle the problem of over-capacity and duplication in London. This was only addressed adequately by developing a plan that looked at the provision of all health services across London.

A fifth question is whether there are adequate resources to support implementation. In the face of the economic collapse that has befallen some of the FSU, causing them to fall within the category of Highly Indebted Poor Countries (HIPC), annual health care budgets have fallen precipitously. Yet even in these countries, most ministries cannot spend their allocated budgets because of their limited institutional capacity. In these circumstances, change becomes possible only with the support of external donors.

The final question is whether we are prepared for the unexpected. As already mentioned, reform often suffers from the law of unintended consequences. The clear implication is that it is necessary to monitor closely the consequences of reform and take effective action at an early stage.

Lessons learned

Although there are many differences between the countries in this region, their experience in restructuring health care delivery systems in the past decade offers some general lessons.

Take account of the context of reform

The first lesson is that policy-makers seeking to implement reform should take full account of the context within which they are operating. The challenges they face differ both within and between countries. Most obviously, they often face quite specific health needs, but they also face varying degrees of constraint on the resources available to them. Yet while concern about resources often focuses on money, this may not be the most important issue. Some western European countries that have tried to increase health expenditure have discovered that more money is of little use if there is nothing to buy, especially if there are insufficient staff with the appropriate training. Some reforms simply increase transaction costs, with little impact on access or service quality. Access to large numbers of staff with inappropriate training is, of course, a quite different matter. The models of care adopted should be consistent with what is affordable. There is little point in purchasing expensive equipment if there are neither the staff nor the funds to use it.

Coordinate finance and planning

The second lesson is that effective change requires close coordination between financing and planning. Countries that have relied on market mechanisms to reduce capacity have

generally been unsuccessful. Health care facilities confronted with reduced budgets have several options other than simply to close, and giving them managerial autonomy almost guarantees that they will focus on the survival of their institution rather than on reconfiguring services to meet the health needs of the population. Typically, they will allow their facilities to deteriorate, reduce the services they provide or simply run up a deficit, maintaining arrears to suppliers and expecting to be bailed out at some point in the future. In contrast, a regional planning system makes it possible to look at how different health care facilities can work together to meet health needs. The responses to growing levels of chronic disease are inevitably complex, spanning different settings and specialty groupings. They are unlikely to arise by chance.

Change will involve the closure of existing facilities, but nearly always it will also require the creation of new ones. Put simply, patients have to go somewhere; the challenge is to ensure that they go to settings that are most appropriate to their needs.

Engage with appropriate stakeholders

A third lesson is that the demise of the command and control economy requires policy-makers to engage with a much broader range of stakeholders than in the past. Consumers are better informed and more vocal, the free press is a powerful institution, and lobbyists of all sorts will aggressively pursue their objectives. These diverse groups must agree on clear objectives and identify both the constraints they face and the opportunities for change. A successful policy will bring all of the relevant stakeholders on board, persuade them that alternative ways of providing care are not just possible but desirable, and ideally convince them that they have all won in some way or other. In doing so, it is essential that their quite justifiable anxieties about job security and earnings are taken into account. It is also necessary to understand that change requires adequate resources, both financial and managerial.

Align incentives

A fourth lesson is the need to align incentives. Too often, change introduced in one part of the health care system creates incentives that are entirely incompatible with those in another part. In the Netherlands, for example, paying primary care physicians on a capitation basis and specialists on a fee-for-service basis virtually guarantees high referral rates. The incentive system should also incorporate a means of promoting long-term investment, both to prevent further deterioration of the facilities that already exist and to make it possible to provide newer and more appropriate ones in the future.

Make stewardship a reality

Finally, governments must accept responsibility for the stewardship function. This means that they must agree, in association with other interest groups, a clear health strategy within which health care providers can work that focuses on promoting health and not just keeping facilities open. They must ensure that the prerequisites for high-quality care are in

place, such as effective regulatory systems for professionals, pharmaceuticals and technology, but also systems that will promote involvement in quality assurance activities throughout the health care system. All too often, and particularly in the FSU, finance ministries tend to associate the health sector with the “unproductive” social sectors that yield no return on investment. For this reason, the social sectors receive only a residual budget allocation. It is the state’s role to invest in human capital, i.e. in the people who will bring about change. These are both managers and health professionals, who need the skills to interpret and adapt evidence of effective models of care, and researchers, who must assess the health needs to be met and the applicability of different responses to them.

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Ten years of health sector reform in CEE and NIS:

An Overview

A background paper prepared for USAID Conference, Washington, DC
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Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia

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This draft paper is part of a series commissioned by USAID to provide a conceptual framework and overview of the main thematic topics of the USAID conference "Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia." Following the conference, each team of authors will revise the papers, compiling the final versions in a book by the European Observatory on Health Care Systems, which will be made available to conference participants in early 2003.

1. Introduction

The decade since the break up of the Soviet bloc has brought enormous political and socio-economic change. The health sector has not been spared the effects of transition and the countries emerging from the process have each engaged in varying degrees of health system reform. It is at last possible to reach some judgement about how this process has unfolded, and to identify successes and failures, and to understand better the scale and nature of the remaining challenges. It is now timely to take stock of these experiences and to draw lessons for the future development of health systems in this complex and dynamic region.

In all countries one of the greatest challenges facing those undertaking health systems reform is how to develop an overall 'health system perspective'. In practice, policy-makers tend to focus their attention on individual initiatives that all too often are perceived as 'magic bullets' that they will cure all of the health sector's ills. We begin instead from the position that the need is for a better understanding of the intricacies and complexities of health systems as a whole, and the nature of the interrelationships between their different elements.

This introductory paper aims to provide such a perspective, offering an integrated conceptual framework that brings together a series of themes that encompass health system reforms in the region. For each theme it highlights a number of priority areas, and outlines key successes, failures and future challenges. It provides a map for policy-makers that is embedded in a systematic approach to the evidence on health system reform.

The themes are: facing the challenges of health care financing; improving the continuum of care; improving the quality of health services; linking with the community; and advancing public health. Each is examined in much more detail in the accompanying papers. Finally, the paper looks at the process of reform to identify which factors (whether contextual or linked to capacity) begin to explain why some reforms are implemented successfully and others are not.

2. Facing the challenges of health care financing

Much of the initial reform effort in the region has focused on the key theme — financing of health systems. Financing includes funding *i.e.*, the collection and pooling of financial resources, and the allocation of these resources to providers *i.e.*, the purchasing of services. In most countries the intention of the reform was to shift away from the centralized and integrated tax-based state model of Shemasko to decentralized, contract-based social health insurance reflecting the core features of the western European Bismark model. The shift has changed the way money is collected and pooled, and created a new relationship between purchasers and providers of care. It was intended to earmark or protect health funds, prompt greater efficiency and responsiveness and signal a move away from the

perceived shortcomings of the past. It often took place however, against a backdrop of socio-economic and institutional upheaval. The countries of central and eastern Europe (CEE) and the newly independent states (NIS) therefore face a new and challenging environment, in terms of the total funding of health care and also of the effectiveness with which they collect and pool resources and purchase services.

On the funding side three important areas demand consideration. First, *the implementation of effective health insurance systems*, which has been central to financing reform in a large number of countries, has proved problematic. General government revenues often continue to play a significant funding role despite the switch to social health insurance contributions. There is now a substantial body of evidence that helps to explain this and other experiences of implementing insurance. Where social insurance has been seen to fail, failure can be attributed to the weak macroeconomic context; the reliance of poorer countries on out-of-pocket payments and general taxation; low levels of employment and formal activity within labour markets; poor compliance and high levels of corruption; and lack of transfers from tax or social security funds to health insurance. Tackling these issues will not be simple. Wider economic recovery and institutional capacity building may go some way towards increasing the revenue collected through payroll taxes but further efforts to ensure compliance will also be necessary including dealing with corruption.

Second, *defining a more realistic benefit packages* will be a key strategy in ensuring financial sustainability. The commitment to fund both universal coverage and a truly comprehensive benefits package is unrealistic and unsustainable in many countries in the region. Despite political and technical difficulties and concerns about equity, countries may need to consider explicitly defining more limited entitlements to ensure that public revenues are targeted at the most cost effective interventions and the poorest segments of society and protect public health.

Finally, *addressing informal payments* must be a major priority in many countries. Data on their extent in a range of eastern European countries suggest they are widespread in both ambulatory and hospital care and that in a small number of NIS countries they form the largest source of funding. Informal payments are a response of the health care system, particularly providers, to the lack of financial resources and a system that is unable to provide adequate access to basic services. Cultural and historical factors also help determine the response of patients although the implications for access, equity and indeed efficiency are highly problematic. Formalizing payments and establishing systems of pre-payment (or insurance) is nonetheless, extremely difficult and requires considerable government and technical capacity and the explicit recognition of external constraints.

On the purchasing side two areas of reform have been particularly important. First are efforts to *enhance the cost effective purchasing of services* through the separation of purchaser and provider functions; ascribing purchasing functions to insurance funds; and employing contracts as the main tool for resource allocation. The introduction of these new models in CEE and NIS has been challenging for a number of reasons including the inadequacy of

funding and the unpredictability of funding flows; low provider autonomy; the absence of routine information systems; a lack of timely information; and sparse technical capacity and information management skills. Second, the introduction of *performance related payment systems for providers* is a widespread strategy for enhancing efficiency. Capitation has been introduced for primary care services in many countries and it is common for new hospital payment systems to be developed that link payment to a defined unit of hospital output. The results have been mixed to date. This is due to a number of issues including the fragmentation of public sector pooling and purchasing; poor design of payment systems which do not dovetail or complement each other; institutional impediments and vested interests; the financial deficits of public providers; and limited capability to monitor inputs or outcomes.

In order to move towards fulfilling the aims underpinning the reforms of health financing both funding and resource allocation need further attention. Mechanisms for pooling resources need to be strengthened with other sources of public expenditure included with social health insurance contributions to ensure the most cost-effective use of funding. The technical and administrative capacity of purchasers also need to be strengthened to exert maximum pressure for provider efficiency. This requires the development of information and monitoring systems, which can deliver timely and accurate data on provision and the training of personnel to use this information effectively. Similarly, government regulation and stewardship will be vital in ensuring that purchasers act in the best interests of the population.

Regardless of how well the collection and pooling of funding is organized and the extent to which resource allocation is enhanced, these can only be means to an end. The ultimate end point is an improved impact on health outcomes, which depends in turn on the quality and cost effectiveness of the services provided. Arguably, the initial focus of much of the reform effort in CEE and NIS on creating a structure of financial incentives has been at the expense of the reform of health care delivery itself. Clearly, the incentives created have not proved sufficient to prompt the 'spontaneous' improvements in the delivery systems. Indeed it now emerges that for these financial reforms to succeed in their overarching objectives they need to be accompanied by an independent, in-depth but articulated reform of the provision of care.

3. Improving the continuum of care

The nature of health care provision has changed almost beyond recognition over the past fifty years, in terms of the diseases being treated and the opportunities to diagnose and treat them. Many once common diseases, especially childhood infections, have been significantly reduced or eliminated. Ageing populations now experience multiple chronic diseases. Innovative treatments have turned many diseases that were once fatal into lifelong conditions that people die with rather than from. Collectively these changes can be characterised as a shift from simplicity to complexity. They have transpired in the east of Europe as well as the west and demand new responses from health systems region wide.

The classic Soviet model provided basic care, including immunisations and first aid to dispersed populations. It may have been suited to previous, more straightforward conditions but is no longer adequate. There now needs to be a more complex interaction of health professionals with a range of skills, each intervening when necessary. The management of diabetes is a case in point. While most care will be self-managed in conjunction with a primary care team there should always be allowance for recourse to a range of different specialists. Each element must be in place and, as importantly, there must be clear guidance to ensure the patient's way through this complexity is signposted and facilitated.

The policy-makers of CEE / NIS are only beginning to address this, not least because of their focus on financing and the absolute shortage of finances experienced. If they are to bring about the changes in health care delivery that will meet the complex needs of patients they face four main dilemmas. They must improve the performance of hospitals; restructure health care facilities; shift the boundaries between primary secondary and tertiary care; and strengthen and modernise primary care. These issues cannot be considered in isolation but as part of a single integrated delivery structure or 'continuum of care' and within the broader health system context.

First, *the effective improvement of hospital performance* includes upgrading the organization of hospital services and increasing efficiency and appropriateness of services. Decentralization of management in combination with shifts in payment mechanisms have been pursued as the key strategies in delivering better performance. There has not however, been sufficient investment to ensure that the information systems needed to measure performance are in place or that staff have the appropriate skills to review their actions or to act on evidence. Nor are there the funds to ensure that facilities are appropriately designed and equipped. Health professionals and managers will require adequate tools to deliver appropriate services. This implies the replacement of obsolete facilities and equipment, new training programmes and clear standard setting with access to monitoring and feedback and the wherewithal to take steps to enhance performance. These needs are of course linked with the efforts to improve quality (see below) but must also be seen as fundamental to improving the continuum of care.

Second, *hospital restructuring strategies* are needed to address the oversupply of beds and the inefficiencies of secondary and tertiary services. Hospital capacity in many countries of the region is excessive with basic indicators, such as the ratio of hospital beds to population, suggesting that levels of provision in some countries are about 50% higher than in the west. There have been cuts in bed numbers but these have been patchy across the region. Moreover, the concept that restructuring revolves around bed closures is far too simplistic. It fails to recognize the very different role of hospitals in this region or to acknowledge that in many cases they are still the main providers of social care. While, this is rarely the most cost-effective means of service provision, patients have few other options. Closures will certainly be desirable at some stage but they can only follow on the provision of alternative, and more appropriate, facilities and the creation of social support systems.

Third, *shifting the boundaries between primary care and hospitals* will be key to any successful reform process. It raises the issue of how and when patients are admitted to hospital and how and when they are discharged. There is clear evidence that many patients who could be more appropriately managed in a non-hospital setting are admitted to hospital. It is also the case that patients who could be discharged are kept in even after they have ceased to receive treatment. Both these problems have a common solution. This is the provision of alternative and more appropriate and cost-effective care settings with a simple and uncomplicated interface between them.

Finally then and central to the above there must be *effective strategies for strengthening and modernising primary care*. In Soviet influenced systems, primary care was the poor relation of the hospital sector. Staff were poorly paid and of low status, and the inadequacy of their training, facilities and equipment meant that their role was limited to little more than referring patients for specialist care or regulating sickness absence. Almost all countries have accepted the need for reform and they have achieved varying degrees of progress. Reforms have tended to centre on the development of a conception of family medicine with all that implies about continuity of care, capitation payments and physician responsibility. These need to be pushed forward with organizational reforms, to give primary care professionals or institutions more control over levels of care, allowing them to steer patients to the most appropriate care setting, whether it be in hospital, nursing home or a patient's own home. There also needs to be an expansion of the range of services and functions primary care delivers, including new or enhanced services currently seen as 'secondary', provided that the primary care context can be shown to be appropriate in terms of effectiveness and efficiency. This requires that a full range of primary care professionals are furnished with the necessary skills and that effective communication between levels can be established to allow primary care to successfully lead the process of the "virtual integration" of the different modalities of care.

Reforming delivery is complex and the problems are compounded by the multiple demands placed on health ministries which are expected to manage change. Their capacities are already stretched by the day-to-day operation of the health care system and few therefore have been able to step back to exercise oversight and address how to promote health rather than just keeping facilities open. Even given additional capacity though, there are no simple rubrics for achieving a seamless continuum of care that balances affordability, equity and efficiency in a complex environment. Nonetheless it is the role of policy-makers to take a whole system perspective and develop a clear health strategy with established rules within which various health care providers can work. This will depend on prerequisites like effective regulatory systems and mechanisms to promote participation. It will also require that the quality of services at all levels of the health care system can be monitored effectively.

4. Improving the quality of health services

Reform programmes have consistently underestimated the complexities involved in introducing new skills and genuinely changing practice but reforms of provider organizations can only improve outcomes if they change the quality of clinical practice. Many commentators have argued therefore that for reform to be effective it must be “bottom up” and start with improvements in clinical practice and with the training and standards of health professionals. These will depend on measures that include a range of accreditation, evidence based medicine and quality assurance mechanisms and on appropriate human resource policies. These systems and human resource development aspects are addressed in turn.

Strengthening quality improvement systems is dependent on the existing clinical context and the legacy of the past. At the outset it must be conceded that promotion of high quality care in CEE and NIS is made difficult by the lack of resources, the failing infrastructure and inappropriate management structures inherited from the Soviet models of the past. However, even allowing for these constraints it is apparent that the quality of care provided is often much worse than it need be. This is particularly striking when seen in contrast to western European and north American preoccupations with quality over the last three decades.

Many of the ideas underlying the increased emphasis on quality in the west had their origins in manufacturing and service industries and reflected concerns with efficiency and with consumer responses that did not feature in command economies. They saw management systems develop to streamline production (for example in car manufacturing), to ensure customer satisfaction (the hotel industry), and reduce errors (the aviation industry). Organisational theories on concepts of quality management have also become increasingly influential in health care. In line with work in the wider economy the emphasis in health has shifted from structures, standards and norms to outcomes and process linked to outcomes by scientific evidence. This “outcomes movement” underpinned the approach of the American Institute of Medicine in generating a definition of quality in health care. The definition is “*the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.*” It allows the concept of quality to be operationalized and raises many important issues, including the meaning of professional knowledge and the definition of outcomes and there is now an extensive literature on these issues.

It is clear that clinical guidelines should no longer be based on the opinions or instincts of senior physicians but must stem from systematic reviews that critically appraise the evidence of relevant research and combine the results using explicit techniques such as meta-analysis. It is also clear that the production of clinical guidelines is not in itself, sufficient to change clinical practice. A central challenge therefore, is how to put evidence-based guidelines into routine clinical practice and how to change in reality the two key components that constitute care — its technical content and the organisation of its delivery.

It might be supposed that this would be more difficult in the west, with its traditions of physician independence and the historical role of anecdote and opinion in determining clinical practice. It might also be supposed that the Soviet inspired traditions of standards and norms would provided a strong basis for applying guidelines to enhance the quality of care. In reality the west has experienced a revolution in its approach to evidence, albeit a gradual one, while CEE and NIS has been characterised by a failure to develop a culture of evidence-based medicine and the continuing and widespread use of ineffective treatments.

This is not to say that there has been no progress in the region. Since transition individuals in many countries have formed professional associations to promote quality in health care. It has also proved possible to introduce systems to enhance quality of care with beneficial effects on effectiveness, efficiency and humanity of care in some areas. Yet there have been many problems. The command and control nature of Soviet inspired systems, which might have eased implementation has actually prevented change, in large part because of an initial reluctance by those in positions of leadership to delegate decision making to more junior staff. It is only gradually, and in limited areas, that leaders have become more open to this quality focused way of working, and have been able to identify new and often more satisfying roles for themselves in improving services. One of the greatest challenges has been and continues to be the empowerment of those involved so that the message that change is possible is conveyed and so that practitioners can develop a real sense of ownership of quality initiatives.

This touches on the second dimension inherent in achieving quality care that is *improving the quality of health professionals*. This requires that the staff in place have the appropriate and necessary diagnostic, technical and caring skills and that the right mix of professionals is in place. The centrally planned approach before transition saw the over supply of doctors, rigid demarcation between professional groups, the under development of the nursing role and an inappropriate skill mix. Priority areas are therefore, the reform of human resource planning to address the new balance of staff required and to ensure production of more family practice specialists, public health professionals (doctors, nurses and others) and managers; training programmes, including continuing education which will develop and maintain the right skills; and strengthening professional standards and accreditation.

It will also be crucial to enable and motivate staff so that they are in a position to deliver quality care and contribute to the ongoing improvement of services. This implies addressing the levels of pay, employment security and conditions under which all groups of staff work. Certainly, staff who are expected to rely on under-the-table payments, who fear losing their job or who have to work without access to the equipment needed to treat patients adequately cannot be expected to deliver quality care or to respond appropriately to patients' needs in the long-term.

Improving the quality of health services will depend therefore on the expansion of evidence-based medicine and the application of modern quality improvement methods,

including the appropriate treatment of staff. These are critical issues that must be explored over the next ten years of health reform if there are to be real improvements in the quality of care. Certainly, as long as there is widespread use of ineffective treatments, increasing the level of funding for health care will increase waste rather than bringing about substantial improvements in health. If the goal is to improve the health of the population, interventions funded from scarce resources must be based on scientific evidence of their effectiveness and carried out by suitably qualified staff applying best practice and monitoring and responding to outcomes.

5. Linking with the community

In many respects total quality of health care and health care services implies appropriate treatment of individuals and the involvement of their communities. Certainly empowering the citizen and strengthening community participation have been referred to extensively in reform programmes that seek to respond to consumers needs, decentralize power and become increasingly democratic. However, the legacy in CEE and even more so in the NIS have not made this easy. The countries of the region have a recent history of highly formalized, state-centred systems, with only a limited presence of civil society and formulaic approaches to participation in social and public life. The nineteenth century traditions of central Europe were subsumed by communist state monopolies and civil society gave way to quasi social organizations in sports, culture and education, which were dominated by the state. Individual participation in the running of the health system was virtually non-existent, with no choice of providers and low consumer responsiveness. Many countries in transition have sought to address this although this often involves only lip service as in the broad participatory strategies described in their reform programmes. It has often been difficult however, to overcome resource constraints, cultural blocks and professional resistance either in linking with the individual or the community.

Empowering the citizen has been seen as an important reform focus not least as a means of prompting system changes and increased responsiveness. Four major sets of strategies are included here; allowing consumers a choice of providers and/or insurers; encouraging patient participation in clinical decision making (as co-producers of care); promoting citizen participation in the running of the services at various levels (for example in agreeing the basic package of care); and introducing patient rights legislation. These strategies are included in many reform programmes, yet so far progress has been mostly at the level of good will or rhetoric and only limited change has actually taken place. The most positive evidence of action has been in the areas of patient choice and patient rights legislation.

An increase in choice of provider by patients is a relatively common goal of reforms and the introduction of health insurance and of contracting with providers has in some cases allowed consumers to select general practitioners, specialists and hospitals. However, in reality, choice is inevitably constrained by difficulties of access exacerbated by the short supply of certain services and the widespread use of informal payments. In some cases it exists

on paper only. Nonetheless, the issue is at least recognised. Similarly, in a small number of countries consumers are also allowed to choose between competing insurers. This however, has proven to be difficult to regulate and has had an unintended negative impact on efficiency and solidarity.

The introduction of patient rights legislation and patient charters is the other main area of progress and charters have become a common feature in a number of countries, particularly in CEE. These set out a series of patient rights; outline standards covering issues like access to care or waiting times, and establish complaints procedures. The main challenge is that in most cases there are no effective mechanisms in place to ensure implementation. Without any legal or financial sanctions to promote compliance with standards they often dwindle to formal statements of principle with few real consequences.

Strengthening community participation might reinforce the rights of the citizen but this dimension goes beyond the individual perspective to consider the role of the community, reflecting the wider democratization of the CEE and the NIS. It is complicated by the fact that while there is good evidence about the positive contribution of social networks to health status much less is known about how best to empower communities as social actors in health systems.

Community participation strategies are generally new to communities in the region, at least as they operate on a formal level and outside government control. They are especially new in the health sector. Health reforms have begun to include stakeholder analysis and this has expanded to address intersectoral partnerships for health reform and health development. However, there is little evidence yet of the creation of sustainable civil society initiatives for health in communities. This is despite the significant role of non-governmental organizations (NGOs) as intermediaries in this respect. The rapid proliferation of NGOs in the region, especially in countries like Hungary and Poland may be encouraging in its broadest terms but only a small percentage of them work with health issues and those that do tend to represent groups of individuals responding to a deterioration of services. They tend not to represent a movement explicitly promoting health or advocating for healthy public policy. Furthermore, many NGOs lack proper technical expertise, management and training in advocacy techniques, and most if not all are poorly funded.

Although the civil society sector for health continues to be weak in many countries, a series of successful programmes launched by the WHO Regional Office for Europe has provided an opportunity to foster the exchange of experiences within and between local communities on health and capacity building issues. Programmes such as WHO's Healthy Cities Project, Safe Communities Initiative and the Health Promoting Schools Project have stimulated the growth of local community action for health and suggest that citizen empowerment and community participation will play an increasing role in the health systems of CEE and the NIS.

6. Advancing public health

The ultimate reform strategy would be to ensure that populations were healthy and that there was no need for health services. Certainly while health services play a significant role in reducing mortality and improving quality of life, much of the health gap between west and east can only be addressed through wide population and intersectoral strategies. In this context, reform debate in the region must shift from 'health care reform' to 'health reform'. Ultimately, and ideally, policy makers should be able to act across the entire spectrum of policies (including personal, population based, and inter-sectoral interventions) on the basis of the contribution that each can make to enhance population health.

The first step in improving population health is to draw on the extensive research available to better understand why health is so much worse in this part of Europe. This is attributable to a range of factors acting at different levels with many of the well-established risk factors linked to chronic disease, premature mortality and morbidity being especially high in the region. Smoking has traditionally been common among men in the region with visible and current consequences. The sustained onslaught of western tobacco companies, often in collusion with senior politicians, promises ongoing problems and the increasing inclusion of women in the mortality and morbidity data. Diet is also a major factor. It is typically high in fat content, and the relative lack of year round fruit and vegetables is now also being recognised as an important cause of chronic disease. Alcohol is an especially important problem in this region, as was apparent from the spectacular reduction in deaths that accompanied the 1985 anti-alcohol campaign in the Soviet Union. Its impact is especially large as it contributes not only to cardiovascular and liver diseases but also plays a major part in the very high death rates from injuries and violence. Finally, infectious diseases are returning with a vengeance, but in much more complex guises, as with HIV and drug resistant tuberculosis.

The public health system established in the Soviet Union in the 1920s and 1930s did have many important achievements, in part because of the high political priority given to it. The seriousness with which the threat of disease was regarded is illustrated by Lenin's dictum in respect of typhus that "If communism does not destroy the louse then the louse will destroy communism". However this extensive, but basic system is no longer adequate for the complex challenges faced. Despite the potential contribution that public health services could make, they have received remarkably little attention in the process of reform so far. Any changes that have occurred were often a by-product of wider organisational change. The two priority areas for reform must be; restructuring public health services; and strengthening health promotion.

Restructuring public health services is a necessary response to the outmoded structures in place and the increasing recognition that public health has a strategic role in health systems. Before 1990, public health services in CEE and the NIS were organized in line with the Soviet model.

Responsibility for public health and prevention was vested in the highly centralized Sanitary-Epidemiological (San-Epid) services and focussed on a traditional and limited core of public health activities. Perhaps the most tangible achievement of the San-Epid system was its contribution to vaccination programmes and communicable disease control, which achieved remarkable successes across the region. On the other hand, it was relatively ineffective in combating problems like environmental pollution, occupational diseases and non-communicable disease. Nor was it effective in producing any of the information that might have allowed public health specialists to assess needs or respond effectively to emerging patterns of ill health. Finally, the system was singularly ill equipped to engage with the public to promote health or encourage behaviour change.

Public health services did undergo a series of changes during the 90s with decentralization of powers to local authorities; fragmentation and blurring of responsibility. These were not purposive reforms and coupled with the decline in funding of the San-Epid system they led to a decline in the quality of those functions that were previously successful (specifically communicable disease control). There has been subsequent under-investment in the development of relevant skills and in the information systems on which modern public health depends. There have been some notable successes, and cohorts of specialists equipped for a more strategic role have been trained but the reform of public health services still has a long way to go.

Strengthening health promotion is the second public health dimension that requires priority attention. It was largely ignored in CEE and the NIS before 1990 but has benefited subsequently being recognised as a core public health function in many countries in transition. In general preventive strategies such as those aimed at drug users and HIV prevention have received most attention and have been best linked with emerging civil society. There is however a relative lack of intersectoral action. Blocks to work across sectoral boundaries include; a general attitude that population health is largely a product of medical (curative) services and not a cross-sectoral issue; and territorialism of ministries and difficulties in collaborating between agencies. In addition, there are explicit problems in adopting and enforcing public health legislation which creates conflict with key interest groups so for example the tobacco lobby efforts have often prevented advertising bans or tax increases. Nonetheless, there are networks and activities that encourage intersectoral action (Healthy Cities, Health Promoting Schools, health impact assessment) and demonstrate that success is possible particularly at the local level.

The challenge facing public health remains considerable but experience to date has helped identify key principles that should underpin change. The first is to preserve the good. The inherited system had successes, especially in immunisation and child health and while these need modernizing they should not be abandoned. The second is to attack the bad. While transition has brought benefits, it also has a downside. Just as open borders can increase access to 'healthy' products (year round fresh fruit and vegetables), so they have increased exposure to risks (cigarettes). The third is to reform the institutions and the fourth to increase the level of skills available. Almost all countries urgently require a restructuring

of public health services to allow them to respond to the complex challenges ahead and almost all have a major shortage of individuals trained in modern public health able to lead the transformation. There are some well-established and very successful Schools of Public Health, (in Hungary, Croatia, and Lithuania), but there is still a great unmet training need for those already working in the field and for the next generation of public health professionals. Fifth, governments must protect the public health budget and recognise that public health services are a public good. If the state does not invest in them then no-one will, with adverse consequences for everyone. Finally, there is a need to think much more widely than before and to adopt new forms of and approaches to interdisciplinary and intersectoral working.

7. Implementing successful reforms

Health reform has been harder to implement than expected, and too often it has had unintended consequences. Many of the difficulties experienced have had more to do with the complexity of changing custom and practice than the actual content of the reform programmes and to a significant extent the success or failure of reform has depended on the ability of policy-makers to implement and manage change.

The reform debate focuses increasingly on those contextual and process factors that enable or obstruct change. The experience of CEE and the NIS to date in implementing health reform signal which are most relevant in this region but nonetheless the key issues group around generic concerns and include; context; stakeholders; effective stewardship; steering implementation processes; and building institutional, human and management capacity.

Understanding the context is fundamental. A key lesson for reform implementation is the importance of mapping and appreciating the impact of the social, political, cultural and economic context within which reforms take place.

The historical experience of countries, their national culture and popular custom all help shape expectations of the health care systems and responses to proposed reforms. The ideological dimensions of national politics and of government policy will clearly shape reform content and will also have an impact on approaches to implementation. Similarly long periods of political change and instability will inevitably affect the political context and tend to undermine the sustainability of reform efforts although they may also represent windows of opportunity. Clearly major political and social transformation creates the possibility of introducing change, and may give new governments the legitimacy to execute policies that is otherwise denied. The seizing of these historic opportunities is amply illustrated across the region where new democratic governments often implemented sweeping reforms. However, in many instances this political 'honeymoon' was short lived.

Another important factor contributing to (and being shaped by) context is the role of external influences in reform development and implementation. Many reform notions have

been developed in western countries and transferred across national boundaries to the region. On occasion countries have been lured into adopting structural health sector arrangements that are incompatible with their health sector traditions, cultures and values and that they have neither the societal interest nor the organizational capacity to sustain. International organizations sometimes contribute to this phenomenon through their activities. In order to make an effective and positive use of these external influences and evidence countries need to develop a stewardship capacity (see below) and to adapt useful reform models to the cultural context, establishing clearly their own health sector objectives and managing donor inputs.

These contextual dimensions are complex to deal with not least because of the difficulties of delineating and defining them. Other more tangible elements of context are easier to measure but no less powerful and economic context is a case in point. The continuing macroeconomic pressures in the region constitute a major obstacle to reform implementation. The deep recession that followed the demise of centrally planned economies led to a significant decline in the financial resources available for health services which inevitably had consequences for health care provision. In some NIS countries these financial cuts were of up to 50 per cent of the health care budget. They created substantial flows of informal payments and can be shown to have slowed or stalled the implementation of health care reforms.

It is unsurprising that economic retrenchment and decreasing health budgets should have affected the scale of reform and the extent of implementation. Many reforms (like contracting hospitals) require substantial additional investments in management training and information systems in their start up phase. Even when reforms are intended specifically to contain costs or generating savings (like hospital restructuring), initial investments are required before the effects can be felt. This does not however, lead inexorably to the conclusion that reform cannot succeed in the face of major financial constraints. Rather, the main contextual obstacle to implementation of change may be unrealistic expectations about the likely benefits of reform, both from decision-makers and the population at large. For instance, in many NIS countries, market reforms were expected to increase quality while maintaining universality in the face of dwindling financial resources. The demands made of the reforms were unsustainable, early experiences were inevitably deemed failures, which in turn hampered further implementation. Policy-makers may begin to address these dilemmas by acknowledging the full financial implications of reforms proposed and tuning expectations accordingly. This means that implementers may need to be less ambitious, maintain some current structures and focus on affordable areas of reform and on marginal but high priority shifts between areas.

Given that the contextual issues are addressed reform development and implementation will still require that policy-makers are effective in *dealing with stakeholders*. Health system reform inevitably involves a large number of stakeholders from patients and professionals to politicians. The ability to identify and then deal with them is key to implementation and three strategies play a particularly central role.

First, ensuring the political willingness to support the reform will be key to success. A lack of political will has posed a major obstacle to reform in several countries of the region and explains some of the slowness in introducing change. This is not surprising, particularly since the complex nature of health care reform demands major changes in the status quo and creates benefits felt only in the longer-term, which inevitably clashes with the short-term nature of many political agendas. The difficulties of achieving change in this environment are exacerbated in some CEE and NIS countries by weak coalition governments and political instability. Frequent political changes, not only of governments and ministers but also of high level officials within the relevant Ministries, have often lead to multiple overlapping or competing reform proposals and overall inaction. In contrast, reforms backed by a strong political will within a politically stable setting have sometimes achieved implementation in otherwise unfavourable circumstances. There are no simple ways of securing political commitment to reform, but strategies that have been shown to work include; using comparative analysis to highlight how reform models work; pilot projects to demonstrate the impact of particular reform strategies; decentralizing implementation to local levels; and consensus building from the outset to maximize political support for reform.

Second, setting strategic alliances with key health sector actors is central to implementation efforts. There are numerous examples in the region of pivotal stakeholders such as the medical profession having blocked or enabled reform. In many CEE countries for example, physicians played a central role in the introduction of social health insurance in the expectation that this would increase their income. While there is a good understanding of the importance of stakeholders and of forming strategic alliances with them it is less clear how best to steer diverse interests into policy coalitions to support reform. Every reform effort needs nonetheless to be preceded by a political mapping of key stakeholder interests and to include the development of alliances; and, if possible, the cultivation of policy champions if implementation and sustainability are to be secured.

Finally, public support of reform is becoming increasingly important in much of the region. In the former communist systems the public made little real contribution to the running of the health services but there has been a growth of civil society and the development of health NGOs and consumer groups recently. Furthermore, many new reform strategies give the public a major role in exercising voice and exit powers in areas such as choosing providers. This has largely been an untapped force in the region but must increasingly be an important reference point for policy-makers who want to ensure reform success.

Steering the process or the design and the management of the implementation process itself is also crucial. Inadequate planning and management of implementation has helped to account for numerous reform failures. Key strategies here include; making reform objectives explicit; establishing an appropriate management structure; allocating responsibility clearly; assessing available financial, technical and managerial resources; using a range of mechanisms and tools including legislation and financial incentive; timing and pacing reform appropriately; and putting in place appropriate information and monitoring systems. Overall

the effectiveness of these organizational management techniques is uncontroversial, two strategies though deserve special consideration given the characteristics they take on in this region.

First, the development of enabling legislation has been a major challenge to reform implementation in CEE and the NIS. Many countries in the region have failed to enact appropriate legislation due to the political uncertainty resulting from short-term coalition governments. However, to have legislation in place does not necessarily generate subsequent implementation. In parts of the NIS, legislation typically in the form of inadequately thought through presidential decrees, acts as a formulaic expression of official values to which no one subscribes in practice.

A second strategy in steering the process of reform, selecting the most appropriate timing and pacing of reform, has been the subject of some controversy. Choosing the most appropriate timing, perhaps when there are specific and supportive social or political circumstances, is an important factor in achieving successful implementation. As noted, recent periods of major social transformation have proved to offer windows of opportunity for radical change. Rapid 'big bang' reforms such as in the Czech Republic were effective in bringing about change in a short time. However, experience shows that for this to be sustainable and effective in the long term two prerequisites are crucial; first, a degree of technical 'certainty' as regards the reform model to be introduced is needed; and, second, there must be a broad social consensus behind the chosen model. The lack of either one of these in some countries that underwent a 'big bang' reform has resulted in major reform reversals.

A more incremental approach whereby change is tested locally with pilot projects before being extended nationally may be more effective. This approach yields more evidence about the effectiveness of different models and in the long run may lead to more socially sustainable policies. There are many successful examples of pilot projects linked to successful national reforms such as the introduction of General Practitioner based systems in some CEE countries. This is not to say that all countries undergoing incremental reform have done so by design or following on from the results of pilot experiences. Often incrementalism has taken place by default and is explained by contextual factors including political instability and macroeconomic constraints. Moreover, incrementalist approaches do have drawbacks. A slow pace of reform will allow key groups of stakeholders to organize resistance before change is introduced. Incremental approaches may also flounder when faced with the difficulties of generalising the results of pilot experiences, with factors such as the self selection of human resources in pilot sites or the lack of financial resources available to extend established best practice confounding implementation efforts.

Ultimately, the 'best' approach to implementation in any country will depend on its particular contextual circumstances. However, there seems to be a consensus about the need to combine an incremental and flexible approach to reform with a series of small "bangs" that

can put in place particular reform strategies, particularly in those cases where there is both organizational certainty and social consensus.

Building institutional, human and management capacity is also crucial to the success of reform implementation. Many reform strategies such as the introduction of provider markets require sophisticated information systems as well as substantial technical and managerial skills which have been lacking in much of CEE and the NIS. The absence of these preconditions helps to explain the minimal progress achieved with some reform strategies in a number of countries in the region and remedying these shortfalls will enable implementation.

A related factor in determining reform success is the extent to which there is institutional capacity, particularly in the public sector, to steer the reform process. The introduction of some complex organizational and market reforms together with the decentralization of state functions has highlighted the need to increase the capacity of the State for governance, monitoring and regulating new organizational relationships. A central factor in the failure of reforms in some countries has been the lack of capacity of the Ministries of Health to adopt these new functions. Two key contributory factors to this failure are; the rapid turnover of public sector employees migrating to better paid jobs in the private sector; and the chaotic decentralization of authority to health insurance agencies and/or regions which have left ministries with accountability for implementation but little authority or capacity to drive reforms forward. These issues are further developed as part of the consideration of how to build an effective stewardship role for the State.

WHO's *World Health Report 2000* on health systems performance identifies ensuring effective stewardship as fundamental to health systems. Stewardship was defined as having three main components: i) health policy formulation – defining the vision and direction for the health system; ii) regulation — setting fair rules of the game with a level playing field, and iii) intelligence – assessing performance and sharing information. This concept combines many of the elements discussed above and underlines the importance of the State in ensuring effective reform implementation.

Effective government stewardship is key in ensuring the appropriate performance of all health system functions and it becomes particularly important when introducing reform strategies. For instance, the introduction of market incentives together with the loosening of direct managerial control and accountability mechanisms may result in a series of perverse incentives that will require monitoring and regulation.

- 3 The analysis of experience in the region shows that the introduction of reforms only succeeds when these are accompanied with strong regulatory, managerial and information capacity, which is often lacking in countries. In other words, if the stewardship role of the government is weak, regardless of the merits or otherwise of particular reform models, these may lead to catastrophic results for the society.

If governments are to succeed, they must provide a clear policy vision which makes health

policy goals and trade offs explicit; demarcates the role and functions of the private sector; sets out a level playing field for the public and private sectors; and includes the definition of a basic package of benefits. Second, governments need to put in place appropriate information systems that allow monitoring of results of reforms and support the introduction of quality assurance mechanisms such as accreditation of facilities and auditing. Finally, governments will need to construct a strong and efficient regulatory framework.

These demands highlight the importance of putting in place programmes to strengthen institutional governance aimed at public bodies and in particular Ministries of Health charged with steering health reforms. It will also be particularly important to plan for a new skill mix and to introduce appropriate training programmes for existing and new human resources.

8. Conclusions

The paper has outlined a conceptual framework that integrates the key strategies that must be addressed and linked if policy-makers are to create the kinds of health care systems that citizens of the region ought to be entitled to. It has examined how financing, coordinated service delivery and quality measures matter independently and it has highlighted the need to interweave them effectively with citizen and community participation mechanisms and a far reaching concern for public health. It has also reviewed the complex issues that hinder or help the implementation of reforms and suggested how critical an understanding of context, stakeholders and capacity will be to delivering change. It draws attention to a number of priority areas for further reform and suggests that policy-makers will need to forge alliances, mobilize political will and the public and draw on a range of legal, technical and managerial strategies if they are to steer reform implementation effectively.

Ultimately reform success or failure will depend on the impact of reforms on the societal objectives of health improvement, equity and efficiency and on the extent to which health systems respond to consumers. There are no simple solutions to the challenges faced. It is rather the case that complexity must be an inherent factor in any realistic approach to balancing affordability and effectiveness in what is an immensely complex environment surrounded by powerful interest groups. Policy-makers need therefore to address stewardship and to take a whole system perspective, adopting a clear health strategy and sponsoring effective regulatory systems so as to provide the framework health care purchasers, providers and public health professionals need. This paper gives some indication of the degree of complexity and the elements they will need to combine. Subsequent papers examine each individual component in more detail. The extent to which these different elements will combine in any given country context to have an impact on health outcomes remains open to debate and is an area where national policy-makers must bring their expertise to bear.

Promoting quality in health care

A background paper prepared for USAID Conference, Washington, DC
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Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia

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Executive Summary

Promoting quality in central and eastern Europe (CEE) and the countries of the former Soviet Union (FSU) is difficult because of the lack of resources and inappropriate structures inherited from the Soviet model of health care provision (Semashko). Even with limited resources, it is apparent that the quality of care provided is often much worse than it need be. The paper begins by looking at how quality was organized in the Soviet model. It identifies as a major problem in quality the widespread use of ineffective treatments. The paper explores the critical lack of a clinical tradition of evidence-based medicine in the region, and describes the old system of quality assurance based on promulgation of standards and norms, and the punishment of individuals who failed to heed them.

The second part of the paper develops a general conceptual framework for the quality of health care and its improvement. The level of quality problems in health care is in stark contrast to those in other industries, which have a long history of using quality management systems to improve quality (such as the car manufacturing industry), increase customer satisfaction (such as the hotel industry) and reduce errors (such as the aviation industry). Since the 1990s, with popularization of the work of organizational theorists such as Deming and Juran, the concepts of quality management have become increasingly influential in improving quality in health care. Emphasis has shifted from structures, standards and norms to outcomes and process that are linked to outcomes through scientific evidence. This is often referred to as the "Outcomes Movement." This approach has been operationalized in a widely used definition of quality in health care that has been developed through a process of consensus by the US Institute of Medicine: "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

The paper goes on to explore the implications of the definition, focusing on the critical concepts of outcomes, likelihood and professional knowledge. For the former Soviet Union, a critical issue is what constitutes professional knowledge. Another critical issue is how this knowledge is delivered to the patient (the organization of care). Soviet medicine was isolated from the emerging developments in clinical epidemiology and evidence-based health care, with the result that randomized controlled studies were very rare. Soviet medicine relied on a special form of professional guidelines called "methodological recommendations," which were developed and driven into the system using a top-down approach. Guidelines should be based on a systematic review of the literature, using critical appraisal skills (meta-analysis) to combine all randomized controlled trials.

The third part of the paper explores how to put evidence-based guidelines into routine clinical practice. This is the critical step in improving the quality of care and outcomes. As experience with evidence-based guidelines has accumulated, it has become clear that their production is not sufficient to change clinical practice. To make improvements in health care one must tackle its two key components: content and organization. The content of care must be compatible with the best scientific evidence available. Organization of care means the way in

which health care is delivered through the processes and systems of care. The paper presents a conceptual model for reorganizing the processes of health care to enable the implementation of evidence-based practice.

The final section of the paper examines some aspects of what has happened in the CEE and FSU in quality improvement and in applying modern health care quality improvement methodology. Given limitations of space, the paper highlights two successful examples of development projects that have improved the quality of care in practice. The case studies reviewed in this paper show that it has been possible to introduce systems to enhance quality of care in countries in transition, with significant improvements in effectiveness, efficiency and patients' experience of care.

In conclusion, evidence-based medicine and the application of modern health care quality improvement methodology are the critical issues that need to be explored over the next ten years of health reform, if there are going to be real improvements in the quality of care. As long as there is widespread use of ineffective treatments, it is unclear whether increasing the level of funding to health care will lead to real improvements in health. Furthermore, even improvements in "efficiency" may not lead to improvements in outcome. Hospitals may improve their throughput, but if the treatments are not effective this will not lead to improvements in health. The goal is to improve the health of the population, which has been deteriorating since transition, and this requires a focus on improved outcomes. This, in turn, requires that interventions funded from scarce public resources are based on scientific evidence of their effectiveness.

Introduction

The fundamental goal of a health care system is to promote health. Clearly there are certain prerequisites if it is to achieve this. It requires adequate resources, which are not just financial but include trained staff and appropriate facilities, equipment and pharmaceuticals and it should be organized in a way that makes it possible to provide care that meets the needs of its population. It must be accepted that the lack of resources and inherited, often inappropriate structures place the health care systems in central and eastern Europe and the former Soviet Union at a disadvantage as they seek to promote high quality care. Yet even in these difficult circumstances it is apparent that the quality of care that is provided is often much worse than it need be. In some countries many treatments provided are ineffective, employing resources that could be better used in other ways. Simple maintenance issues, such as provision of adequate lighting or safe electrical wiring are ignored, while hospitals invest in technology that is under-used. Patients are treated with little respect, in ways that contrast with the changing nature of personal interaction in the growing commercial sector.

The level of quality problems in health care is in stark contrast to some other industries, which have a long history of using quality management systems to improve quality (such as the car manufacturing industry), increase customer satisfaction (such as the hotel industry), and reduce errors (such as the aviation industry). Since the 1990s, with popularisation of the work of organizational theorists such as Deming and Juran, the concepts of industrial quality management have become increasingly influential in health care. Its advocates claim it is as effective in service industries as manufacturing, and has great potential in health care.^{1,2} Much of health care falls far below the quality levels achieved in industry but there are examples of success. For example, deaths related to anesthesia occurred at rates of 25 to 50 per million in many industrialised countries. Improved monitoring, the widespread adoption of practice guidelines, and other systematic approaches to reducing errors has reduced this to less than 5 per million.^{3,4,5}

This paper focuses on the provision of high quality health care. It begins by arguing that the Soviet model of health care provision, despite its achievements in providing basic universal care, had many important weaknesses. Some of these weaknesses, such as an inappropriate deference to opinions of senior professionals even when not supported by evidence, were also present in western countries at one time. However understanding of evidence of effectiveness, and its role at the heart of efforts to enhance quality of care has advanced greatly since then. Thus, the second part of the paper provides a definition of quality and explores its components, in particular focusing on the knowledge base underpinning it, specifically how one can know if an intervention is effective.

The Soviet system

At the heart of the issue of quality of care in the countries of the former Soviet Union is the nature of medical knowledge during communist rule. It should be noted that the following section applies mainly to the former USSR where access to ideas developed elsewhere was extremely limited. The situation was much less problematic in many parts of central and eastern Europe and in the Baltic Republics that had been able to maintain contacts with western scientists.

The isolation of many parts of the former Soviet Union becomes apparent when one looks in detail at clinical practice. Superficial comparisons have tended to obscure the magnitude of the differences in routine treatment for many common disorders.

Many health facilities contain equipment that is either unknown or long abandoned in the west. Examples include an array of machines to provide electric, magnetic, laser, and ultraviolet light therapy. Many common treatments are similarly unfamiliar. They include the use of ATP and co-carboxylase for the treatment of myocardial infarctions, the use of hepato-protectors for hepatitis, antibiotics for asthma, and auto-injection therapy for allergies. So why did these treatments become accepted medical practice in the Soviet health care system and not in the west?

One factor is the ideological domination of science during the communist period. Marxist-Leninist theory taught that many of threats to health were transient, attributable to the transition to communism, and thus expected to resolve spontaneously over time.⁶ There was a rejection of experimental methods, an absence of open and effective peer-review and an extremely hierarchical academic structure. As a consequence, knowledge accumulated only with age, leading to many ideas that had no scientific basis and which were often harmful. The use of transfusions to treat undernourished Romanian children is only an extreme example. This problem is exemplified by the legacy of a Ukrainian agriculturalist, Trofim Lysenko.⁷ Lysenko rejected Mendelian ideas, arguing that change in plants arose from adaptation to changing circumstances within a few generations. Although he was eventually discredited in the 1960s, his views remained widely held for several decades and the academic culture that allowed him to thrive was that in which many senior Soviet scientists were trained. They were well aware of the personal consequences of expressing a view that challenges the official orthodoxy.⁸

Although many of the particular beliefs that emerged from this system are now of only historical interest, their true legacy is of a culture in which dissent and open debate, especially with those in senior positions, are often strongly discouraged.

The issues involved can be illustrated further by considering a specific example: the use of hyperbaric oxygen chambers. Hyperbaric oxygen chambers are enclosed chambers containing oxygen at increased atmospheric pressure. They increase oxygen levels in the blood and thus the body tissues. In theory, this might be thought to have a positive effect where a disease is characterized by lack of oxygen, such as a myocardial infarction. Of course, while

the problem may be a localised lack of oxygen in body tissues, the cause may be, for example, a lack of blood supply, so that increasing concentration in the blood will have no effect. This is confirmed by the lack of effect found in randomised controlled trials undertaken in the west, which have identified only two clinical conditions for which hyperbaric therapy is effective: decompression problems in divers and gas gangrene. Yet in the USSR hyperbaric oxygen treatment was specified for over 100 clinical indications and the treatment remains in widespread use throughout the former Soviet Union.

Those using this treatment are quite convinced of its effectiveness in treating conditions as diverse as liver cirrhosis, myocardial infarction and prematurity. The reason for these very different beliefs only becomes clear when the evidence base is examined. It is true that there are many papers in the Soviet literature that support these uses. However the vast majority are from research in basic science, in particular from experts in biophysics and physiology. In a laboratory situation, hyperbaric oxygen chambers can increase oxygenation of tissues in certain circumstances. Yet the real question is whether the findings in these rather artificial settings translate into a measurable clinical effect. This can only be addressed by a properly designed study based on the principles of clinical epidemiology.

Unfortunately much Soviet medical research papers suffered from many methodological limitations. They were typically single centre studies using historical controls. Randomised controlled studies were very rare and Soviet medicine was isolated from the emerging developments in clinical epidemiology and evidence-based health care. As a consequence it continues to be difficult, in some places, to engage in meaningful discussion about evidence because of the very different paradigms that apply. This is seen by some as the greatest issue in addressing quality of care in the former Soviet Union. It will require a profound change in understanding of evidence. The challenges are apparent in the few areas where there has been sustained international contact concerning detailed clinical management. Evidence for the effectiveness of Directly Observed Therapy Short Course (DOTS) treatment for tuberculosis has met with resistance and, although implemented in pilot projects, it has not been possible to change practice more generally in the network of Russian tuberculosis dispensaries, where ineffective treatments such as vitamin C injections and artificial pneumothoraxes remain common. Similarly, there has been little success in implementing syndromic outpatient management of sexually transmitted infections.

A second factor was the lack of consumer orientation that pervaded the communist system. Again, this was most obvious in the USSR, as authorities in some of the satellite states, whose populations were more familiar with developments in the west, were forced to respond to popular demands from time to time. Individuals were limited in their ability to employ either of the usual strategies to force an improvement in how they were treated; exit (by going elsewhere) or voice (by expressing publicly their concerns). As a consequence, services in all sectors were unresponsive to their clients. This was accentuated in health care, which was a low political priority and where the inevitable information asymmetry, which places health professionals in a position of power, was exacerbated by the absence of alternative sources of information.

Formally, however, the Soviet Union did place an emphasis of quality control. This included the development of standards and norms related to the organization of health care and to clinical practice, a system of quality assurance reviews, and mechanisms of regulation. Similar systems were in place in most of the other socialist countries.

The Soviet system incorporated a very elaborate system for setting standards in health care. These standards covered a broad range of issues including what health care facilities are “needed” for a particular population in a particular setting. This was elaborated in terms of levels of care; what services should be provided at each level, their staffing, equipment, and supplies. Another important aspect was the so-called “volume of services” to be provided in each clinical diagnostic entity. This was a set of instructions that outlined what a physician should use in terms of diagnostic tests, procedures, treatment, and other services for different diseases. In cases of disputes, this was the reference against which physicians could be held accountable.

The standards were set by senior physicians appointed by the Ministry of Health. Most often, they would be developed by an expert from one of the large number of institutes in the major cities. It would then go through a review by one or more peers after which a designated staff member of the Ministry of Health would authorize it, making it the official standard (the Soviet term is “normative standard”). Standard setting was a top-down process and the perspectives of practicing physicians and other staff, and the realities they faced, were not taken into account. There was no systematic process for updating the standards.

The standards took different forms including books published for use by the different organs of the Ministry of Health. The standards related to “volume of services” were published in the form of directives “prikaz,” or “methodological recommendations” which often accompanied the prikaz.

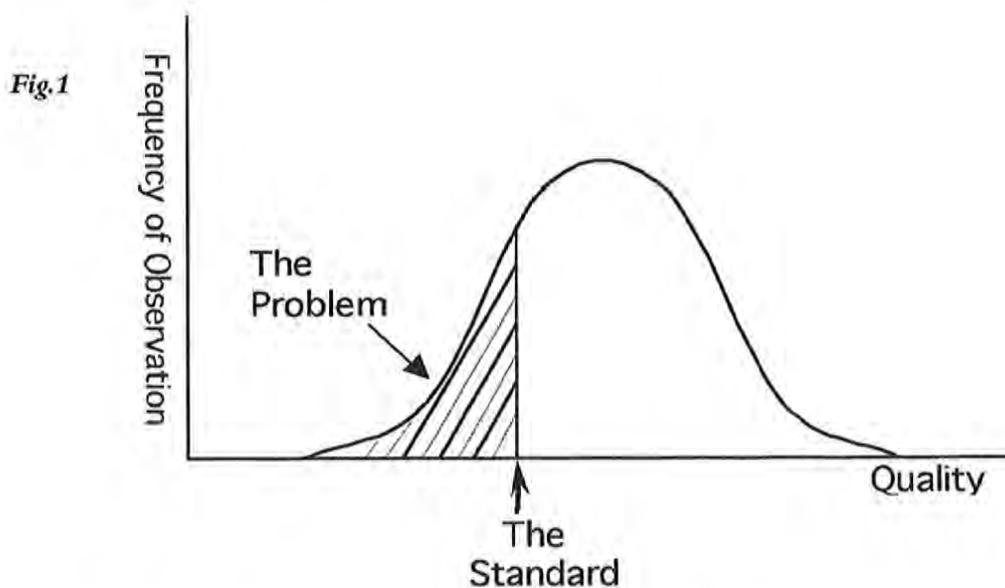
In addition, the Soviet health care system had a large, well-developed system of quality inspection. This role was fulfilled by the so-called “sanitarno-epidemiologicheskaya sluzhba.” Interestingly, this was quite separate from the Ministry of Health and so acted as an independent arm of the government. It was a large organization of inspectors who systematically examined health facilities to check for compliance with the standards. Their roles went beyond health care delivery facilities and included, for example, restaurants and other food outlets. They focused on structures, record keeping, equipment, and cleanliness rather than clinical practices. Much of what they practiced was conceived as contributing to infection control, although in practice this was often ineffective, in part because of an inadequate knowledge of modern microbiological issues.

The inspection system was able to ensure some level of compliance with the standards. However it also had weaknesses. It was understood that inspectors would invariably find issues of non-compliance. Consequently the process and its outcome depended on the relationship the inspected facilities could strike with the inspectors. This created perverse incentives to try to please the inspectors, especially in the poorer, more remote facilities

where the staff were “less connected” (with local leadership) and hence more vulnerable. It also created rent-seeking behaviour on the side of the inspectors.

Other regulatory mechanisms also existed in the Soviet Union. As an organ of government, the Ministry of Health was responsible for the licensing of physicians, certification of the facilities, and issuing directives to govern medical practice in the country. However, virtually all physicians worked for the government. The professional associations, which have played an important part in quality assurance in western countries, had a minimal role.

In its essence, this particular quality assurance framework (commonly known as traditional quality assurance) is based on developing standards, then measuring different providers against these standards, and giving some assessment of how they measure against this standard. Graphically, this can be expressed as follows (Figure 1):



For any given measurement of quality, one can express quality as a continuous variable along the x-axis of the graph. Somewhere along this continuous variable lies the standard, which has been developed for this particular quality issue. The standard becomes the cut off point below which quality is unacceptable. Depending on how stringent our standard is, more or less facilities will lie on either side of the cut off point.

There are two main weaknesses with this quality assurance framework. First, it is extremely difficult to develop standards that fulfil all the criteria required for a process of this nature. Ideally, the standards need to reflect the best available knowledge (which, as noted above, was a major problem), they need to be set high enough without being unrealistic, they need to be applicable to a variety of different settings, they need to be continually updated, and they need to be properly communicated.

Second, it does not provide a means for improvement. If properly used, it can serve as a quality assessment framework but it is not a quality improvement framework. This is especially the case when the quality measurement is the result of a complex system (as with most results which interest us in health care), not an individual action.

In summary, although there was a formal commitment to improving quality of health care during the Soviet era, it was largely unsuccessful. Obviously one factor was a lack of resources. The USSR simply could not obtain the modern equipment and pharmaceuticals being developed in the west, either because of a shortage of hard currency or, in the case of computerised equipment, western export controls. However it also faced problems of isolation from the developments known as evidence-based care, with a failure to see the weaknesses of its own system for accumulating medical knowledge. Another problem was the low priority given to consumer demands, unsurprisingly, as consumers had no choice but to accept what they were given.

In these circumstances even the most dedicated advocate of quality care would face problems. Unfortunately those who did try to tackle the situation adopted a model that, although perfectly in tune with the prevailing ideology based on norms and on command and control, exhibited the same weaknesses in health care as it did in agriculture and the wider economy. As a consequence, like the larger Soviet model, it was unable to meet the challenges it faced.

Towards an understanding of quality in health care

There has been a profound change in thinking about quality of health care in west in the 1990s. Drawing on earlier, seminal work by Donabedian, which drew a distinction between structure, process and outcome,⁹ it is often referred to as the “Outcomes Movement.”

The new approach goes beyond earlier approaches such as the Soviet model described above and has two distinctive elements. The first is a departure from the former emphasis on setting standards for, and inspecting the structures within which care is provided, instead focussing on the outcomes of that care. The second involves a recognition that it is rarely individuals who are responsible for adverse events, but rather problems in the relevant system.^{10,11,12}

This approach has been operationalised in a widely used definition of quality in health care is that has been developed through a process of consensus by the United States’ Institute of Medicine. This is “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”¹³ This definition offers a helpful framework to think about some of the key issues involved in quality, examining what some of these terms mean in practice.

“Desired Outcomes”

At first glance, the desired outcome of health care should be obvious – survival. The goal of an intervention is to decrease mortality and extend life. At the aggregate level, this is captured mathematically as life expectancy. At the level of the physician, this is captured as survival after an intervention (e.g. 5 year survival after treatment for cancer).

Unfortunately mortality is an incomplete as a measure of desired outcomes. First, differences in outcome of many interventions take time to become apparent. Clearly differences in five-year survival following treatment for cancer can only be detected six or more years after the treatment was administered.

Second, as deaths following many interventions are uncommon, differences may simply reflect random variation due to small numbers. In contrast, measures of process may make it easier to detect differences in a timely manner. Thus, an analysis of monitoring scenarios to detect differences in management of myocardial infarction showed that use of process measures could identify important differences that would only show up in mortality after 73 years of data collection.¹⁴

Third, mortality neglects quality of life. Many health care interventions do not decrease mortality but they increase the quality of life: such as hip replacements, cataract extraction, or treatment of mental illness. Furthermore, there is often a trade-off between survival and quality of life, most apparent in palliative care for those with advanced cancer. A patient may reject an intervention that will improve survival, but only by a few weeks, but which will make him or her so sick that they have to be hospitalised. This illustrates the importance of taking into account patients' preferences as part of desired outcomes.

There are now many measures that can be used to measure quality of life. These can be divided into profiles, that measure quality of life on several dimensions, such as pain or mobility, and do not attempt to combine them, and indexes, that bring these measures together into a single value. They can also be divided into generic measures, which relate to overall quality of life, and disease specific measures, which focus on a single condition, such as arthritis or ischaemic heart disease.

These instruments have often remained as research tools. Some, such as the Short Form 36 (SF-36), a generic profile based on 36 questions, have however been adopted into routine practice in some places as a means of monitoring outcomes, for example following non-urgent surgery. However their main importance for policy makers and professionals in countries in transition is the need to be aware that they exist and to be able to interpret research that uses them.

A second issue is the relationship between the outcome achieved and the cost of doing so. Discussion of desired outcomes should take into account cost-effectiveness, a topic on which there is now a large amount of evidence.^{15,16,17} It is, however, important to note that cost-effectiveness studies are highly context specific,¹⁸ as both the combination of inputs

and their costs will vary from one setting to another. A finding that treatment A is more cost-effective than treatment B in the United States does not mean that the same will be true in Ukraine.

“Likelihood”

The definition of quality emphasises the importance of increasing the ‘likelihood’ of desired outcomes. This indicates the importance, when comparing performance, to take account of the role of statistical probability. Specifically, if two hospitals are found to have different outcomes, can it be assumed that there is a true difference? There are other possible explanations. First, it may be due to chance, because the numbers involved are small. Second, it may be that the two hospitals are treating quite different types of patients, with different levels of initial severity. The first question is amenable to standard statistical techniques that make it possible to determine the probability that an observed difference is real. The second question can be addressed by the use of additional data on severity to adjust for the characteristics of patients, although this is less straightforward and results should be treated with caution.

“Current professional knowledge”

The definition sets as its standard ‘current professional knowledge’. This is one of the most contentious issues in quality and it has been at the heart of the evidence-based health care movement that emerged in the 1970s. The most famous proponent of a rigorous approach to evidence of effectiveness was Archie Cochrane whose seminal book *Effectiveness and Efficiency* was first published in 1972 and who gave his name to the international Cochrane Collaboration, which has taken a leading role in the development of evidence-based health care.¹⁹

Traditionally, in the west as in the Soviet bloc, knowledge of effectiveness was largely based on opinions of senior professionals, who based their judgements on their own experience. Although, in a very few cases, the effectiveness of an intervention may be obvious, as was the case with penicillin when it was introduced in the 1940s, this process is subject to numerous biases and it is now well recognised that it has both delayed the introduction of effective treatments, such as treatment with streptokinase for myocardial infarction, and allowed ineffective treatments to remain in use.

In nearly all cases it will be necessary to assess the effectiveness of a clinical intervention formally by comparing it with either no treatment or another established treatment (a control). However it is essential to ensure that those subject to the intervention being tested are identical to those in the control group. This is usually achieved by allocating subjects to the two groups at random. In a few cases randomisation may be very difficult or impossible, in which case comparison of groups may still be possible, but only with great care.²⁰

However a single randomised controlled trial may be insufficient to establish the effective-

ness of an intervention as there may be questions about whether the findings can be generalised to different settings or whether the study was sufficiently large to be confident that the result was not due to chance. These concerns have led to the development of systematic review, which seeks to identify and assess the quality of all studies that have examined the intervention in question. There is now a large methodological literature on both identification of studies and critical appraisal of their findings, which has revealed the potential for bias and thus misleading findings if not undertaken with adequate rigour. An associated technique is meta-analysis, a statistical method to combine the results of different studies.

Cochrane had once challenged health care professionals, saying "It is surely a great criticism of our profession that we have not organized a critical summary, by speciality or subspeciality, adapted periodically, of all relevant randomised clinical trials."²¹ His ideas were taken up by individuals such as Chalmers and led to the publication of a major systematic review of the effectiveness of interventions in obstetrics, a specialty that had been notorious for using interventions that were often based on little more than folklore, such as the use of enemas and perineal shaving before labour.²² This process evolved into the International Cochrane Collaboration, a network of researchers and practitioners who collaborate to collect and synthesise evidence, and whose methods have been adopted widely by organizations responsible for advising health policy makers in industrialised countries, such as the British National Institute for Clinical Excellence. In 1998, the first Cochrane Centre in the former Soviet Union was established in the Russian Federation.

From evidence to guidelines

Having obtained the evidence of effectiveness, the next step is to apply it to routine clinical practice. This is not as straightforward as it might seem, especially where evidence is lacking or contradictory. As with the methods used to assess effectiveness, those used to develop and disseminate clinical guidelines are now increasingly well understood.

David Eddy, one of the leading experts on quality, has outlined six steps which should be carried out in developing practice guidelines:^{23,24}

1. A clear formulation of the problem to be evaluated;
2. A complete search of the medical literature;
3. A formal analysis of the information contained in the medical literature;
4. Estimation of the magnitudes of important outcomes and the uncertainty associated with each outcome;
5. Assessing patients' preferences for the various outcomes;
6. Design of the guidelines.

Eddy's definition makes clear that not all clinical guidelines are evidence-based. The traditional approach collapses these into a single step which Eddy calls "global subjective judgement."

There are now many sources of evidence-based guidelines, such as the British NHS Centre for Reviews and Dissemination. All of these have in common a reliance on systematic reviews of the literature rather than expert opinion of senior clinicians.

As experience with evidence-based guidelines has accumulated it has become clear that their production is not sufficient to change clinical practice. Similarly, individual interventions, such as education sessions, are often of limited effectiveness. Instead, change is most likely to be brought about as a result of a multi-faceted strategy combining a range of methods within an environment that is supportive of quality. This is discussed further later in this paper.

Who is responsible for enhancing quality?

A high quality health care system is the result of efforts by many different groups and individuals.

Governments play an important role, increasingly recognised as the idea of stewardship. This includes their roles in setting strategic direction for the health care system and ensuring that the resources needed for providing care are adequate. As noted above, this includes not only financial resources but also trained staff, appropriate facilities, and effective pharmaceuticals.

Those responsible for purchasing health care, such as insurance funds, also have an important role, in establishing funding regimes that promote, rather than obstruct the provision of high quality care.

In many western countries professional associations have also played an important role, establishing clinical guidelines and systems of continuing professional development. However the most important players are those involved in direct patient care. One way of doing this is described in the following section.

Modern health care quality improvement methodology

One approach to quality improvement methodology²⁵ is based on the concept, that every system is perfectly designed to achieve exactly the results it achieves. Therefore, it regards improvement as essentially the result of changes in the systems by which work is accomplished. However the opposite is not necessarily true. Some changes may yield improvement, other changes may not do so, and some changes make even reduce quality.

Using this framework, quality improvement can be considered to consist of four steps as follows:

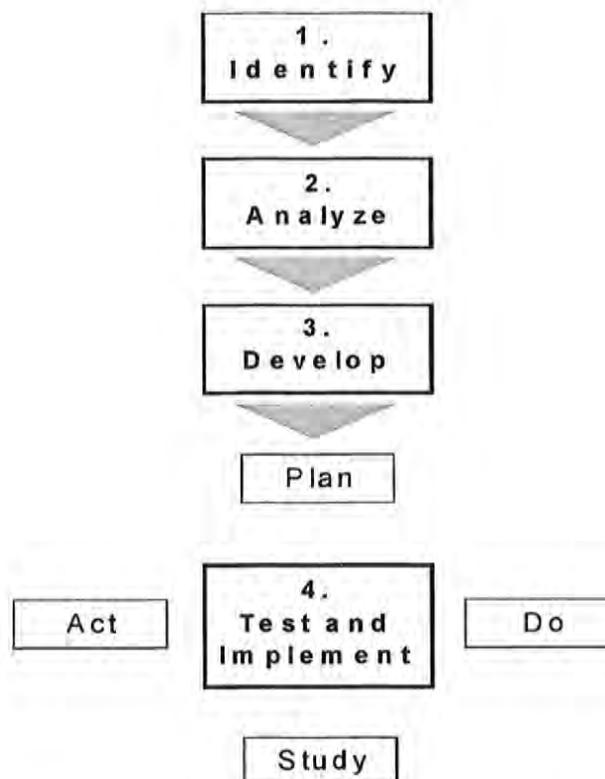
Identify: The first step is to state explicitly what improvement is to be made. This is usually done by reviewing existing data in the light of knowledge of priorities for improvement

amongst relevant. An example from primary care might be to improve the care of patients with hypertension. The system of care is conceptualised and its various components are determined. In this case, components might include updating clinical guidelines in accordance with the best evidence, organization of the process of health care delivery, developing a screening programme appropriate for the population at risk, and resource re-allocation to make the system work.

Analyze: Those providing care analyse existing systems of health care delivery, both clinical and organizational. The organization of health care processes is commonly represented in the form of flowcharts. Key aspects (such as diagnostic criteria, referral criteria, criteria for different interventions and drug use) of clinical care are also noted.

Develop: The evidence on the effectiveness of different interventions and organizational structures is compiled. The evidence is contrasted with existing clinical practices and decisions are made on the changes needed in existing clinical practices in order to become compatible with the best available evidence. The organization of health care delivery is reviewed and enhanced in order to enable the implementation of the updated practices. The new system of health care delivery is normally formalized as a clinical guideline. The indicators reviewed and updated. This is to ensure that the effect of the changes in the systems of health care delivery could be measured through these indicators.

Fig.2



Test/Implement: The team considers how best to test the new systems of care on a small scale (Plan), the tests are then conducted (Do), the results are monitored and interpreted (Study), and then depending on the results, decisions are made regarding the next steps. These are to either implement the changes where the results are satisfactory, or not to implement them or modify them where the results are not satisfactory.

This approach to enhancing quality is based on a series of beliefs about individuals and organizations that are often markedly different from those that characterised the Soviet health care system and is based on the following four key principles:

Understanding work in the form of processes and systems: Delivery of health care can be expressed in terms of various processes that convert inputs from suppliers into outputs for customers by taking them through a series of steps where different actions are done to them. A system is the sum of all processes directed at achieving a single output or outcome.

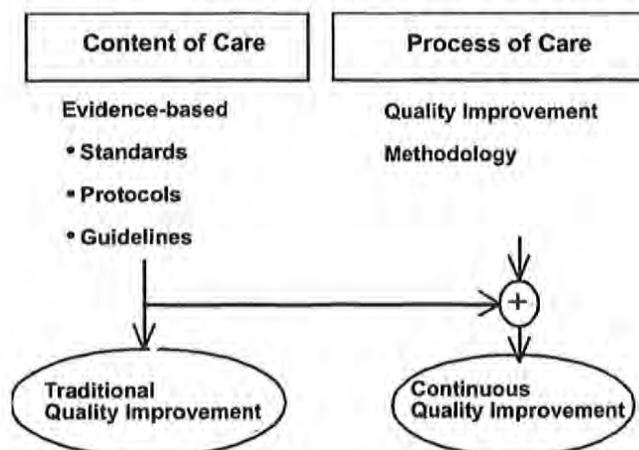
The importance of teams: Since different professionals are involved in the various steps of a process and these professionals have their own insights into the processes they work in, to improve processes we need necessarily to involve them in bringing about improvement. This also plays a major part in their ownership of the new systems and consequently their commitment to implementation.

Customer focus: Quality can be seen as a function of the extent to which we meet the needs and expectations of our customers. This stresses the importance of eliciting and understanding the needs and expectations of patients and striving to meet or exceed them.

Use of scientific methodology: As outlined earlier, quality in health care is based on evidence of effectiveness of both the interventions and the organizational framework within which they are delivered. These are intimately linked, as illustrated in Batalden's framework, which has proved helpful in several projects in transition countries.

Figure 3

Batalden's Framework for Clinical Quality Improvement^{25,26}



In brief, the framework implies that to make improvement in health care one must tackle the two key components that constitute the care. These are the content of the care, and the organization of care. Thus, the content of care must be compatible with the best scientific evidence available. Organization of care means the way in which health care is delivered through the processes and systems of care. This requires re-organizing the processes of health care delivery to enable the implementation of the evidence-based practice.

Quality improvement as an organizational philosophy

Quality improvement is not, however, simply a technical exercise. Dr. Melnikov, who led a process of change in Tula Oblast described “a new work culture.” This is one that emphasizes improvement in health outcomes, in the patients’ experience of care, and in efficiency of health care delivery. This improvement is seen as the core work of the organization, not as an add on. It is a culture that focuses on the system in which care is delivered. Consequently, individuals are not blamed for poor quality. It is also a culture that acknowledges the role of different professional roles in health care delivery and incorporates this understanding in its approach to improvement. Thus, teams of professionals become decision-makers. It is a culture in which leadership is facilitative and empowering. Thus the old style command and control system becomes obsolete. Importantly, as an organizational philosophy, it requires adaptation to the cultural environment it is to be implemented in. This is a cornerstone for its successful implementation.

Experience since transition

Since the transition individuals in many countries have formed professional associations to promote quality of health care. For example, groups from many countries in central and eastern Europe and the former Soviet Union participate in the European Society for Quality in Health Care (ESQHC) and the International Society for Quality in Health Care (ISQua). The remainder of this section reports the experience of two such groups.

In 1995 The National Center for Quality Assessment (NCQA) in Krakow, Poland assisted by USAID funded technical assistance, began to implement modern quality assurance methods in Polish hospitals. The initial phase led to several notable achievements.²⁸

- A reduction in the waiting time for ambulatory ophthalmic surgery from an average of 71 to 10 days in a Krakow hospital.
- A reduction in the delay before surgery from an average of 5.8 to 1.1 days in a hospital in Lodz.
- An 18% reduction of repeat laboratory tests (due to loss of samples or results) in a Lodz hospital.
- Reducing the number of patients who waited for three hours or more for mammography from 18% to 7% at the diagnostic centre in Legnica.

- A reduction in outpatient waiting time for ultrasound examination from 14 to 7 days at a hospital in Krakow.

In 1998, the Health Committee of the US-Russia Joint Commission on Economic and Technological Cooperation funded by USAID initiated a programme to implement quality improvement methods in several oblasts in Russia.²⁹

In a number of cases significant improvements in care were achieved, frequently leading to better outcomes at lower cost. For example, a programme to improve management of hypertension in primary care³⁰ increased the number of patients managed in that setting by more than seven-fold. Hypertension related hospitalisations decreased by 85%, and hypertensive crises by about 60%. Although the cost incurred in primary care increased by 39%, this was outweighed by a reduction of 41% in the cost of hospital care, resulting in a net reduction of 23% in the cost of managing patients with hypertension.

An enhanced system of care for women with pregnancy-induced hypertension^{31,32} (PIH) was associated with a reduction in the rate of diagnosing PIH from 43% to 5.6% (based on evidence on what constitutes PIH), and a fall in hospitalisations of 61%. An economic analysis found an 87% reduction in the cost of care.

A new programme to improve care for neonates suffering from respiratory distress syndrome³³ reduced cases of hypothermia to negligible levels and was associated with a 64% reduction in deaths due to respiratory distress syndrome.

The obstetric and neonatal programmes are now being implemented in all 42 hospitals in Tver Oblast. The hypertension programme is being implemented in general practices and polyclinics in Tula Oblast. This has been associated with a reduction in early neonatal mortality in Tver, from 10.8/1000 in 1998 to 5.3/1000 in 2001, although obviously other factors will be involved.

Conclusions: Enhancing quality of care in transition countries

The case studies reviewed in this paper show that it has been possible to introduce systems to enhance quality of care in countries in transition, with beneficial effects on effectiveness, efficiency and patients' experience of care. However, the scale of the task is enormous and quality of care has largely been neglected by the international donor community. Over the last ten years of health reform, the main goal has been to increase financing and improve efficiency. Many countries have opted for health insurance, which has not significantly increased health expenditures, but more importantly, it has failed to improve the quality of health care and improve health outcomes.

In the next decade of health care reform, improving the quality of health care must be at the top of the agenda. This requires a large-scale effort to embed a culture of evidence-

based health care in Eastern Europe and the former Soviet Union. This means profound changes in how research is organized, converted into evidence-based clinical guidelines, and how those guidelines are disseminated. This must be complemented by changes in the organization and financing of health care that often impede efforts to improve quality. As we have seen in the West, it is not enough just to produce clinical guidelines. The guidelines need to be implemented and this requires incentives to change behaviour. It also requires significant changes in the fragmented and uncoordinated Soviet model of health care delivery.

In conclusion, there is a need to move beyond issues such as health care financing to focus reform efforts on improving outcomes. This requires a re-thinking of health reform and a greater emphasis on the content of medical care.

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Advancing public health:

10 years of transition in central and eastern Europe and the newly independent states of the former Soviet Union

A background paper prepared for USAID Conference, Washington, DC
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Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia

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Executive summary

The health of populations in central and eastern Europe (CEE) and the newly independent states of the former Soviet Union (NIS) is substantially worse than in western European countries. Most of the east-west health divide is due to chronic disease in middle-aged and older people, but many countries in the region face new and serious threats to public health such as increasing rates of HIV infection and intravenous drug use. The causes of poor health in CEE/NIS are complex, but they appear to be strongly related to underlying social conditions such as economic instability, unemployment, migration, organized crime, alcoholism and increased availability and use of illicit drugs.

In this paper we discuss how organized public health services, and governments in general, can respond to these challenges. While public health services alone are unlikely to substantially improve population health, they can make an important contribution, not least by advocating a broad approach to health and its determinants.

We present a conceptual framework that recognizes the complex nature of health determinants, the crucial role of the social environment and the core functions of organized public health. We briefly describe the changes in public health systems, from the Soviet system of sanitary-epidemiological stations before 1990 to a less centralized service oriented more towards health promotion. We list some of the factors obstructing advances in public health, such as the overall macro-economic and social conditions, general attitudes to public health, inadequate training and the lack of a multisectoral approach. Finally, we offer several principles for developing future policy options. These include: preserving the positive aspects of the public health service (e.g. communicable disease control); attacking the major threats for each country; protecting the public health budget; reforming the service; training public health professionals; and adopting multidisciplinary and multisectoral approaches.

1. Introduction

The health of populations in central and eastern Europe (CEE) and the newly independent states of the former Soviet Union (NIS) at the beginning of the 21st century is substantially worse than in western Europe or North America. The high rates of mortality, morbidity and disability are important for a number of reasons: they constitute a humanitarian tragedy, impose a burden on the health and social sectors, and impede prospects for economic prosperity and overall development.

This paper examines the following issues: (a) the major determinants of the poor health in CEE/NIS; (b) the role and realistic potential of public health services in improving health, and how steps taken during societal transformation affect this potential; (c) the key factors enabling and obstructing advances in public health in CEE/NIS; and (d) the policy options available to improve the effectiveness of public health services in the countries in transition.

We present two well known conceptual models of the determinants of health. These models also illustrate different levels of possible intervention. We believe that social and economic factors are the primary causes of ill health, and that the policy response to improve health needs to be interdisciplinary and multisectoral. We also argue that public health services and medical care alone are unlikely to improve population health, but that they can nevertheless make an important contribution to the process.

2. Conceptual framework

Efforts to improve population health must address the important determinants of health. Proximal factors, such as obesity, tobacco and alcohol, are important but the adoption of unhealthy lifestyles does not depend solely on an individual's choice (Cockerham 1997). There is abundant evidence that population health is related to features of society, and to social and economic conditions (Marmot & Wilkinson 1999). Our conceptual framework recognises the complex nature of determinants of health and the core functions of organized public health, and it identifies the role of the public health system in the process of improving the health of the population.

2.1. Determinants of health

Fig. 1 (page 2) shows the main determinants of health as concentric circles, with layers one over another (Dahlgren & Whitehead 1991). At the centre is the individual, with his or her personal characteristics such as age, sex, genetic makeup, etc; these factors are important but cannot be changed. The individual's health is influenced by his or her lifestyle and health behaviour (the second layer). However, individual lifestyles are influenced by social norms and community networks (the third layer). These, in turn, are influenced by living and working conditions, education, health care, etc (the fourth layer). All these layers of factors are affected by the overall macroeconomic and environmental conditions of society

Fig. 1

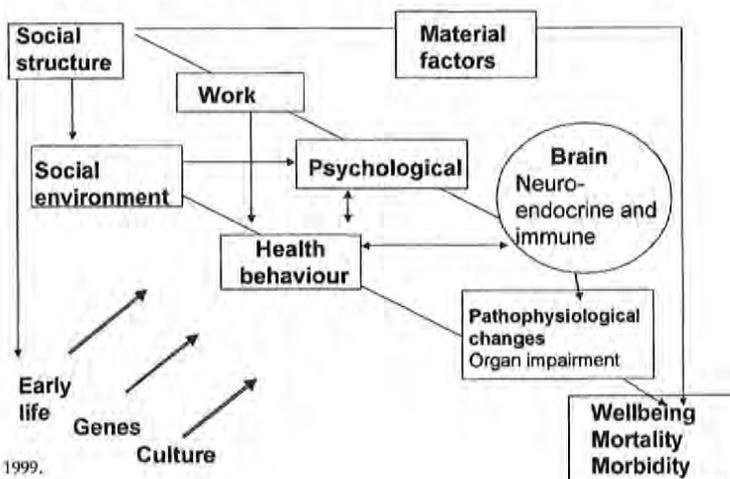


(the outer layer). Fig. 1 illustrates the limitations of the usual reductionist approach to public health, such as focusing on smoking in isolation from other factors, (such as screening for high blood cholesterol and reducing it by dietary or pharmacological means).

Both models show that, while such downstream interventions are important, their effect will be limited as long as they ignore the underlying determinants of health — i.e. the upstream factors related to the social and economic environment and living conditions. One can ask, for example, why smoking is so common and fruit and vegetable consumption so low in CEE/NIS. A plausible explanation is that for people with a low sense of control, no hope for the future and low social and financial resources, it makes little sense to worry about the health hazards of tobacco or to spend money on expensive and unnecessary foods.

The close relation of changes in health status to changes in social conditions in CEE/NIS during the transitional period (Marmot & Bobak 2000) further emphasizes the need to focus on the broader determinants of health. In fact, the improvement in mortality in the Czech Republic and Poland after 1990 has been attributed to improved diet rather than improved health services (Bobak et al. 1997; Zatonski et al. 1998). The improved nutrition, in turn, has been largely due to the greater availability and lower prices of unsaturated fats and fruits and vegetables; these factors are beyond the realm of the health services.

Fig. 2. Conceptual model of determinants of health



Source: Marmot & Wilkinson 1999.

Public health services can and should play an important role in developing policies to improve health. However, as mentioned above, it is unlikely that a substantial improvement in health can be achieved by the health sector alone. Public health services should set up and conduct downstream interventions (e.g. changing health behaviour) but public health professionals also need to propose and advocate upstream policies. A wide range of such upstream policy options is given in the independent inquiry into inequalities in health in the United Kingdom (Acheson 1998).

2.2. Public health

Public health is a broad term with no universal international definition and structure. A useful definition is that it is a process of promoting health, preventing disease, prolonging life and improving the quality of life through the organized efforts of society (Vetter & Matthews 1999). In some countries, public health includes functions of the state other than health care and public health services (education, housing, transport, etc); in others it denotes all health service provision and management; and in others public health is understood in its narrow sense as the sum of functions provided by the public health services. It is clear from the previous section that we advocate the broadest meaning.

Nevertheless, most specialists agree that the core functions of public health practice include: (a) monitoring population health and its determinants; (b) prevention and control of disease, injury and disability; (c) health promotion; and (d) protection of the environment (Bettcher et al. 1998). We believe that these functions cannot be fulfilled successfully by public health services or even the health sector alone.

3. Comparative overview

3.1. Health status in CEE/NIS

Health in CEE/NIS is substantially worse than in western European countries. At the end of the 1990s, the difference between the European countries with the highest and lowest life expectancies at birth was more than 10 years in both men and women; virtually all countries with low life expectancy are in CEE/NIS (WHO). Even at age 45, there is an 8-year difference in male life expectancy between the best and the worst European countries.

This difference in health (the much debated east-west gap) has long-term and short-term components (Bobak & Marmot 1996). After the Second World War, life expectancy improved rapidly in both eastern and western Europe, but the two started to diverge in the 1960s. Western European countries enjoyed a further increase in life expectancy between 1970 and 2000 (by 6 years on average). However, improvements in CEE/NIS until the early 1990s were at best negligible, and in Bulgaria, Hungary and Poland male life expectancy at age 15 actually declined (reflecting the increase in mortality among adults).

The situation deteriorated further in most of CEE after the collapse of communism in 1989. The mortality trends followed those seen in socioeconomic indicators. After a universal deterioration in health in the early years, mortality improved in most CEE countries, where the transition was relatively successful, but it remained high or continued to rise in most NIS, where the negative social impacts of the transition were much worse (Cornia 1997; United Nations Children's Fund 2001).

3.2. Determinants of poor health in CEE/NIS

The diseases responsible for the gap in life expectancy may guide us as to the measures that may help to reverse the unfavourable trends. Of the 6.1-year gap in life expectancy at birth between CEE/NIS and the rest of Europe in the early 1990s, only 15% developed in infancy; 43% originated in the 35–64-year age group and 23% in those 65 and older. Cardiovascular diseases accounted for 54%, followed by external causes (23%) and respiratory diseases (16%) (Bobak & Marmot 1996). Interestingly, cancer is no more common in CEE/NIS than in western Europe. Separate analyses of German, Hungarian and Russian data confirm these aggregate findings (Chenet et al. 1996; Jozan 1995; Kingkade & Boyle Torrey 1992). The contribution of external causes (injury and violence) is higher in the former Soviet Union, particularly since the late 1980s (Bobak & Marmot 1996; European Centre on Health of Societies in Transition 1998).

A number of studies addressed the question of the causes of poor health in CEE/NIS. The evidence suggests that medical care contributed only modestly to the long-term east-west divide that has opened up since the 1960s (Bobak & Marmot 1996; Boys et al. 1991; Velkova et al. 1997); most of the east-west difference is due to high disease incidence rather than substantially higher case fatality in CEE/NIS than in the west (Bobak & Marmot 1996). A possible exception is infant mortality, which decreased more rapidly in countries or areas with better neonatal care technology (Koupilova et al 1998; Nolte et al. 2000).

The lack of efforts to control common risk factors for chronic disease (blood pressure, smoking, cholesterol) probably made a substantial contribution to the gap, mostly through the mortality rise since the 1960s. Smoking rates are high among men and are rising in young women (Bobak et al. 2000). The prevalence of obesity is high in most countries of the region (Principal Investigators 1989). Nutrition is often poor, with high intakes of saturated fats and low intakes of fresh fruit and vegetables, and leisure-time physical activity is typically low.

On the other hand, environmental pollution, commonly blamed for high mortality in the region, probably did not play a major role (Bobak & Feachem 1995; Bobak & Marmot 1996; Hertzman 1995).

The causes of the dramatic fluctuations in mortality in the 1990s are not fully understood but there is a general consensus that changes in health are related to changes in social and economic conditions. Social and economic circumstances deteriorated in all countries in

the early stages of transition. Unemployment rose and income inequalities increased in all countries, and in some NIS they reached levels seen in Latin America (World Bank 1996). Social inequalities in health also increased (Bobak & Powles 2001; Koupilova et al. 1998; Koupilova et al. 2000; Shkolnikov et al. 1998). The negative economic changes had a large impact on people's behaviour and health. Indirect evidence suggests that high consumption of alcohol and binge drinking contributed to the changes in mortality, particularly through alcohol poisoning, injuries and violent deaths, and possibly cardiovascular diseases (McKee 1999; McKee et al. 2001).

Apart from cardiovascular diseases, injuries and alcohol, there are other threats. There has been a sharp increase in a number of communicable diseases in some parts of the region since 1989, such as diphtheria, viral parenteral hepatitis, tuberculosis and HIV infection (Netesov & Conrad 2001). The latter is closely related to the sharp increase in intravenous drug use. In the Russian Federation and some other countries, illicit drug use has reached epidemic proportions (Blinova et al. 2000; Veekens 1998). While the absolute levels of these diseases are not high, the steep increase observed over the last few years is alarming. If the current trends continue, hepatitis and HIV and other infections will become a major cause of morbidity and mortality.

Some of the problems in the 1990s were due to the disintegration of public health services and a lack of funds for drugs and immunization. Nevertheless, the general worsening of health status reflects deeper social problems such as economic instability, unemployment, migration, organized crime, alcoholism and increased availability and use of illicit drugs. All this indicates that the roots of the health crisis in CEE/NIS lie in the social environment. Psychosocial resources, such as perceived mastery, optimism, sense of control or social networks are, on average, low (Bobak et al. 2000; Cornia 1997; Marmot & Bobak 2001). The worsening in the 1990s can also be attributed to psychosocial stress resulting from acute, transition-related dislocation in the labour market, income inequalities and family disruption, and by a grossly inadequate public policy response to these social emergencies (Cornia & Pannicia 2000). The major task for organized public health, and for governments in general, is to respond to these challenges.

3.3. Public health services in CEE/NIS before 1990

Before 1990, public health services in CEE/NIS were organized according to the Soviet model. Responsibility for public health and prevention lay with a highly centralized system of sanitary-epidemiological (sanepid) services. The system was hierarchical, with sanitary-epidemiological institutes at lower administrative levels (e.g. districts) subordinate to higher-level (regional or national) institutes. At the same time, the sanitary-epidemiological institutes were also part of the regional (district) health services structure. The sanepid services combined monitoring, inspection, preventive and (sometimes) research functions. A typical institute serving a larger region had departments dealing with environmental health, general health, occupational health, nutrition and food hygiene, child and adolescent health and communicable disease control (epidemiology and microbiology).

Perhaps the most tangible achievement of the sanepid system has been its contribution to vaccination programmes and communicable disease control, achieving remarkable success in most parts of CEE/NIS. On the other hand, it was relatively ineffective in combating environmental pollution, occupational diseases and noncommunicable diseases. The failings of the old system were partly related to the lack of real power (for example, the sanepid services monitored air pollution but often had no direct regulatory power), but also to the political regime (opposing party decisions required personal courage).

The sanepid services reported on infections, immunizations, serological surveys, occupational disease and some other outcomes. Information on curative services or noncommunicable conditions was often collected within the health sector (e.g. cancer registers) but these data were not often used. There were large differences between countries but it became apparent after 1990 that, in general, the information base for public health was inadequate and often of poor quality. In addition, much of the data on health status (e.g. mortality and birth outcomes) came from state vital statistics or other sources (for example, the WHO MONICA Project was the main source of information on the incidence and treatment of cardiovascular diseases and the prevalence of risk factors in many countries in CEE/NIS).

3.4. Public health services in CEE/NIS after 1990

After 1990, public health services, as with most other public institutions, underwent reform in most countries. To our knowledge, there has been no formal assessment of the public health reforms in CEE/NIS. The following is based on informal observations in a sample of countries. The reforms were different in each country, but there were several common themes.

Decentralization

In some but not all countries, the public health systems were partly decentralized. In most countries, the subordination to higher administrative levels became weaker and the link with local government became stronger. In virtually all countries the central public health institutions remained under the control of the Ministry of Health, but in some countries local public health services were incorporated into local government, or local governments were given more say about public health in their areas. This has had some positive consequences. The public health institutes respond better to local problems, for example by conducting surveys for local government or by providing specific services (e.g. HIV/AIDS counselling). In some countries, the public health institutes also have freedom to raise extra funding for additional activities.

Changes in funding, legislation and responsibility

In many countries, mostly in the NIS, the national economic crises reduced public sector funding. The impact on public health services was usually larger than that on curative services. As a consequence, the public health services could not deliver the services they used to (e.g. vaccination) and could not start new programmes. Owing to legislative changes, public health services in some countries lost some of their previous functions. In the Czech Republic, for example, monitoring of environmental pollution was partly moved to

the Ministry of the Environment, the monitoring of food quality to the Ministry of Agriculture, and radiation hygiene to a new governmental Agency for Nuclear Safety.

Blurring of responsibilities and loss of discipline

While some elements of decentralization and new legislation were necessary, the combination of these changes often brought about a reduction in control and blurring of responsibilities. This, combined with the fall in real funding, often led to a decline in the quality of previously successful functions (e.g. communicable disease control). Another by-product of decentralization was that, in many countries, public health was removed even further from the interests of the ministries. Public health is often low among the priorities of local administrators, and funding cuts have affected public health agencies disproportionately.

Reductions in the numbers of staff

Similar to other health services, the public health services were well staffed before 1990. After the political changes, there were fewer people working in the system. While some reduction was desirable (Feachem & Preker 1991), many of those who left the service were the more dynamic and better trained people. The two main reasons for leaving the service were uncertainty about the future of the service and low salaries.

Introduction of health promotion

Health promotion strategies can be divided into three groups: (a) campaigning strategies (e.g. tobacco control policies); (b) responsive strategies (e.g. programmes for drug misusers and HIV prevention); and (c) intersectoral collaboration (e.g. working with housing, transport or even finance ministries). While health promotion was largely ignored in CEE/NIS before 1990, it subsequently became one of the core functions of the public health service in many countries; much of this was led by the WHO Regional Office for Europe.

In general, the responsive strategies have received most attention. Most countries have now some policies towards HIV control and harm reduction among intravenous drug users, child development, lifestyle factors, etc. As with many other public health initiatives after 1990, harm reduction activities have been strongly influenced by international agencies, particularly by the International Harm Reduction Development programme of the Open Society Institute, focusing on intravenous drug users and HIV prevention (<http://www.soros.org/harm-reduction>, accessed 17 June 2002).

The relative lack of intersectoral programmes may be due to the difficulties that national governments have in adopting and enforcing public health legislation (e.g. banning tobacco or alcohol advertising or increasing tax on tobacco and alcohol). In many countries, anti-tobacco and anti-alcohol legislation and taxation has been attempted and approved (Kralikova & Kozak 2000). The tobacco industry has mounted considerable opposition to these initiatives, however, and has often been successful in reversing legislation or blocking its implementation (the most recent example being the reversal of anti-tobacco legislation in the Czech Republic in May 2002). The low priority of public health in government policy is reflected by the lack of communication with agencies in different sectors.

There have nevertheless been a number of success stories. A well known example of a multisectoral approach is the Healthy Cities Network, which promotes intersectoral work at the local level. This approach has been welcomed in CEE and NIS, since it appears new and encourages health promotion, participation and engagement of politicians with people's concerns. The Regional Office has supported national networks of cities in CEE and the Russian Federation so that, for example, Croatia has a network with 60 full or affiliated member cities (<http://www.who.dk/healthy-cities>, accessed 17 June 2002). Other examples include the European Network of Health Promoting Schools, led by WHO and funded by the European Union and the Council of Europe, which includes most of the CEE and provides a base for national development of school-based health education; the health-promoting hospitals networks, again mostly in CEE but also in Kazakhstan; and the Health in Prisons Project, which includes Latvia, Poland, the Russian Federation and Uzbekistan.

Environmental health

Before 1990, public health services were unable to reduce exposure to environmental pollutants. For political reasons it was often difficult to address the problem. This has changed since 1990. The issue of environmental pollution and health has become a priority, and many countries have initiated programmes of training and research. On the other hand, health impact assessment has yet to become standard practice. Perhaps the most extensive attempt to integrate research and policy in the area of environmental health is the Czech National Programme of Environment and Health, which integrates the collection of data on exposures and assessment of health status. Another example of a new approach to environmental health are the WHO-led National Environmental Health Action Plans (NEHAPs) adopted by a number of CEE/NIS. This framework attempts to coordinate different sectors of the economy and government in formulating sustainable strategies for environment and health. Unfortunately, much of it remains on paper.

Health information systems

Investments have been made to improve the quality of information systems and health monitoring tools. Information systems have been modernized, and many countries now have computerized systems for the reporting of different diseases or health outcomes. Many of these data are reported to WHO, UNICEF and other international agencies, and some are available in on-line or off-line databases. For example, WHO's European health for all statistical database (<http://www.who.dk/hfadb>, accessed 17 June 2002) contains a large number of health-related and social indicators. The WHO Regional Office for Europe, with other international partners, also supports the development of Health Care Systems in Transition (HiT) profiles, which offer important overviews of the health system and public health issues (<http://www.observatory.dk>, accessed 17 June 2002). The computerized information system for infectious diseases (CISID) (<http://cisid/who.dk>, accessed 17 June 2002) contains communicable disease surveillance data. Data on cardiovascular risk factors are available through the WHO countrywide integrated non-communicable diseases intervention (CINDI) programme (<http://www.who.dk/eprise/main/WHO/Progs/CINDI>, accessed 17 June 2002). UNICEF has developed the TransMONEE database of health and socioeconomic indicators in 27 countries in

CEE/NIS (<http://www.eurochild.gla.ac.uk/documents/monee>, accessed 17 June 2002).

Data quality depends, of course, on the quality of primary data collection, and for some outcomes and countries this information may be unreliable. The use of such data is further limited by a lack of information on the distribution of health outcomes within populations (e.g. by socioeconomic group).

In addition, ad hoc surveys or repeated surveys in population samples have been initiated in many countries to collect data on health behaviour and individual risk factors. On the other hand, the relaxation of control has also affected health information systems, with many data sets becoming less complete and less reliable. As before, communication between different agencies collecting or maintaining information is generally poor, even within the health sector.

4. Key factors enabling and obstructing advances in public health

Overall macroeconomic and social conditions

As mentioned above, the overall economic situation in many countries is poor. There are also other major societal problems, such as high levels of corruption and crime, weak civic society structures, low social capital, rising unemployment and income inequalities. It is difficult to reform institutions under these circumstances, and all these factors have a negative influence on health (Cornia 1997).

General attitudes to public health

In many countries the predominant view is that population health is largely a product of medical (curative) services. Most people and policy-makers see medical services as crucial. Most would agree that it is important to maintain immunization programmes and other measures to control communicable diseases. Some people would support health promotion programmes in the area of chronic diseases or substance misuse. But few would assert that actions taken by other sectors (e.g. education, transport, pensions) have an impact on health. Very few people consider health as a marker of the successful development of a society. As a consequence, policy-makers in different sectors do not consider the impact of their decisions on health, and it is often difficult to obtain support for health-related initiatives outside the health sector. For example, a review of public health policy documents in the Russian Federation revealed that, while most authors demanded preventive programmes, the vast majority only considered activities within the health sector (Tkachenko et al. 2000).

The inherited system

It will take time to refocus the old system towards health promotion and prevention. Cooperation with other sectors has traditionally been poor and it is difficult to change this attitude.

Lack of a multisectoral approach

Even in newly organized programmes that are set up to be multisectoral, collaboration between different sectors and institutions may be difficult. For example, Parvanova (2001) analysed environmental health policy and practice in six formerly socialist countries in eastern and southern Europe. She found that, in all countries, the importance of both environmental health and a multisectoral approach to it were well recognized. Nevertheless, there was universal difficulty in collaborating with other agencies, often within the same sector.

Training

There is urgent need for re-training of public health workers in key areas, such as health promotion, medical statistics and informatics, and risk or health impact assessment. The understanding of "evidence" often differs markedly from that in western European countries. The evidence-based approach has not yet been established in CEE/NIS. Medical schools pay little attention to public health and its determinants and health promotion strategies, and postgraduate training in public health still largely focuses on communicable disease control. Non-medical professionals are still undervalued in public health services.

5. Policy options

In early 1991, a consultation by the World Bank with the Czech Republic proposed six principles to the future of public health. These were: (a) to preserve the good (communicable disease control and vaccination); (b) to attack the bad; (c) to reform institutions; (d) to develop training in public health; (e) to safeguard the public health budget; and (f) to adopt a multidisciplinary and multisectoral approach (Feachem & Preker 1991). We believe that these principles are still valid.

Preserve the good

It is crucial to preserve or rebuild the capacity of the public health services for communicable disease control, vaccination and the maintenance of child and maternal health programmes. Those countries that preserve the effective parts of the old services are better prepared to meet new challenges than those that allow the entire public health service to disintegrate.

Attack the bad

The list of public health issues is very long, and differs between countries. In the medium term, each country needs to prioritize its health problems. These may include: new and old infectious diseases; safe practice in health care facilities; health behaviour and risk factors; substance abuse; birth control; and injuries and accidents. Programmes to prevent or control these problems need to take account of the major determinants of each condition, and should use multidisciplinary and multisectoral approaches to tackle the determinants of health (see, for example, Acheson 1999).

Reform the institutions

Reforms should encourage retention of bright and motivated staff, should increase the

effectiveness of the public health service, and should encourage intersectoral and multidisciplinary approaches.

Train in public health

Schools of public health have been established in several countries, but they frequently focus on health service management rather than on epidemiology, population health, prevention and health promotion. While sending students abroad may not be feasible, it should be possible to develop new or reform existing schools of public health. There are several examples of successful initiatives: in Hungary, a School of Public Health was established with international assistance (McKee et al. 1995); the American University in Yerevan, Armenia, offers a Certificate in Public Health programme; and there is a public health programme at the University of Varna, Bulgaria, supported by the EU TEMPUS programme. The collaborative effort of the Open Society Institute and the Association of Schools of Public Health in the European Region (ASPHER) (http://www.ensp.fr/aspher/C_projects/osi/osi_aspher.htm, accessed 17 June 2002), which focuses on education and training in public health in 13 countries of the region, is another considerable resource.

Protect the budget

Countries need to recognize that preventive services are a public good that should be financed from public funds, and that there should be some elements of compulsion and state control. Governments should protect the public health budget, perhaps as a proportion of the total health budget. The rationale is that, although the public values curative services more than public health services, investing in well designed preventive services has a greater impact on population health.

Adopt interdisciplinary and intersectoral approaches

The causes of ill health in CEE/NIS (and elsewhere) are complex. While public health service or health sector interventions as a whole can make a valuable contribution to improving health, the problem of poor health of the population cannot be solved without addressing the broader determinants of health. Local services need the support of central government, and coordination between different ministries, public institutions and agencies and nongovernmental organizations will be needed. Public health professionals must advocate this broad approach to health and its determinants.

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VIII. Hotel and Area Information

A. General Hotel Information

Hilton Washington & Towers

1919 Connecticut Avenue NW, Washington, DC 20009
Telephone: 1-800-HIL-TONS or 202-483-3000
Fax: 1-202-232-0438.

The Hilton Washington and Towers is located between Adams-Morgan and DuPont Circle, about four blocks north of the Dupont Circle metro stop. Below is some general hotel information. Further information is available through literature in your room or at the front desk.

Automated Teller Machine (ATM)

Located on the terrace level; there is \$1.50 per transaction fee.

Business Center

The hotel business center offers cellular phone rental, express mail service, a fax machine, photocopying, and more. Open Mon-Fri, 8 am – 5 pm; Sat, 8 am - 3 pm. Sun closed. Large print jobs can be done at Kinko's, 1612 K St NW (202-466-3777).

Check in/out

Check-in time is 3pm Check-out time is 11am

Concierge Desk

Located in the lobby; open from 6 am – 11 pm

Fitness Center

Use of the fitness center is \$10.00/day. For consecutive days usage the price decreases to \$7/second day; \$5/third day; \$4 fourth day; and \$3/fifth day.

Foreign Currency Exchange

Available at the front desk, 24 hours a day.

Guided Tours

Arranged through the transportation desk, open 7 am– 7 pm

Hotel Restaurants

The Capital Café has a la carte and buffet service for breakfast, lunch, and dinner.
Open 6:30 am - 11:30 pm

The 1919 Grill is only open for dinner and serves steaks, seafood, and pasta.
Hours vary.

The Deli is open for breakfast and lunch and serves sandwiches, salads, snacks, and beverages.
Open 7 am – 4 pm

McClellan's serves cocktails, snacks, and hors d'oeuvres from 2 pm – 1 am

Internet Access and Computer Terminals

AIHA will provide 20 computers—15 with Internet connectivity—and four laser printers for conference participants to use in the Military Room. Open 8 am - 6 pm

Laundry service

Available at \$4.50 for shirts; \$7.75 for trousers or skirts; and \$14.00 for suits. See form in your room.

Parking

Available at \$15.00 per day with in and out privileges for in-house guests.

Phone

To make a telephone call, a credit card or cash deposit is required by the front desk. Phone calls cost \$1.00 plus the highest AT&T current market rate. For international calls, dial 8-011 then the country code and number. The hotel does not charge for the first 60 minutes of a toll-free (1-800 or 1-888) call.

Pool

Open free to guests 6 am – 10 pm; towels are provided.

Room Service

Available 6 am – 12 am; see menu in your room.

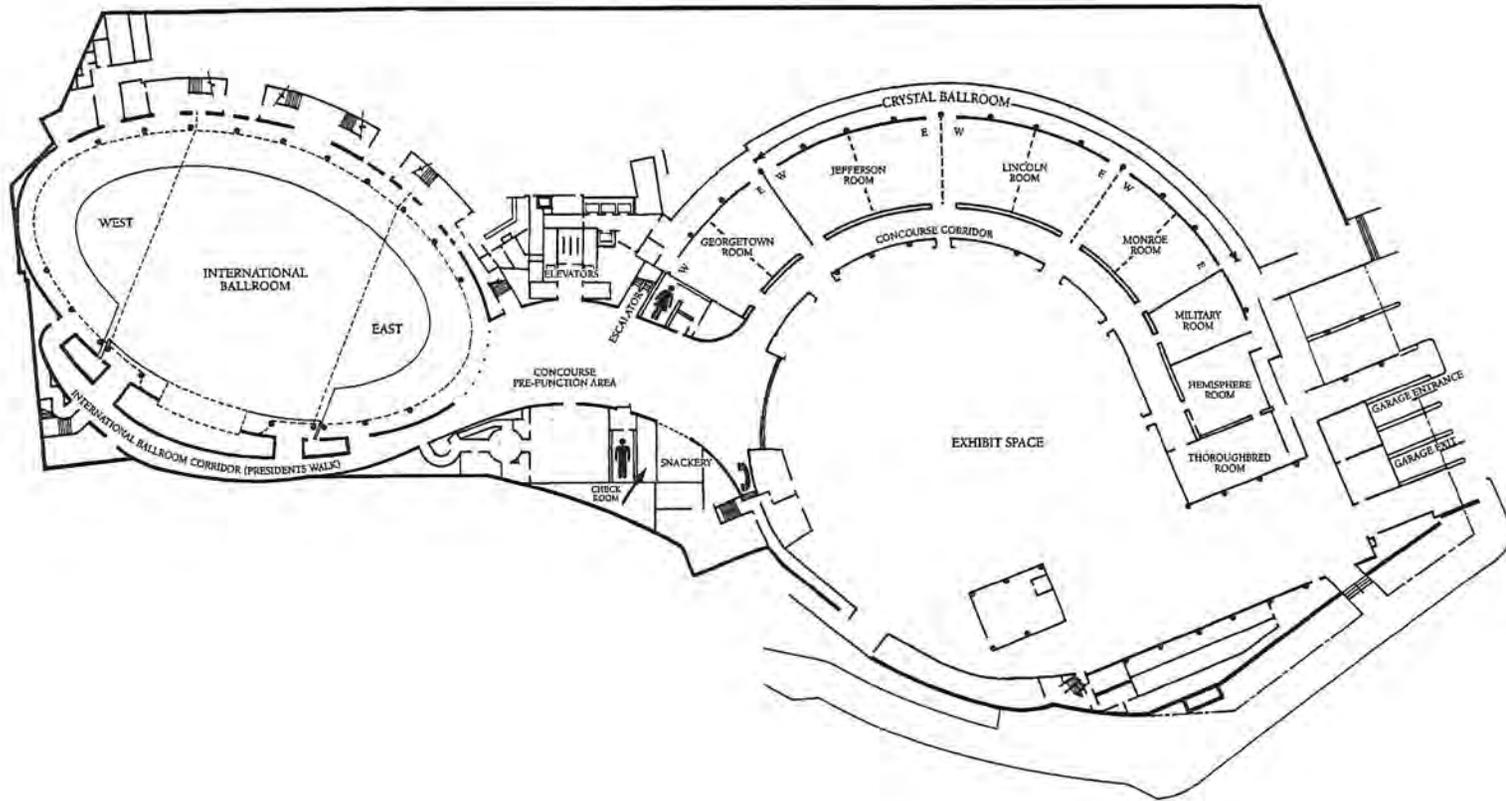
Safety Deposit Boxes

Complimentary safety deposit boxes are located in the front office; see the front desk.

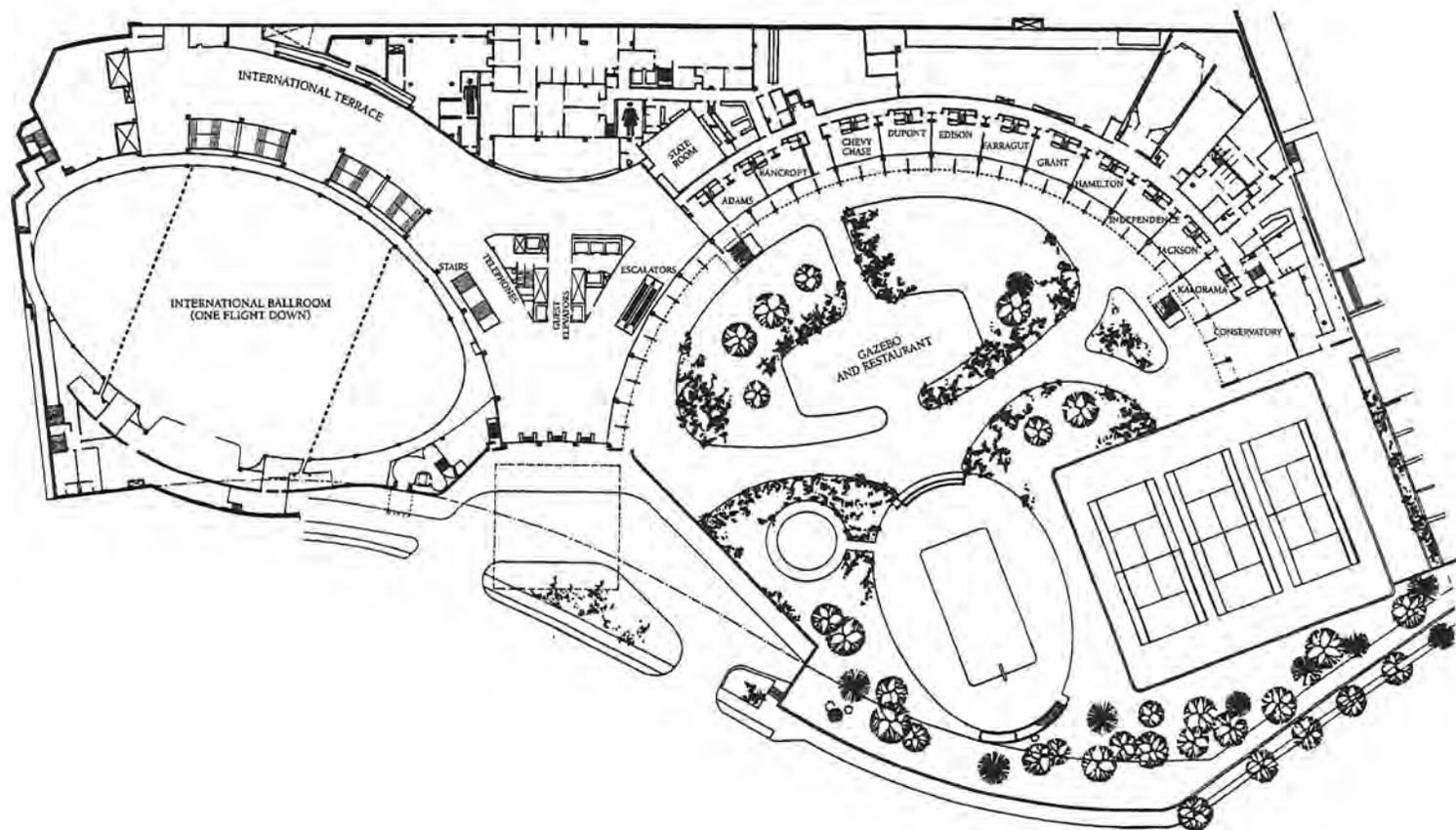
Tennis Courts

Tennis court rental fees are \$20/hour; racket rental fees are \$4/hour; and a can of tennis balls can be bought for \$5.00.

WASHINGTON HILTON AND TOWERS



WASHINGTON HILTON AND TOWERS



C. Area Information

Welcome to Washington DC! We hope you enjoy your stay in our nation's capitol and take time to visit the attractions that make Washington famous. Washington is a cosmopolitan city with ethnic neighborhoods and restaurants and a city center that is famous for its magnificent architecture, monuments and parks.

Getting Around

The hotel transportation desk can arrange a guided tour, or you can contact Tourmobile Sightseeing (202-554-5100 or 1-888-868-7707) for a 19-stop bus tour (9:30 AM – 4:30 PM. Adults \$18, Children \$8).

If you will be walking, you will notice that the Capitol building divides the city into four quadrants and that Washington's streets form a grid. Lettered streets run east-west and numbered streets run north-south. The simple layout is interrupted by large diagonal avenues and traffic circles. The Beltway is the freeway bypass that divides the city and suburbs.

With five lines and 83 stations, the Metro is America's second-largest rail transit system. Traveling by Metro is a convenient way to avoid traffic and parking problems. Metro stations are marked by large brown columns. Train routes are organized by colors, and each train's line color is displayed on its front and back. Metros are clean and safe, as they are monitored by video cameras and transit police issue citations to riders that eat, drink, smoke or litter in the stations or on trains. (Purchase farecards and one-day passes at the stations. You will need your farecard both to enter and exit the station. Rides cost \$1.10 to \$3.25, depending on the distance traveled. An unlimited one-day pass is \$5. Trains run 5:30 AM – 12 AM weekdays, Fri. and Sat. 8 AM – 2 AM, and Sun. 8 AM – 12 AM.)

Popular Sights

Below is a list of the area's most popular sights, areas, restaurants and shops. For more details, talk with the concierge at the hotel or a member of AIHA's Washington, DC staff.

The US Capitol Building is the city's center and houses the US House of Representatives and the US Senate. The Capitol is open to the public for guided tours only. (Tours Mon – Sat 9 AM–4:30 PM. Closed Sun. Tickets distributed beginning at 8.15 AM on a first-come, first-serve basis at the Capitol Guide Service kiosk. Free. 202-225-6827. The kiosk is located along the curving sidewalk southwest of the Capitol, near First Street and Independence Avenue SW. Metro: Capitol South or Union Station.)

The White House is the president's home. It is best viewed from the Ellipse, a large open field behind the White House, or from Lafayette Park in front of the building. The White House Visitor Center offers a limited number of tours. (Tours: Tues – Sat. Ticket distribution begins 7.30 AM, tickets specify tour time. Free. 202-456-7041 or 202-208-1631. Tickets, 15th and E Streets SE. White House, 1600 Pennsylvania Avenue NW. Metro: Federal Triangle.)

The Smithsonian National Zoological Park has a small mammal house, elephant house, great ape house, bears, reptiles and more. (Grounds 6 AM – 8 PM. Buildings 10 AM – 6 PM. Free. 202-673-4800. 3001 Connecticut Avenue NW. Metro: Cleveland Park or Woodley Park/Zoo.)

The US Holocaust Memorial Museum pays homage to the victims of the 1933 to 1945 Nazi tyranny in Europe. Exhibits include short films, audio recordings, photos and personal belongings. (10 AM – 5:30 PM. Free. Entry pass required to view permanent collections and available at the museum or by phone, 1-800-400-9373. 100 Raoul Wallenberg Place SW. Metro: Smithsonian.)

The National Mall

The National Mall is the heart of Washington and is famous for its elms, cherry trees and monuments. (Park Rangers on site 8 AM – 11:30 PM. Metro: Smithsonian.)

The Washington Monument is best viewed from the steps of the Lincoln Memorial at the western end of the Mall, where an inverted image appears in the large reflecting pool. At 555 feet (185 meters) tall, it is the Washington skyline's most prominent feature. Visitors can take an elevator to the observation deck. (8 AM – 11:45 PM. Elevator ride, 50 cents. 202-426-6840. Constitution Avenue and 15th Street NW. Metro: Smithsonian.)

The Lincoln Memorial is at the western end of the Mall near the banks of the Potomac River and the Arlington Memorial Bridge. It contains a 19-foot-high (six-meter) marble statue of Abraham Lincoln. (8 AM – 12 AM. Free. 202-634-1568. Constitution Gardens, 23rd Street and Constitution Avenue NW. Metro: Foggy Bottom.)

The Vietnam War Memorial is Washington's most popular memorial. The two walls of polished black marble are inscribed with the names of the 58,202 Vietnam veterans killed or missing from the war. (8 AM – 12 AM. Free. 202-619-7222. Constitution Avenue and Henry Bacon Drive NW. Metro: Smithsonian.)

The Korean War Memorial shows 19 figures of US ground troopers moving toward an American flag. (8 AM – 12 AM. Free. 202-619-7222. On the Mall, southeast of the Lincoln Memorial. Metro: Smithsonian.)

The Jefferson Memorial is located across the tidal basin from the western end of the Mall. It is a white marble, circular-domed structure patterned after a classic Greek temple. It contains a 19-foot (six-meter) tall bronze statue of President Jefferson. (Open all hours. Free. 202-426-6841. Tidal Basin's south bank at 15th Street NW. Metro: Smithsonian.)

The FDR Memorial is located along the cherry tree walk on the tidal basin near the national mall. The monument has four outdoor rooms that depict the 12 years that Franklin D. Roosevelt was president. (8 AM – 12 AM. Free. 900 Ohio Drive SW. 202-426-6841. Metro: Smithsonian.)

The Smithsonian Institute

Smithsonian Institution includes 14 separate museums. (9 AM – 5:30 PM. Free. 202-357-2700. 1000 Jefferson Dr SW. Metro: Smithsonian or Federal Triangle.) Among them are:

The National Air and Space Museum is the most popular museum in the world. The museum features original historic aircraft and spacecraft, a planetarium, an "Imax" theater, and full-scale models of a Lunar Lander and a spacelab. (9 AM – 5:30 PM. 7th Street and Independence Avenue SW. Metro: L'Enfant Plaza or Smithsonian.)

The National Museum of Natural History exhibits include dinosaur bones, plant and animal specimens from around the world, the legendary Hope Diamond and other gems, an "African Voices" exhibit, and an "Imax" theatre. (10 AM – 8 PM. "Imax" tickets: \$6.50 adults, \$5.50 seniors and children under 18. Museum: Free. 10th Street and Constitution Avenue NW. Metro: Smithsonian or Federal Triangle.)

The National Museum of American History. The diverse Americana collection includes first ladies' inaugural gowns and the original American flag. (10 AM to 5:30 PM. Free. 14th Street and Constitution Avenue NW. Metro: Smithsonian or Federal Triangle.)

The National Gallery of Art. (Working hours for museum and sculpture garden vary. Free. 202-842-6188. Independence Avenue and Seventh Street SW. Metro: Smithsonian)

Arlington, Virginia

Visitors can tour Arlington National Cemetery (the burial site of George Washington, John and Robert Kennedy and Jacqueline Kennedy Onassis, as well as thousands of statesmen, politicians and US armed forces veterans) and the Pentagon, which is the headquarters for the Department of Defense. (8 AM – 7 PM. Tours \$4.50. 703-697-2131. Tours begin at the west end of Memorial Bridge in Arlington, VA. Metro: Arlington National Cemetery.)

Restaurants and Cafes

A list of popular Washington restaurants and cafes listed by area of the city

Areas in Walking Distance from the Hilton

Adams Morgan: Adams Morgan is known for its nightlife and for being Washington's most ethnically diverse neighborhood. You can either exit the Hotel onto Connecticut Avenue and take Connecticut north to Columbia Road, where many of the restaurants are located, or exit the Hotel onto T Street and make a left. Follow T Street to 18th Street and make a left onto 18th. There are many restaurants and shops going up 18th.

On Columbia Road

Cashion's Eat Place, American/French, 1819 Columbia Rd., 202-797-1819
Grill from Ipanema, Brazilian, 1858 Columbia Rd., 202-986-0757
Pasta Mia, Italian, 1790 Columbia Rd., 202-328-9114
Perry's Restaurant & Catering, American/Sushi, 1811 Columbia Rd., 202-234-6218

On 18th Street

Felix Restaurant, American/Kosher, 2406 18th St., 202-483-3549
La Fourchette, French, 2429 18th St., 202-332-3077
Lauriol Plaza, Cuban/Mexican, 1835 18th St., 202-387-0035
The Little Fountain Café, American/Bistro, 2339 18th St., 202-462-8100
Tryst Coffeehouse and Bar, American/Deli/Smoothies, 2459 18th St. 202-232-5500
The Diner, 2453 18th St., 202-232-8800

Woodley Park

Exit the hotel onto Connecticut Avenue and walk to the right, heading up hill, or north. Woodley Park is located on the far side of the bridge, about four long blocks from the hotel. There are a number of restaurants located right on or just off Connecticut Avenue.

Chipotle, Fast Food/Mexican/Tex-Mex, 2600 Connecticut Ave., 202-299-9111
Lebanese Taverna Restaurant, Lebanese/Turkish, 2641 Connecticut Ave., 202-265-8681
New Heights Restaurant, American, 2317 Calvert St., 202-234-4110
Petits Plats, French, 2653 Connecticut Ave., 202-518-0018
Tono Sushi, Japanese, 2605 Connecticut Ave., 202-332-7300

Dupont Circle

Dupont Circle is a lively area with an urban park and eclectic shops. Exit the Hilton Hotel onto Connecticut Avenue and turn left, walking down the hill. Along Connecticut you will find many shops and places to eat.

City Lights of China, Chinese, 1731 Connecticut Ave., 202-265-6688
Bistro du Coin, Bistro/French, 1738 Connecticut Ave., 202-234-6969
Chipotle, Fast Food/Mexican/Tex-Mex, 1629 Connecticut Ave., 202-387-8261
Etrusco, Italian, 1606 20th St. (Q and 20th), 202-667-0047
Firehook Bakery & Coffee House, 1909 Q St. (Q and Conn.), 202-362-2253
Johnny's Half Shell, American/Seafood, 2002 P St. (P and Conn.), 202-296-2021
Raku – An Asian Diner, Asian, 1900 Q St. (Q and Conn.), 202-265-7258

Areas Accessible by Metro or Taxi

Capitol Hill is just what it says, the area surrounding the US Capitol Building. While it is accessible by Metro, we suggest you take a taxi to this part of town.

Anatolia, Turkish, 633 Pennsylvania Ave., 202-544-4753
Banana Café & Piano Bar, Caribbean/Cuban, 500 8th St., 202-543-5906
Barolo, Italian, 223 Pennsylvania Ave., 202-547-5011
Bistro Bis, Bistro/French, 15 E St., 202-661-2700
Café Berlin, German, 322 Massachusetts Ave., 202-543-7656
Market Lunch, American/Barbecue/Crabs/Seafood, 225 Seventh St., 202-547-8444

Chinatown/Downtown

Take the red line Metro from Dupont Circle toward Glenmont and get off at Gallery Place/Chinatown. Not only will you get to see the famous Friendship Arch of DC, but you will be able to enjoy all the fine food this area has to offer.

For these restaurants, use the Chinatown Metro exit

Full Kee Restaurant, Cantonese, 509 H. St., 202-371-2233

Burma Restaurant, Burmese, 740 Sixth St., 202-638-1280

Tony Cheng's Seafood Restaurant & Mongolian Barbecue, 621 H St., 202-371-8669

For these restaurants, use the MCI Center Metro exit

Austin Grille, American/BBQ/Tex-Mex, 750 E St., 202-393-3776

District Chophouse & Brewery, American/Steakhouse, 509 Seventh St., 202-347-3434

Jaleo, Spanish/Tapas, 480 Seventh St., 202-628-7949

Cleveland Park

There are many restaurants in this neighborhood known for historic rowhouses and a vibrant, urban, yet residential feel. The best way to get there is to take a taxi from the hotel or take the Red Line train in the direction of Shady Grove (or Grovesnor) from the Dupont Circle station.

Ardeo, American, 3311 Connecticut Ave., 202-244-6750

Lavandou Restaurant, French, 3321 Connecticut Ave., 202-966-3002

Nam-Viet & Pho-79, Vietnamese, 3419 Connecticut Ave., 202-237-1015

Palena, American, 3529 Connecticut Ave., 202-537-9250

Spices Asian Restaurant & Sushi Bar, Asian, 3333-A Connecticut Ave., 202-686-3833

Yanni's Greek Taverna, Greek, 3500 Connecticut Ave., 202-362-8871

Georgetown

Georgetown is a former tobacco port and is the capital's wealthiest neighborhood, known for elegant homes and upscale shops. Taxi may be the best way to reach Georgetown as the closest Metro station (Foggy Bottom) is a 10-block walk from this area of the city.

Aditi Indian Cuisine, Indian, 3299 M St., 202-625-6825

Amma Vegetarian, Indian/Vegetarian/Vegan, 3291 M St., 202-625-6625

Bistro Med, Turkish, 3314 M St., 202-333-2333

Chopsticks, Japanese, 1073 Wisconsin Ave., 202-338-6161

Billy Martin's Tavern, American, 1264 Wisconsin Ave., 202-333-7370

Old Glory BBQ, American/BBQ/Southern Soul, 3139 M St., 202-337-3406

Paolo's, Italian/Pizza, 1303 Wisconsin Ave., 202-333-7353

Red Ginger, Caribbean, 1564 Wisconsin Ave., 202-965-7009

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